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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: C2VE

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 **10/21/2013** (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 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Pat Halverson, Unit Supervisor — 12/10/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Program Specialist — 12/26/2013 (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
Posted 1/3/14 ML C2VE

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/28/2013
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5414

At the time of the standard survey completed August 8, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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. The facility was given an opportunity to correct before remedies were imposed. Annual LSC waiver K 55 has been appoved.

On October 21, 2013 the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on August 8, 2013 effective October 1, 2013, therefore the remedies outlined in our letter to you dated August 21, 2013, will not be imposed.

See attached CMS-2567B form for the results of October 21, 2013 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5414 December 26, 2013

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

Dear Mr. Dahl:

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

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

Effective October 1, 2013 the above facility is certified for:

92 Skilled Nursing Facility/Nursing Facility Beds

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

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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 10, 2013

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

RE: Project Number S5414024

Dear Mr. Dahl:

On August 21, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 8, 2013. 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 October 21, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 8, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 1, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 8, 2013, effective October 1, 2013 and therefore remedies outlined in our letter to you dated August 21, 2013, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under 0055 at the time of the August 8, 2013 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245414	A. Building B. Wing	10/21/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **10/01/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/01/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **10/01/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **10/01/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **10/01/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **08/08/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** PH/AK	**Date:** 12/10/2103	**Signature of Surveyor:** 12835	**Date:** 10/21/2013
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/8/2013	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C2VE

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 **08/08/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Chris Elmgren, HFE NEII 09/13/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 10/25/2013 (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
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5414

At the time of the August 8, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

Life safety code continuing waiver for deficiency cited at K55 is recommended for approval. Refer to the CMS 2567 and related documents for additional information.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5582

August 21, 2013

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

RE: Project Number S5414024

Dear Mr. Dahl:

On August 8, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pat Halverson
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802

Telephone: (218) 723-4637

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 17, 2013, 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 17, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 8, 2013 (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 February 8, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

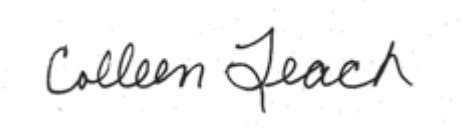
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

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 _____	08/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. CENSUS = 89	F 000	The following combined plan of correction and allegation of compliance is submitted solely to maintain certification in the Medicare and Medicaid programs. These written responses do not constitute an admission of non-compliance with any requirements nor an agreement with any findings.	ok 9/3/13 RN
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F279 DEVELOP COMPREHESIVE CARE PLANS The facility will use the results of the resident assessment to develop, review, and revise the resident's comprehensive plan of care. The facility will develop a comprehensive care plan for each resident that includes measureable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] NHA — TITLE: Administrator — (X6) DATE: 08/30/13

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 _____	08/08/2013

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 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed develop a comprehensive care plan for 1 of 6 residents (R83) who had complaints of burning with urination. Findings include: R83's diagnoses included benign prostatic hyperplasia (BPH), urinary incontinence, Parkinson's associated dementia, hypertension and congestive heart failure (CHF). The annual minimum data set (MDS) dated 5/22/13, indicated R83 had severe cognitive impairment, clear speech and usually understood others and needed assistance of one staff for activities of daily living (ADL's). The MDS also indicated R83 was frequently incontinent of urine. The care area assessment (CAA) dated 5/22/13, indicated R83 did not have a history of urinary tract infections (UTI's) but had risk factors contributing to UTI's such as frequently incontinent of urine and needed assistance for toileting needs. The assessment indicated R83 was on a prompt void scheduling program and was to be prompted to void on the toilet before brunch, supper and as needed (PRN). Staff were to report signs and symptoms of frequency, urgency, complaints of flank pain and burning to the nurse.	F 279	R83 was assessed and the care plan was reviewed and revised to address specific urinary symptoms and ongoing concerns such as c/o burning with urination. R83 will be insured a comprehensive care plan to reflect his urinary incontinence and history of burning with urination. It will also address nursing interventions to address urinary infection symptoms. The care plan will include the following: monitoring for resident c/o burning with urination and interventions to try to reduce the complaints of burning episodes during urination. Facility standing orders have been changed and the order to collect a UA/UC has been removed. This will ensure that if the resident is having symptoms of a UTI an MD will be called to update and an order would need to be received before collecting a urine sample.	

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 _____	08/08/2013

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 279	Continued From page 2 R83, interviewed on 8/6/13, at 10:31 a.m., stated there was still some burning with urination. A few minutes later nursing assistant (NA)G entered R83's room. NA-G informed R83 it was time to use the bathroom and used a gait belt to assist with walking to the bathroom. R83's family member was present and stated R83 tells the staff when he has burning with urination. After R83 had voided on the toilet, NA-G asked if there was burning during urination. R83 replied, "Not this time." NA-G stated R83 complained of burning with urination around the beginning of July. NA-G stated she had reported it to the nurse. A nurse progress note dated 7/5/13, indicated R83 was experiencing burning during urination. The medical record lacked any further documentation regarding R83's complaints of burning during urination. The elimination care plan dated 8/7/13, indicated R83 was frequently incontinent of bladder, prompt to void on the toilet or with the urinal before brunch, supper and prn. Assist with changing incontinent product. The care plan lacked any interventions to try to reduce the burning episodes during urination. The director of nursing (DON), interviewed on 8/8/13, at 11:05 a.m., stated . would expect the RN to follow up on resident complaints/concerns. The DON was questioned if interventions to reduce burning urination were attempted. The DON was not sure if interventions such as	F 279	Training will be provided to all nursing staff on the revised standing orders and steps to follow regarding general UTI symptoms and what to report to the nurse/MD. Training will be completed by 9/30/13. Completion Date: October 1, 2013.	

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 _____	08/08/2013

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 279	Continued From page 3 increased fluids had been suggested or attempted. The DON verified the care plan did not address interventions to try to reduce episodes of burning while urinating for R83.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan for safe transfers and the use of a gait belt was followed for 1 of 3 residents (R56) who were reviewed for accidents. Findings include: R56's diagnoses included diabetes mellitus type 2, anxiety state, restless legs syndrome, chronic airway obstruction and osteoarthrosis. The quarterly minimum data set (MDS) dated 6/13/13, indicated R56 was cognitively intact, required extensive assistance with transfers and toileting, and was occasionally incontinent of bladder and always continent of bowel. R56's care plan for elimination dated 1/10/13,	F 282	F282 SERVICES BY QUALIFIED PERSEONS/PER CARE PLAN The facility will ensure that the services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. The NAR involved in incident occurring on 8/7/13 was issued a discipline regarding transfer of resident R56 without use of a gait belt. R56' care plan was updated to reflect what staff is to do to prevent resident from self-transferring before a gait belt is applied. Training will be provided to nursing staff on R56 care plan, with regard to residents' transfer status instructions including use of gait belt and what to do if a resident is self-transferring	

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 _____	08/08/2013

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 282	Continued From page 4 indicated R56 required one staff for assistance during the day due to occasional incontinence of bladder and to toilet R56 upon request during the day-time hours. R56's care plan for transferring dated 10/8/12, indicated R56 required the assistance of one staff with gait belt. A To Do List Report (pocket care plan for nursing assistants) dated 8/6/13, indicated R56 required assistance of one staff for elimination assistance, was occasionally incontinent of bladder during the day, and was to be toileted upon request during day-time hours. The To Do List report further indicated R56 required assistance with transferring with one staff and gait belt. On 8/7/13, at 9:10 a.m. nursing assistant (NA)-D was observed to transfer R56 from the wheelchair to the toilet and back again without using a gait/transfer belt. NA-D was observed to have a white-striped woven cloth gait belt cinched around her waist as she entered R56's room, during the transfer process, and when departing R56's room. On 8/7/13, at approximately 9:30 a.m. NA-D stated R56 is usually shaky and will transfer rather quickly when assisted to stand up. NA-D confirmed a gait/transfer belt should be used when assisting R56 and had failed use a gait belt with R56 during the wheelchair to toilet transfer and return transfer. On 8/8/13, at 9:40 a.m. registered nurse (RN)-E stated R56 should have been transferred using a	F 282	before a gait belt can be applied. This training also includes the safety need to always use a transfer belt and, if a resident refuses, to report it to the nurse. Training will be completed by 9/30/13. Completion Date: October 1, 2013	

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 _____	08/08/2013

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 282 Continued From page 5

gait/transfer belt according to R56's care plan for transfers, toileting, and safety needs.

F 323 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure safety interventions were implemented as directed by the plan of care for 1 of 3 residents (R56) who were reviewed for accidents.

Findings include:

R56's diagnoses included diabetes mellitus type 2, anxiety state, restless legs syndrome, chronic airway obstruction and osteoarthrosis.

The quarterly minimum data set (MDS) dated 6/13/13, indicated R56 was cognitively intact, required extensive assistance with transfers and toileting, and was occasionally incontinent of bladder and always continent of bowel.

F 282 F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

F 323

The facility will ensure that the resident environment will remain free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.

R56, who was able to self-transfer, was reassessed to include an evaluation of current effectiveness of current transfer interventions.

MD was notified regarding R56 acute change in cognitive status to rule out infection. A PT order was received and resident was found to be at prior level of function with no decline in strength for transfers noted. Anti-rollbacks were applied to wheelchair.

Training will be provided to staff to re-educate on facility's Safe Lifting and Movement of Residents policy and procedure which directs on appropriate techniques and devices

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 _____	08/08/2013

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 323	Continued From page 6 The Fall Risk Assessment dated 8/2/13, indicated R56 was at risk for falls due to intermittent confusion, a history of falls, chairbound with assistance required for toileting, multiple medications and multiple diagnoses. R56's care plan for elimination dated 1/10/13, indicated R56 required one staff for assistance during the day due to occasional incontinence of bladder and to toilet R56 upon request during the day-time hours. The care plan for transferring dated 10/8/12, indicated R56 required the assistance of one staff with gait belt. A To Do List Report (pocket care plan for nursing assistants) dated 8/6/13, indicated R56 required assistance of one staff for elimination assistance, was occasionally incontinent of bladder during the day, and was to be toileted upon request during day-time hours. The To Do List report further indicated R56 required assistance with transferring with one staff and gait belt. An Incident Report dated 8/1/13, indicated R56 had an unwitnessed fall while attempting to self-transfer from the toilet to the wheelchair. The Incident Report further indicated R56 was not injured as [he/she] had attempted to transfer, missed the wheelchair and lowered self to the floor. On 8/7/13, at 9:10 a.m. R56 was observed seated in a wheelchair in [his/her] room and to press the call light. Nursing assistant (NA)-D knocked and	F 323	to lift and move residents. Training will be completed by 9/30/13. Random audits of resident transfers will be conducted by DON/designee, 2 X week X 2, then weekly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations. Completion Date: October 1, 2013	

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 _____	08/08/2013

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 323	Continued From page 7	F 323		

entered R56's room and asked R56 if [he/she] needed to use the rest room. NA-D was observed to have a white-striped woven cloth gait belt cinched around her waist as she entered R56's room. NA-D pushed R56's wheelchair into the rest room in R56's room, positioning the wheelchair at a 90 degree angle to the toilet. NA-D locked the brakes on R56's wheelchair, closed R56's room door, and then proceeded to wash her hands. R56 was able to undo the zipper and button on [his/her] pants. NA-D was observed to stand in front of R56, hooked her right arm under R56's right arm and assisted R56 to stand. R56 was observed to reach for and grab the steel gray, wall-mounted grab bar to the left of the toilet and hold on with both hands while NA-D assisted R56's pants and undergarment to loosen and fall toward's R56's knees. R56's legs were observed to be shaking during the sit-to-stand process. R56 pivoted to the left and sat shakily down onto the toilet seat. NA-D and surveyor stepped out into R56's room near the entrance to R56's bathroom to provide R56 privacy. NA-D asked R56 to tell her when [he/she] is finished. At approximately 9:15 a.m. NA-D was observed to put on gloves as R56 signaled her verbally [he/she] was done in the bathroom. R56 reached for the wall-mounted grab bar with both hands as NA-D stood in front of R56, hooked her left arm under R56's right arm. NA-D used her right gloved hand with some toilet paper and assisted R56 in wiping R56's bottom area. NA-D disposed of the toilet paper in the toilet, pulled up R56's undergarment and pants, and held onto R56's right arm while R56 pivoted on [his/her] feet to the right. R56 then sat down in the wheelchair while NA-D guided the back of R56's pants/waistband with her right hand. R56 was observed to secure the front

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 _____	08/08/2013

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 323	Continued From page 8 zipper and button of [his/her] pants. NA-D unlocked the wheelchair brakes. NA-D removed the gloves and washed her hands. NA-D pushed R56 into the room and left R56's room. On 8/7/13, at approximately 9:30 a.m. NA-D stated R56 is usually shaky and will transfer rather quickly when assisted to stand up. NA-D confirmed a gait/transfer belt should be used when assisting R56 and she had failed use a gait belt with R56 during the wheelchair to toilet transfer and return transfer. On 8/8/13, at 9:40 a.m. registered nurse (RN)-E stated R56 should have been transferred using a gait/transfer belt according to R56's care plan for transfers, toileting, and safety needs. RN-E further stated R56 had not been evaluated for transfers after the 8/1/13, fall, and had been safe with transfers up to that point. RN-E confirmed R56 is still receiving restorative nursing, has been shaky and unsteady, and has been dealing with some sort of upper respiratory problem which is being evaluated. A Safe Lifting and Movement of Residents policy and procedure (undated) directed the facility staff to use appropriate techniques and devices to lift and move residents. The policy and procedure further directed staff to document resident transferring and lifting needs in the care plan, and responsible staff will be trained in the use of manual lifting devices such as gait/transfer belts.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329	F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	

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 _____	08/08/2013

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 329	Continued From page 9 drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic 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 adequately identify, assess and monitor indications for ongoing use of medications for 1 of 5 residents (R 43) reviewed for unnecessary medications. Findings include: R43, whose diagnoses included depression, chronic airway obstruction (COPD), anxiety and insomnia, did not have a gradual dose reduction	F 329	The facility will ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition is diagnoses and documented in the clinical record; and residents who use antipsychotic drugs received gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. MD was notified again of R43 need for dose reduction on resident's two antidepressants and explanation of CMS requirements. Since notification, MD has since reduced Zoloft and completely discontinued the other. All other residents on an Antipsychotic medication will be reviewed by the IDT team with regards to psychotropic medications they are currently taking, last dose reductions (if any), clinical need for medication, if medication is currently still effective at current	

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 _____	08/08/2013

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 329	Continued From page 10 (GDR) attempted for her two prescribed antidepressants. R43 was admitted on 12/7/11, with physician orders for Zoloft (antidepressant) 50 mg every morning. R43 scored 14 out of 27 on her admission PHQ-9 (a tool for screening for and measuring depression,) which indicated moderate depressive symptoms. Remeron (an antidepressant with a different type of action than Zoloft,) 15 mg every night at bedtime, was added to her medication regimen on December 15, 2011. R43 remained on the same dosages of both the antidepressants as of 8/8/13, without a GDR attempt, or rationale as to why a GDR was clinically contraindicated. Review of the monthly pharmacist consultant (Pharm-D) reviews revealed a note from the Pharm-D to the physician on 8/20/12, asking the physician to "re-evaluate continued need for Zoloft 50 mg daily and Remeron 15 mg qhs (at bed time.) Please consider a reduction... to ensure the lowest effective dose." On 8/22/12, the physician responded, "Pt (patient) is doing well on these doses. No changes at this time." The monthly Pharm-D reviews, dated 9/11/12 through 7/8/13, established no other Pharm-D recommendations were made concerning a GDR of the two antidepressants. Review of the physician's documentation noted no other mention of a GDR or rationale as to why a GDR was clinically contraindicated.	F 329	dose, and if a dose reduction need is appropriate. MD would be notified if there is any issue with any specific medication and topics listed above. Letters are currently being drafted and sent to rounding MDs to re-educate on requirements for attempted dose reductions on psychotropic medications and the need for appropriate clinical rationale if dose reduction is contraindicated. Pharmacy consultant continues to round monthly to review all medications to ensure reductions are requested from MD. Audits will be completed for all new residents coming into the facility with an order for an antipsychotic medication, to ensure the physician addresses the medication and there is an appropriate clinical rationale if dose reduction is contraindicated. Resident audit results will be brought to the QAPI committee for review and further recommendations. Completion Date: October 1, 2013	

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 _____	08/08/2013

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 329	Continued From page 11 Subsequent PHQ-9s indicated R43 was minimally to moderately depressed through 9/24/12, and minimally depressed, or not at all, from 12/20/12 through 6/10/13. R43's care plan, dated 1/11/13, directed staff to monitor and progress note of any anxiousness, sadness or worries. The nursing To Do List Report, dated 8/6/13, directed staff to monitor for anxiousness, sadness and worries. Review of the shiftly report for 7/7/13 through 8/6/13 established R43 showed no signs of anxiousness, sadness or worries. The Care Area Assessment (CAA) summary dated 6/10/13, noted no documented depressive behaviors in the previous seven days. The registered nurse (RN)-A stated, on 8/9/13 at 12:20 p.m., that R43 had not expressed any depressed thoughts to her or showed any depressed behaviors since May (2013). However, when R43 experience a exacerbation of her COPD, she was more reclusive and might stay in her room for meals.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY The facility will ensure that food is procured from sources approved or considered satisfactory by Federal, State, or local authorities; and store, prepare, distribute and serve food under sanitary conditions.	

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 _____	08/08/2013

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 371	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was served in a sanitary manner in 2 of 2 dining rooms. This had the potential to affect all 89 residents served in the 2 dining rooms. Findings include: Disposable gloves were procured from an unclean location and used to assist R16 with food preparation. On 8/7/13, at 11:45 a.m. nursing assistant (NA)-E was observed in the Central Park dining room to sit down next to R16 and remove a pair of disposable gloves from the right hand pocket of her uniform top. NA-E was then observed to put the gloves on, handle R16's sandwich with the gloved hands, open up the sandwich to spread mayonnaise on the bread, and then put the sandwich on R16's plate. NA-E was then observed to remove the used gloves from her hands and place the gloves on the table top along with the used knife resting on top of the used gloves. R16 was observed to pick up the sandwich and take a few bites. At 11:52 a.m. NA-E was observed to pull another pair of disposable gloves from the right hand pocket of her uniform top, put on the gloves, and pick up R16's muffin, the used knife, and a small, disposable container of butter off of the table. NA-E was observed to remove the outside paper	F 371	(NA)-E and (DA)-E was disciplined regarding incident on 8/7/13. (DA-E) was suspended pending investigation after incident noted on 8/7/13. Training will be provided to staff to re-educate on facility's Preventing Foodborne Illness Employee Hygiene and Sanitary Practices Policy. Audits will be completed by dietary manager 3x/week X 4, then weekly X 2 of dining room to ensure that all staff is in compliance with this policy. All food service employees will also be re-educated on the proper use of utensils such as tongs and gloves as tools to prevent food borne illness. Audits will also be completed by dietary manager 3x/week to ensure this is occurring properly. Audit results will be brought to the QAPI committee for review and further recommendations. Completion Date: October 1, 2013	

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 _____	08/08/2013

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 371	Continued From page 13	F 371		

wrapper from the muffin, open the small butter container, and spread butter on the muffin before handing the muffin to R16. R16 took a few bites of the muffin and returned it to the plate. NA-E removed the gloves from her hands and set them on top of the previously used gloves on the table.

On 8/7/13, at 12:20 p.m. NA-E stated she always puts gloves in a pocket when going to help with feeding the residents in the dining room. NA-E further stated she touched R16's sandwich and muffin with gloves from pocket.

On 8/7/13, at 2:10 p.m. the dietary manager (DM) was interviewed and stated nursing assistants should not be using gloves out of their pockets and touching the food when helping the residents with a meal. The DM further stated the nursing assistants should be using hand sanitizer after the gloves are removed in order to clean their hands.

On 8/7/13, at 11:00 a.m. during observations of the brunch meal in the main dining room, dietary aid (DA)-A was wearing gloves on both hands and pushing a cart from table to table to pour milk, juice and water for individual residents. DA-A was observed to fill four resident water glasses with ice from the tub used to chill plastic containers of milk. DA-A dipped the glasses into the ice and push the ice into the glass or pick up ice with the other gloved hand.

The dietary manager (DM), interviewed on 8/7/13,

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 _____	08/08/2013

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 371	Continued From page 14 at 11:12 a.m., stated there should be a separate container of ice. DA-A should not be scooping the glass into the ice or touching the ice. At 11:25 a.m. the DM indicated that was not the way things were done. That was not how the staff was trained and it was not the facility's policy. The facility's Preventing Foodborne Illness Employee Hygiene and Sanitary Practices Policy (the policy was not dated) indicated all employees who handle, prepare or serve food would be trained in the practices of safe food handling and preventing food borne illness. Employees would then demonstrate the knowledge and competency in these practices prior to working with food or serving food to the residents. The policy directed staff to wash their hands after handling soiled equipment or utensils. Food service employees would be trained in the proper use of utensils such as tongs and gloves as tools to prevent food borne illness.	F 371		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide clean grab bars in 8 of 23 shared resident bathrooms.	F 465	F 465 SAFE/FUNCTIONAL/SANITARY/ COMFORTABLE ENVIRONMENT The facility will ensure that the Resident bathroom grab bars will remain free of tape and sticky adhesive and resident bathroom grab bars will be inspected making sure the bars will not have tape on them.	

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 _____	08/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 15 Findings include: During the initial tour on 8/5/13, at 1:00 p.m., on the Canal Park and Green Valley units, residents' bathrooms were shared between two residents. R75's bathroom grab bar was noted to have black adhesive sandpaper material held tight with red tape (similar to duct tape). During resident observations on 8/6/13, at 9:10 a.m., R28's bathroom was noted to have the same type of black sandpaper tape on the grab bar. The environmental tour on 8/8/13, at 10:45 a.m., established numerous bathrooms, including but not limited to R90, R103, R33, R94, and R29, had black sandpaper type tape on bathroom grab bars. Some of the tape was peeling off the grab bar with a sticky adhesive remaining on the bar. All were observed to be soiled. The Maintenance Engineer, interviewed on 8/8/13 at 10:30 a.m., stated the sandpaper grip tape was difficult to clean and required the use of a scrub brush. The grab bars were to be cleaned everyday when the bathrooms were cleaned. The sandpaper-like grip tape was soiled and had not been cleaned the way it should have been. He stated there were approximately 12 bathrooms with the black sandpaper tape on the grab bars.	F 465	All residents' bathroom grab bars were cleaned and tape and adhesive was removed. Maintenance Supervisor will educate the Housekeeping staff re: cleaning of resident bathroom grab bars. Monthly audits of grab bars will be completed by the Maintenance Supervisor. The Administrator will be responsible for compliance. Completed date: August 8th, 2013	

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

F 5414021

PRINTED: 08/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

Building #1

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

FIRE SAFETY

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division . At the time of this survey, Viewcrest Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:

Health Care Fire Inspections
STATE FIRE MARSHAL DIVISION

POC ok
w/AW for K55
PB 9-13-13

RECEIVED
SEP - 9 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

DC: 09.17.2013
EXIT: 08.08.2013

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

Robert Dahl | Administrator | 09/05/13

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 01 - MAIN BUILDING 01 B. WING _____	08/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		

444 CEDAR STREET, SUITE 145
ST PAUL, MN 55101-5145 or
By email to:

Barbara.lundberg@state.mn.us and
marian.whitney@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

Building #1

Viewcrest Health Center, Building #1, is a 1-story building with a partial basement. The original building was constructed in 1960 with additions constructed in 1968, 2002 and 2008. The 1960 and the 1968 building is type II(111) construction. The 2002 building is two (2) story Type II(000), and the 2008 building is Type II(11) 2-story. Therefore, the 1960, 1968, and 2002 building was inspected as one building to Type II(000) construction. The 2008 building was inspected as a separate building.

The building is fully protected by automatic fire sprinklers. The facility has a complete fire alarm system with smoke detection in the corridors and

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 _____	08/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 92 beds and had a census of 88 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 055 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Every patient sleeping room has an outside window or outside door, except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8 This STANDARD is not met as evidenced by: Based on observation, an exterior courtyard was enclosed in 2002, and an addition was constructed to the West side of the building in 2008. The enclosing of the courtyard and the addition ,created a condition such that some resident rooms no longer have an outside window. This deficient practice could affect all occupants including residents, staff and visitors, in the area without exterior windows. Findings Include: On facility tour between on 8-7-13 at 9:30AM, it was observed that 27 of 92 resident rooms do not have a window to the exterior. This is because an exterior courtyard was enclosed in 2002, and the 2008 addition to the West. The courtyard(s) are now an enclosed year-round usable indoor courtyards. This deficient practice was confirmed by the	K 055	K055 RESIDENT ROOMS Waiver for windows to the outside-please see attached.	

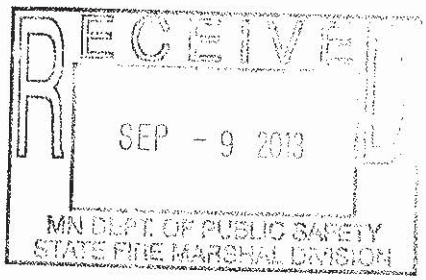
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/07/2013

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING **02 - VIEWCREST HEALTH CENTER** B. WING _____	**08/07/2013**

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

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

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

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

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Friday, September 13, 2013 5:45 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: Juntunen, Jeffrey (DPS); 'rdahl@sfhs.org'; 'Colleen Leach'; 'Jim Loveland'; 'Mark Meath'; 'Mary Henderson'; 'Nicole Steege'; 'Shellae Dietrich'; Whitney, Marian (DPS)
Subject: Viewcrest Health Center (245414) K55 Annual Waiver Request - Previously Approved - No Changes

This is to inform you that Viewcrest HC is requesting an annual waiver for K55, resident rooms without outside windows. The exit date was 8-8-13.

I am recommending that CMS approve this waiver request.

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

Name of Facility: Viewcrest Health Center

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

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

Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature)	Title: Fire Safety Supervisor	Office: State Fire Marshal	Date: 9-17-13