



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 3, 2024

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

RE: CCN: 245414
Cycle Start Date: July 11, 2024

Dear Administrator:

On , we notified you a remedy was imposed. On August 9, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 7, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 8, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 24, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 8, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 7, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



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July 24, 2024

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

RE: CCN: 245414
Cycle Start Date: July 11, 2024

Dear Administrator:

On July 11, 2024, a survey was completed at your facility by the Minnesota Department(s) 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 8, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 8, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 8, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 8, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Viewcrest Health Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 8, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Alex Warren, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

A Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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 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.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 11, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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**

Viewcrest Health Center

July 24, 2024

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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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

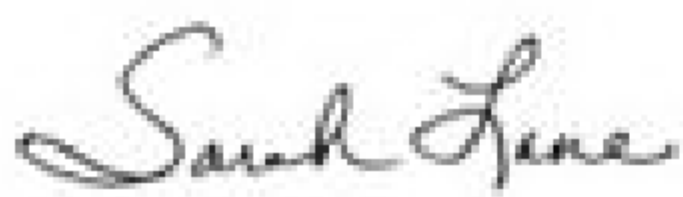
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2024
NAME OF PROVIDER OR SUPPLIER VIEWCREST HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 000	Initial Comments On 7/8/24 through 7/11/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 7/8/24 through 7/11/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54145265C (MN98276) H54145380C (MN104628) H54145381C (MN104629) H54145396C (MN104757) H54145542C (MN104735) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/01/2024

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

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F 000	Continued From page 1			F 000			
F 554 SS=D	Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure nebulized medications were administered safely for 1 of 1 resident (R8) who was observed to self-administer a nebulizer and had not been assessed as safe to do so. Findings include: R8's quarterly Minimum Data Set (MDS) dated 6/14/24, identified intact cognition and diagnoses of spastic quadriplegic cerebral palsy (CP), asthma, chronic cough, and shortness of breath. R8 had functional limitations in range of motion of both upper extremities, needed substantial assistance with oral care, and was dependent for hygiene and transfers. R8's care plan dated 4/2/24, identified an alteration in respiratory status related to asthma and spastic CP with interventions for a nurse to administer inhalers and nebulizer's as ordered as R8 was unable to do so for herself. It further identified nursing staff to monitor lung sounds, report concerns, keep head of bed elevated when			F 554			8/7/24

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F 554	Continued From page 2 in bed, and observe for the need for oxygen. An assessment for self-administration of medication dated 1/4/24, identified R8 was unable to self-administer medication. R8's provider orders dated 9/1/22, identified orders for albuterol sulfate (a medication used to treat and prevent breathing problems) three milliliters (mL) two times daily to be administered via inhalation with a nebulizer (a machine used to directly administer medications into the lungs). During an observation on 7/10/24 at 7:30 a.m., R8 was observed in her bed with the head of bed elevated to about 45 degrees, her eyes were closed, and head was bent to the left and forward. There was a nebulizer machine running and the pipe (the mouthpiece for the medication delivery) was near the left side of her face. It could not be seen how much medication was left in the chamber of the device, if any. At 7:48 a.m., licensed practical nurse (LPN)-A was observed to go into R8's room, wake resident and remove the mouthpiece and tubing from her and set it on the table to the left of the bed and went back to the medication cart. During an interview on 7/10/24 at 1:08 p.m., R8 confirmed she uses the nebulizer two times a day and the nurse would set it up and hand it to her. During an interview on 7/10/24 at 1:12 p.m., LPN-A confirmed setting up R8's nebulizer treatment that morning. The medication administration record did not reflect an order to self-administer nebulizer treatments, which LPN-A thought she had.	F 554	medications will be reviewed for appropriate self-administration. Director of Nursing and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: 1. Random observational audits identifying residents using nebulized medications will be completed by Director of Nursing/designee 2x the week of July 29, 2024, and then 3x/week thereafter beginning the week August 5, 2024, until compliance is achieved. 2. Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: 08/07/2024		

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F 554	Continued From page 3 During an interview on 7/11/24 at 9:42 a.m., registered nurse (RN)-A confirmed the self-administration of medication assessment for R8 indicated she could not administer her own medications. During an interview on 7/11/24 at 11:01 a.m., the director of nursing (DON) stated it would be her expectation that residents who are self-administering medication would be assessed and have an order to do so. The DON further stated this was important for safety. A policy, Self-Administration of Medication by Residents dated 5/1/24, identified the purpose was to provide guidance to staff for assessing and accommodating resident's wish to self-administer their medications. All residents would be asked their preference for self-administration and an assessment would be done on those wishing to do so. An assessment would be performed based on the resident's cognitive status, physical status, and which medication to evaluate if they were clinically appropriate to self-administer medication.	F 554			
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation	F 645			8/7/24

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F 645	Continued From page 4 performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in	F 645			

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F 645	Continued From page 5 the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Level I Pre-Admission Screening and Resident Review (a requirement to help ensure individuals are not inappropriately placed in nursing homes for long term care (PASSAR)) was completed, retained in the medical record, and readily available to ensure continuity of care with mental health needs for 1 of 1 resident's (R30) reviewed for PASSAR. Findings include: R30's quarterly Minimum Data Set (MDS) dated 4/18/24, identified intact cognition and diagnoses of anxiety, depression, and manic depression (bipolar disease). R30's undated face sheet, received on 7/11/24, identified R30 was admitted to the facility on 5/17/23, and diagnoses included bipolar disorder, major depressive disorder, and panic disorder.	F 645	F: 645 It is Viewcrest Health Center's policy have a completed PASARR Screening for MD & ID CFR(s) upon admission into Skilled nursing facility. Director of Social Service and/or designee will implement corrective action for resident R30 affected by this practice by: 1. R30 had updated PASARR completed to review level of care and screening for MD and ID to determine continuation of appropriate placement in SNF on 7/10/2024. Director of Social Service and/or designee will assess residents having the potential to be affected by this practice including: 1. All residents who reside at the facility have the potential to be affected by this deficient practice.		

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F 645	Continued From page 6 During interview on 7/10/24 1:43 p.m., the director of social services (DSS) reviewed the document labeled "PAS" in R30's medical record. The "PAS" document dated 1/8/18, identified "Senior LinkAge Line did not complete the PAS and forwarded the PAS request to a county/managed care organization for PAS processing." DSS confirmed the document did not identify if a PASSAR level 1 was completed or if a PASSAR level II was recommended. During interview on 7/10/24 at 3:15 p.m., the director of nursing (DON) stated the director of social services was responsible for the PASARR and would expect them to complete the task. A policy, Pre-Admission Screening dated 3/7/22, identified the care center will ensure all individuals seeking admission will receive a Pre-Admission Screening (PAS) and the PAS notice indicating he/she has been screened will be retained by the care center.	F 645	Director of social service and/or designee will implement measures to ensure that this practice does not recur including: 1. The PASARR will be indicated as completed prior to admission into facility 2. The PASARR will have appropriate follow up from indicated agencies on PASARR (ex: County) which will be kept on file along with PASARR. 3. All residents who reside at the facility will have PASARR's reviewed for appropriate completion Director of Social Service and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: 1. Specific audits will be completed by the Director of Social service/designee 1x/week for all admissions the previous week beginning the week of July 29, 2024, and then weekly thereafter, until compliance is achieved. 2. Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: 08/07/2024		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695			8/7/24

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NAME OF PROVIDER OR SUPPLIER VIEWCREST HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHURCH STREET DULUTH, MN 55811		
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F 695	Continued From page 7 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to properly care for oxygen and nebulizer equipment for 1 of 2 residents (R8) reviewed for respiratory equipment to help prevent the potential for infection. Findings include: R8's quarterly Minimum Data Set (MDS) dated 6/14/24, identified intact cognition and diagnoses of spastic quadriplegic cerebral palsy (CP), asthma, chronic cough, and shortness of breath. R8's care plan dated 4/2/24, identified an alteration in respiratory status related to asthma and spastic CP with interventions for a nurse to administer inhalers and nebulizers as ordered as R8 was unable to do so for herself, monitor lung sounds, report concerns, keep head of bed elevated when in bed, and observe for the need for oxygen. R8's provider orders dated 9/1/22, identified orders for albuterol sulfate (a medication used to treat and prevent breathing problems) three milliliters (mL) two times daily to be administered via inhalation with a nebulizer (a machine used to directly administer medications into the lungs), oxygen via mask or cannula at one to four liters per minute (LPM) as needed, to change the nebulizer mouthpiece and tubing every week on Friday, and daily at bedtime to wash nebulizer mask, mouthpiece, and reservoir and leave out to dry overnight. The orders did not contain an order set to change the oxygen tubing, cannula, or	F 695	F: 695 It is Viewcrest Health Center's policy to properly care for Oxygen and nebulizer equipment Director of Nursing and/or designee will implement corrective action for resident R8 affected by this practice by: 1. R8's mouthpiece and chamber were cleaned, and her oxygen tubing was replaced on 07/11/2024. 2. R8's oxygen tubing replacement order was completed on 07/11/2024. Director of Nursing and/or designee will assess residents having the potential to be affected by this practice including: 1. All residents with oxygen and nebulized medications have the potential to be affected by this deficient practice. Director of Nursing and/or designee will implement measures to ensure that this practice does not recur including: 1. All licensed staff will be re-educated on nebulized medication and Oxygen care policy the week of July 29th. 2. All other residents with nebulized medications and oxygen will be reviewed for appropriate care of equipment and orders to replace O2 tubing per policy. Director of Nursing and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: 1. Random audits of nebulizer care and		

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F 695	Continued From page 8 bubbler (a bottle used for water to help humidify the oxygen). On 7/8/24 at 2:13 p.m., R8's nebulizer machine was sitting on a table near her bed with the tubing hooked up to the chamber (the piece the liquid medication is placed in), and the chamber attached to the mouthpiece. There was a small amount of clear liquid in the bottom of the chamber and clear droplets of liquid covering the upper portions of the chamber. Oxygen tubing was draped over the table and did not contain a date. R8 confirmed she used the oxygen at night and the nebulizer two times a day. On 7/10/24 at 1:08 p.m., R8 was wearing oxygen and her nebulizer machine was sitting on a table near her bed with the tubing hooked up to the chamber and mouthpiece with a small amount of clear liquid in the bottom of the chamber and clear droplets of liquid covering the upper portions of the chamber. R8 confirmed she used the nebulizer twice a day. During an interview on 7/10/24 at 1:12 p.m., LPN-A stated oxygen tubing was to be changed every Friday night for everyone, it was the same for nebulizer mouthpiece and tubing. LPN-A confirmed she did not disassemble and rinse out the nebulizer chamber and mouthpiece after R8's treatment this morning. During an interview on 7/11/24 at 9:42 a.m., RN-A stated the oxygen and nebulizer tubing, and mouthpieces were changed out weekly on the overnight shift and were to be dated when changed. RN-A also stated the nebulizer mouthpiece and chamber should be disassembled, rinsed out, and left to air dry after	F 695	oxygen tubing replacement will be completed by the Director of Nursing/designee 2x the week of July 29, 2024, and then 3x/week thereafter beginning the week August 5, 2024, until compliance is achieved. 2. Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: 08/07/2024		

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OMB NO. 0938-0391

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F 695	Continued From page 9 use. During an interview on 7/11/24 at 11:01 a.m., the director of nursing (DON) stated her expectation was for tubing to be dated when replaced weekly, and for a nebulizer mouthpiece and chamber to be taken apart and rinsed out after use. These items were important for infection control and medication safety. A document, Viewcrest Health Care Nebulizer Cleaning dated 2/15/23, identified the purpose was to provide guidelines for the cleaning of a nebulizer. After each use, disassemble the nebulizer, rinse each piece with warm water, and let air dry on a clean paper or cloth towel. Daily the pieces were to be washed with warm soapy water and let air dry on a clean paper or cloth towel. A document, Viewcrest Health Care Oxygen dated 9/23/23, identified oxygen tubing and cannula would be replaced and marked with the date weekly.	F 695			
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(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. §483.60(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	F 809			8/7/24

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F 809	Continued From page 10 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(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 interview and document review, the facility failed to consistently offer and provide a nutrient and/or calorie substantive snack after the dinner meal and before bedtime, leaving 15 hours between the evening and morning meals. This had the potential to affect 93 out of 94 residents who take in sustenance orally. Findings include: During interview on 7/08/24 at 5:19 p.m., R47 stated it has been months since a snack was offered after the dinner meal and before bedtime. R47's quarterly Minimum Data Set (MDS) date 4/16/24, identified intact cognition and a diagnosis of diabetes mellitus. During interview on 7/08/24 at 12:14 p.m., dietary manager (DM) stated mealtimes are 7:30 a.m., 11:30 a.m., and 4:30 p.m. with snacks offered at 2:30 p.m. (siesta snack pass) and 7:30 p.m. (bedtime snack pass). Snack carts are prepared and delivered to the units by kitchen staff. Kitchen staff complete the 2:30 p.m. snack pass and nursing staff complete the 7:30 p.m. snack pass. DM used a "snack sheet log" to ensure each resident was offered a snack twice a day.			F 809	F: 809 It is Viewcrest Health Center's policy to provide a nutrient and/or calorie substantive snack after dinner meal and bedtime. Dietary Manager and/or designee will implement corrective action for resident R47 affected by this practice by: 1. R47 will have a bedtime snack offered on a daily basis. Dietary Manager and/or designee will assess residents having the potential to be affected by this practice including: 1. All residents have the potential to be affected by this deficient practice. Dietary Manager and/or designee will implement measures to ensure that this practice does not recur including: 1. Dietary staff will be re-educated on bedtime snack pass. Dietary staff will be responsible to pass the bedtime snack pass to each resident. 2. Snack pass logs will be re-implemented, and dietary staff will be educated on their use.		

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F 809	Continued From page 11 During interview on 7/09/24 at 3:05 p.m., nursing assistant (NA)-A confirmed working afternoon's on R47's unit. NA-A stated kitchen staff do not deliver a snack cart to the unit in the evenings and a bedtime snack pass never occurs. During interview on 7/09/24 at 3:17 p.m., NA-B confirmed working afternoons on a unit other than R47's unit. NA-B stated a bedtime snack pass "sometimes" occurred on this unit. If snacks were distributed/offered, it would be by kitchen staff, not nursing staff. During interview on 7/09/24 at 3:23 p.m., NA-C confirmed working afternoons on a unit other than R47's and NA-B's unit. NA-C stated kitchen staff will "sometimes" provide a snack cart in the evenings. A bedtime snack was not offered to each resident. The snack cart remained next to the nurse's station and if a resident wanted a snack, they would have to ask for one. During interview on 7/10/24 at 1:38 p.m., the director of nursing (DON) explained a bedtime snack pass was required at the facility because there "was too many hours between dinner and breakfast." The DON stated it would be her expectation kitchen staff deliver an evening snack cart to each unit and nursing staff brought the cart room to room, offering a snack to each resident. DON stated it was important to offer a bedtime snack for medical and quality of care purposes. During interview on 7/11/24 at 8:29 a.m., the administrator stated having the expectation a bedtime snack was offered to each resident every evening. A bedtime snack was important for medical and quality of care purposes.	F 809	Dietary Manager and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: 1. Random audits identifying that snacks are being offered to residents at bedtime will be completed by Dietary Manager/designee 2x the week of July 29, 2024, and then 3x/week thereafter beginning the week August 5, 2024, until compliance is achieved. 2. Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: 08/07/2024		

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F 809	Continued From page 12			F 809			
	June and July 2024 snack sheet logs were requested, but not provided. The last documented snack pass occurred on May 4th, 2024.						
	A policy, Weight Monitoring Program dated 1/18/21, identified the care center will ensure there are no more than 14 hours between a substantial evening meal/snack and breakfast the following day, expect when a nourishing snack is served at bedtime.						
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)			F 812			8/7/24
	§483.60(i) Food safety requirements. The facility must -						
	§483.60(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.						
	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure cold beverage items were stored at temperature to prevent				F: 812 It is Viewcrest Health Center's policy to ensure cold beverage items are stored at proper temperatures.		

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F 812	Continued From page 13 foodborne illness. This had the potential to affect 16 out of 94 residents who were served beverages from the dining room beverage cart. Findings Include: On 7/10/24 at 7:28 a.m., dietary aid (AD)-A was preparing five cold beverage carts. Each cart had a bin on the top shelf which contained half gallon containers of assorted milk and juice. One of the five carts also contained milk and juice containers on the second shelf which was not in a bin. Ice was added to all 5 bins containing milk and juice and no ice or other cooling source was applied to the milk or juice on the cart which contained milk and juice on the second shelf. Items on the second shelf included following: -opened whole milk -opened and unopened 2% milk -unopened chocolate milk -opened and unopened almond milk -opened cranberry, pineapple, prune, and orange juice Each juice container stated to refrigerate after opening. On 7/10/24 08:05 a.m., the beverage cart was brought to the dining room. All 16 residents in the dining room received milk or juice from the beverage cart. All milk or juice served to the resident's during meal service was held on ice. On 7/10/24 at 8:49 a.m., meal service concluded. DA-A removed the beverage cart from the dining room and returned it to the kitchen.			F 812	Dietary Manager and/or designee will implement corrective action for resident affected by this practice by: 1. No individual residents were specifically cited. Dietary Manager and/or designee will assess residents having the potential to be affected by this practice including: 1. All residents have potential to be affected by deficient practice. Dietary Manager and/or designee will implement measures to ensure that this practice does not recur including: 1. The milk and juice were discarded. 2. Dietary staff were educated on the food temp and storage policy the week of July 29th. Dietary Manager and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: 1. Random audits of proper beverage storage and temps will be completed by Dietary Manager/designee 2x the week of July 29, 2024, and then 3x/week thereafter beginning the week August 5, 2024, until compliance is achieved. 2. Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: 08/07/2024		

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F 812	Continued From page 14 During interview on 7/10/24 at 8:50 a.m., DA-A stated she was planning to return the beverage cart items to the refrigerator "so they could be served tomorrow." DA-A stated she always stocked the second shelf of the dining room beverage cart with "extra beverages" and these extra beverages are never held on ice. DA-A did not express any awareness of the hazards related to this practice. On 7/10/24 at 8:51 a.m., dietary manager (DM) obtained the temperatures of the beverage items stored on the second shelf of the dining room beverage cart. The temperatures ranged from 48 to 54 degrees Fahrenheit (F). DM stated it was not safe to serve these items and threw each item away. DM stated she has educated staff on the importance of keeping cold beverages ice and plans to re-educate staff. During interview on 7/11/24 at 8:27 a.m., the administrator stated having the expectation cold beverages were stored and served at safe temperatures. This was important to prevent the risk of illness. A facility policy, Food Temperature dated 7/9/11, identified all cold items must be served at a temperature of 40 degrees F or below. The United States Food and Drug Administration (FDA) Food Code dated 2022, identified milk as a temperature control for safety food and foods requiring refrigeration should be maintained at or below 41 degrees F to prevent foodborne illness.			F 812			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/09/2024. 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

07/31/2024

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 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Viewcrest Health Center is a partial 2-story building with only this part having a 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	K 000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER VIEWCREST HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 original building and the 3 additions meet the minimum requirements for existing healthcare facilities it was inspected as one building. The facility has a capacity of 88 beds and had a census of 83 at the time of the survey.	K 000			
K 353 SS=D	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25	K 353	MAIN BUILDING CORRECTIONS K353	8/2/24	

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K 353	Continued From page 3 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could an isolated impact on the residents within the facility. Findings include: On 07/09/2024 between 08:00am and 12:00pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in kitchen pantry storage. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.	K 353	Viewcrest Health Center will have a properly maintained sprinkler system. In order to comply with NFPA 101(2012 Edition), Life Safety Code sections 9.7.5, NFPA 25 (2011 Edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 Editions), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9: 1. Items were removed from the shelving on 07/09/2024 and dietary staff was reminded not to store anything on the top shelves. 2. The Environmental Service Director was trained in making sure to check shelving and storage during routine walk-throughs. The Environmental Service Director completed a tour of the facility and checked all storage areas. 3. The Environmental Service Director will tour the facility randomly to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 08/02/2024		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 372		8/2/24	

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NAME OF PROVIDER OR SUPPLIER VIEWCREST HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHURCH STREET DULUTH, MN 55811		
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K 372	Continued From page 4 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 07/09/2024 between 08:00am and 12:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors Green Valley double doors East by RM 85 and Green Valley double doors West. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.	K 372	K372 Viewcrest Health Center will maintain proper smoke barriers. In order to comply with NFPA 101 (2012 Edition), Life Safety Code sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5: 1. The penetration noted above the Green Valley double doors East and West were sealed on 07/10/2024. 2. The Environmental Service Director completed a tour of the facility and checked above other fire doors looking for penetrations that were not sealed. The Environmental Service Director and maintenance employee were educated on ensuring all penetrations between smoke barriers were caulked properly. 3. The Environmental Service Director will tour the facility randomly to ensure future		

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K 372	Continued From page 5	K 372	compliance.		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition),	K 920	4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 08/02/2024 K920 Viewcrest Health Center will properly use	8/2/24	

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K 920	Continued From page 6 Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/09/2024 between 08:00am and 12:00pm, it was revealed by observation that there were several electrical appliances plugged into a power strip and/or extension cords in the following areas:" 1) Director of Nursing Office 2) IPCO / Nursing Office 3) Activities Directors Office 4) Activities Storage Room (Extension Cord) 5) Patient Care Room 78 (multi outlet plug) An interview with the Maintenance Manager verified this deficient finding at the time of discovery.			K 920	electrical equipment – power cords and extensions. In order to comply with NFPA 99 (2012 Edition), Health Care Facilities Code sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70 (2011 Edition), National Electrical Code, sections 400-8, and UL 1363: 1. The appliances in the offices were unplugged from the power strip and plugged directly into the wall on 07/31/2024. The extension cord was removed from the activity’s storage area on 07/09/2024. The multi outlet plug was removed from patient room 78 on 07/09/2024. 2. The Environmental Service Director completed a tour of the facility to ensure compliance with extension cords and power strips. 3. The Environmental Service Director will tour the facility randomly to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 08/02/2024		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/09/2024. 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

07/31/2024

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Viewcrest Health Center building-03 was constructed in 2019 as a wing addition/remodel is a 1 story building without a basement built in 2019 and was determined to be Type II(000) construction. The building plans and the building codes were reviewed under the 2012 Edition of the NFPA Life Safety Code after 07/05/2016; the facility was inspected under new construction.			K 000			

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K 000	Continued From page 2 The facility has a capacity of 88 beds and had a census of 83 at the time of the survey.	K 000			
K 223 SS=D	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: *Required manual fire alarm system; and *Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and *Automatic sprinkler system, if installed; and *Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/09/2024 between 08:00am and 12:00pm, it was revealed by observation that fire barrier doors that lead to the egress stairwell enclosure (south	K 223	FAZE REMODEL CORRECTIONS K223 Viewcrest Health Center will have doors with self-closing devices and close properly. In order to comply with NFPA 101 (2012 Edition), Life Safety Code sections 19.3.2.1.3 and 19.3.2.1.5:	8/2/24	

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K 223	Continued From page 3 stairwell) did not completely close when tested. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.	K 223	1. The fire barrier doors on the south stairwell were fixed so the doors closed completely on 07/26/2024. 2. The Environmental Service Director completed a tour of the facility and checked all other fire doors for proper closure. 3. The Environmental Service Director will tour the facility randomly to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency.		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353	5. Completion Date: 08/02/2024	8/2/24	

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K 353	Continued From page 4 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, and 5.3.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/09/2024 between 08:00am and 12:00pm, it was revealed by a review of available documentation the facility failed to perform the five (5) year sprinkler system testing. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.	K 353	K353 Viewcrest Health Center will have a properly maintained sprinkler system. In order to comply with NFPA 101(2012 Edition), Life Safety Code sections 9.7.5, NFPA 25 (2011 Edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.1.1.2, and 5.3.2.1: 1. The 5-year sprinkler testing was completed on 07/29/2024. 2. The Environmental Service Director was trained in the 5-year sprinkler requirement. 3. The Environmental Service Director will place a reminder in his fire safety book to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 08/02/2024		
K 781 SS=G	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless	K 781		8/2/24	

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K 781	Continued From page 5 used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement its portable space heater policy per NFPA 101 (2012 edition), Life Safety Code, section 19.7.8. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 07/09/2024 between 08:00am and 12:00pm, it was revealed by observation of portable space heaters in patient care in the following rooms: 1) Room 202-2 2) Room 204 Space heater are strictly prohibited in patient care areas and must be removed immediately. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.	K 781	K781 Viewcrest Health Center will not use portable space heaters in resident rooms. In order to comply with NFPA 101 (2012 Edition), Life Safety Code sections 19.7.8: 1. The portable heaters were removed out of room 202-2 and 204 on 07/09/2024. 2. The Environmental Service Director completed a tour of the facility and checked other resident rooms for portable space heaters. 3. The Environmental Service Director will tour the facility randomly to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 08/02/2024		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related	K 920		8/2/24	

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K 920	Continued From page 6 electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/09/2024 between 08:00am and 12:00pm, it was revealed by observation that there were several electrical appliances plugged into a power strip and/or extension cords in the following areas: 1) Office 122			K 920	K920 Viewcrest Health Center will properly use electrical equipment – power cords and extensions. In order to comply with NFPA 99 (2012 Edition), Health Care Facilities Code sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70 (2011 Edition), National Electrical Code, sections 400-8, and UL 1363: 1. The appliances in office 122 were unplugged from the power strip and plugged directly into the wall on 07/31/2024.		

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NAME OF PROVIDER OR SUPPLIER VIEWCREST HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 920	Continued From page 7 An interview with the Maintenance Manager verified this deficient finding at the time of discovery.	K 920	2. The Environmental Service Director completed a tour of the facility to ensure compliance with extension cords and power strips. 3. The Environmental Service Director will tour the facility randomly to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 08/02/2024		