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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: H18G
Facility ID: 00602

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

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

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

4. TYPE OF ACTION: **2** (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/13/2021** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Colleen Johnson HFE - NE II 06/24/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/21/2021 (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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
June 4, 2021

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

RE: CCN: 245414
Cycle Start Date: May 13, 2021

Dear Administrator:

On May 13, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby 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 Region V Office for imposition. The CMS Region V Office 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 July 4, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 4, 2021.. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 4, 2021.

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.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 $11,160; 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 July 4, 2021, 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 July 4, 2021. 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)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, 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" tag), and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 13, 2021 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:

Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@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
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://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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 ______	C 05/13/2021

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
E 000	Initial Comments On 5/10/21, through 5/13/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance.	E 000		
F 000	INITIAL COMMENTS On 5/10/21, through 5/13/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5414085C (MN56214) with a deficiency cited at F755. H5414089C (MN72128 and MN72106) with a deficiency cited at F563. The following complaints were found to be SUBSTANTIATED: H5414083C (MN51933) H5414084C (MN52659) H5414086C (MN64804). However, NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5414082C (MN60309) H5414087C (MN68445) H5414088C (MN68579) The facility's plan of correction (POC) will serve	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/14/2021

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 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		6/25/21

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F 550	Continued From page 2	F 550		

The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review the facility failed to ensure a resident had privacy when using the bathroom for 1 of 3 residents (R22) reviewed for activities of daily living (ADLs).

Findings include:

R22's Face Sheet printed 5/13/21, indicated R22's diagnoses included Alzheimer's disease, overactive bladder, retention of urine, and urgency of urination.

R22's quarterly Minimum Data Set (MDS) dated 3/15/21, indicated R22 was severely cognitively impaired, required supervision with transfers and with toilet use. R22's MDS further indicated R22 was occasionally incontinent of urine, and always continent of bowel.

R22's care plan start date 2/9/20, indicated R22's elimination goal was to have one or less

It is the policy of Viewcrest Health Care Center to ensure that all residents have a right to privacy and dignity. The facility was able to place a self-closing hinge on the bathroom door of R22. This will ensure that she has privacy when using the restroom. All residents have potential to be impacted by this deficient practice. The care center Dignity policy was reviewed by the IDT with no changes needed. All employees will be educated on resident rights including the right to privacy while using the bathroom and need to report any breaches in this area. All residents will be interviewed to ensure there right to privacy is being honored. The Director of Nursing (DON) or Designee will complete random audits a minimum of 3 per week for one month then monthly for three months to ensure compliance with dignity related to toileting starting 6/18/21. All audits will be

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F 550	Continued From page 3 accidents per day. Approaches included using incontinent product, toilet R22 upon rising, before or after meals, around noon, at bedtime, and with night rounds. The care plan indicated a toileting program was tried and not effective. R22's care plan dated 2/10/20, indicated she was at risk for bowel incontinence. The care plan indicated R22 often forgot to close the bathroom door, staff were to ensure bathroom door was closed if walking by when resident was in the bathroom. R22's care plan indicated R22 had a history of transferring self to the bathroom. Approaches included staff maintaining a consistent environment and routine, re-orientation and cues as needed, assisting R22 with cleaning her hands after using the bathroom. The goal was for R22 to use the call light appropriately and ask for assistance with bathroom use. On 5/11/21, at 8:00 a.m. R22 was observed from the hallway seated on the toilet in her bathroom. On 5/12/21, at 2:45 p.m. R22 was observed from the hallway seated on the toilet in her bathroom. On 5/13/21, at 8:59 a.m. nursing assistant (NA)-D was interviewed. NA-D stated R22 went to the bathroom by herself every 10 minutes, and would not shut the door. -at 9:09 a.m. registered nurse (RN)-A was interviewed. RN-A stated it is was not dignified for R22 to be seen seated on the toilet by anyone passing by her room. RN-A stated staff need to perform more frequent checks, and shut R22's door door. RN-A stated this should be addressed in the daily interdisciplinary team (IDT) meeting. -at 9:21 a.m. R22 was observed from the hallway	F 550	reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee. Corrected by 6/25/21.	

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F 550	Continued From page 4	F 550		

seated on the toilet, with her pants down around her ankles.

-at 9:54 a.m. R22 was observed from the hallway seated on the toilet wiping herself.

-at 9:55 a.m. RN-B was interviewed. RN-B stated he was aware of R22 leaving the bathroom door open. RN-B stated the facility could not keep R22's door closed because she was a high risk for falls. RN-B stated he was not sure what the next step should be. RN-B stated they had not discussed this at their IDT meeting.

-at 11:51 a.m. R22 was observed from the hallway seated on the toilet, with her pants down around her ankles.

-at 2:45 p.m. R22 was observed from the hallway standing in the bathroom with her pants down around her ankles.

-at 2:58 p.m. the administrator was interviewed. The administrator stated it was not dignified for a resident to be seen from the hallway seated on the toilet.

The facility policy Toileting Residents dated 3/12/17, directed staff to assure privacy and dignity for resident, pull privacy curtain and close door.

The facility policy Dignity reviewed/revised 10/23/17, directed staff would be provided guidance on maintaining and enhancing resident's dignity. The policy directed staff would treat each resident with respect and dignity at all times. Staff were directed to promote, maintain and protect resident privacy, including bodily

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F 550	Continued From page 5 privacy during assistance with personal cares and treatments. In addition the staff were directed to treat cognitively impaired residents with dignity and sensitivity.	F 550		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by:	F 563		6/25/21

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F 563	Continued From page 6 Based on interview and document review, the facility failed to allow in-person visits for 1 of 1 residents (R30) reviewed for visitation. Findings include: Guidance from the Centers for Medicare & Medicaid Services (CMS) dated 3/10/21, in conjunction with the Centers for Disease Control and Prevention (CDC) reference QSO-20-39-NH indicated facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission. Visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life. Additionally, visitation can be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, outdoors, and for circumstances beyond compassionate care situations. A nursing home must facilitate in-person visitation consistent with the applicable CMS regulations, which can be done by applying the guidance. Additional guidance from the CDC titled Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes dated 3/29/21, indicated in most circumstances, quarantine is not recommended for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) and do not have close contact with someone with SARS-CoV-2 infection. Additionally, quarantining residents who regularly	F 563	It is the policy of Viewcrest Health Care Center to ensure each resident has the right to receive visitors. The facility policy and procedure on visitation during the COVID-19 pandemic was reviewed and remains current. R30 is noted to have three family members who are designated as essential care givers, these individuals are allowed to visit and provide emotional support at any time including if an individual is in a quarantine period. All residents have potential to be impacted by this deficient practice. The care center policy on Coronavirus Prevention, Screening, and Identification, along with the Care Center Visitation during COVID-19 was reviewed by the IDT with no changes needed. All residents in the facility along with their families will be provided information on current visitation policies. In addition all facility staff will be provided with re-education on visitation policy and procedures. All residents in the facility will be interviewed to ensure they have no concerns with current visitation policies. The facility is currently allowing visitors at all times without an appointment needed. The facility infection control nurse will review any necessary visitation restrictions with the interdisciplinary team prior to making any changes to this policy. The administrator will ensure compliance with current visitation policies through monitoring and review of visitation logs and any noted concern forms. The administrator will continue to audit visitation practices a minimum of weekly to ensure compliance 6/18/21 All audits will be reviewed by the	

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leave the facility for medical appointments (e.g., dialysis, chemotherapy) would result in indefinite isolation of the resident that likely outweighs any potential benefits of quarantine.

Review of the facility provided positivity rates for St. Louis county indicated:
- 4/14/21, 5.2% (yellow) level and the facility was to start weekly testing.
- 4/28/21, 5.3% (yellow) level and the facility was to continue weekly testing.
- 5/5/21, 4.6% (green) level and to continue weekly testing due to this being week one of the decrease to green.

R30's quarterly Minimum Data Set (MDS) dated 3/11/21, indicated R30 had moderately impaired cognition. The MDS indicated R30's diagnoses included dementia and depression. Further, the MDS indicated R30 said it was "very important" to have family or a close friend involved in discussions about her care.

R30's care plan dated 4/9/20, directed staff were to encourage R30 to go out on outings such as being outdoors, and being engaged in conversations during visits such as family and grandchildren. The care plan further indicated some of R30's favorite activities included visiting with family. The care plan also indicated R30 was at risk for COVID-19. Staff were directed to encourage hand hygiene, social distancing, face mask and to provide reminders and redirect as needed. Staff were supposed to remind R30 of appropriate way to wear face mask. The care plan lacked indication R30 was born without one ear, and had a difficult time wearing a mask, and lacked indication of alternate types of masks.

Plan of correction (F 563): facility Quality Assurance Performance Improvement (QAPI) committee.

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On 4/19/21, at 4:00 p.m. R30 went out for a colonoscopy with son to transport and attend appointment. R30 was gone for approximately 6 hours. The progress note indicated R30 was at high-risk for contracting COVID-19 due to colonoscopy procedure at the hospital, her unvaccinated status, and her diagnosis of dementia. R30 was seen in her son's vehicle without her mask on. R30 placed on droplet precautions for 14 days through 5/2/21, because of her risk for exposure to COVID-19. The progress note also indicated R30 had only one ear, and had difficulty wearing a mask at times because of this.

On 5/6/21, at 9:47 a.m. a progress note indicated social worker (SW)-A met with R30 to discuss recent quarantine period due to her recent procedure. R30 stated she had not liked having to stay in her room. SW-A discussed the reasoning behind R30's quarantine. R30 expressed understanding. SW-A discussed since R30 had no signs or symptoms of respiratory issues, she would be able to come out of her room and attend activities, and move about the facility as long as she maintained her mask. R30 expressed understanding.

On 5/10/21, at 2:35 p.m. R30 was interviewed and stated she had been "grounded" for 14 days after having a colonoscopy, and the facility had restricted her visitors. R30 also stated, "I am not grounded anymore, but I never know what I can do and what I can't." R30 stated her family made her very happy, and she enjoyed visiting with them.

On 5/11/21, at 1:56 p.m. family member (FM)-A was interviewed and stated he had tried to

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schedule a visit with R30 outside in the facility parking lot in the days after R30's colonoscopy, and was told by the facility he could not as R30 was in quarantine due to her unvaccinated status. The facility offered a window visit instead (where R30 would remain in her room by a window, and FM-A could visit outside the window). FM-A stated this was not preferred, as R30 had difficulty hearing people at a distance through their masks. FM-A said he did not agree R30's colonoscopy would have given her a high risk exposure for COVID-19, and he did not agree with her quarantine afterward.

On 5/12/21, at 9:26 a.m. the activities director (AD)-A was interviewed and stated when R30 was on droplet precautions following the colonoscopy, family could not visit her and they had had expressed some "displeasure" with R30's quarantine. AD-A stated the regional director and other corporate staff had made the decision.

On 5/12/21, at 11:36 a.m. licensed practical nurse (LPN)-B was interviewed and stated all residents were screened daily for signs and symptoms of COVID-19. LPN-A stated vital signs were documented in the electronic medical record (EMR), and if a resident showed any symptoms of COVID-19, those would be documented in a progress note.

Review of R30's progress notes 4/1/21, through 5/12/21, lacked indication R30 had signs or symptoms of COVID-19.

On 5/12/21, at 2:32 p.m. the assistant director of nursing (ADON) who was also the infection preventionist, stated the facility continued testing

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for COVID-19 weekly, and there were no active cases of COVID-19 in the facility recently. Additionally, the ADON stated greater than 70% of the residents were fully vaccinated.

On 5/13/21, at 1:24 p.m. the administrator, ADON, and corporate nurse practitioner (NP)-A were interviewed together. NP-A stated she was consulted to help determine R30's risk following her colonoscopy on 4/19/21. NP-A and the ADON stated they had not known how long R30 had her mask off for the procedure, nor for how long it was off in the car with her son. The ADON and administrator stated they had not contacted the hospital to determine the risk of the procedure. The administrator stated she was not aware of R30 having any other exposure to COVID-19. The ADON stated when a resident was on quarantine, the facility limited in-house visitation. The administrator stated nobody had asked R30 if she wanted to visit her family. When asked why R30 could not go outside to visit her family in the facility parking lot during quarantine status, the ADON stated it was too high of a risk, but did not elaborate.

The facility policy Coronavirus Prevention, Screening and Identification dated 5/7/21, directed indoor, window and patio visits will occur using visitation policy. These types of visits may be placed on hold when a care center has positive cases within it, county case rates are rising, availability of testing is limited, person protective equipment supplies are low (less than a 7 day supply) and/or care center is utilizing the emergency staffing plan.

The facility policy Care Center Visitation during COVID-19 Pandemic dated 3/22/21, directed

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F 563	Continued From page 11 while taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred. Outdoor visits generally pose a lower risk of transmission due to increased space and airflow. All visits should be held outdoors when practicable and should be facilitated routinely.	F 563		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure annual performance evaluations were completed for 5 of 5 direct care staff (RN-C, LPN-C, NA-F, NA-G, and NA-H) reviewed for performance and competency reviews. This had the potential to affect all 65 residents residing in the facility. Findings include: Annual performance appraisals were requested for review and not received for: - Registered nurse (RN)-C whose date of hire was listed as 1/7/20. - Licensed practical nurse (LPN)-C whose date of hire was listed as 11/14/13. - Nursing assistant (NA)-F whose date of hire was listed as 6/27/19. - NA-G whose date of hire was listed as 5/29/19.	F 730	It is the policy of Viewcrest Health Care Center to ensure that all staff receive timely and accurate performance reviews at least annually. RN-C, LPN-C, NA-F, NA-G, and NA-H have all had their annual review completed and are now currently up to date. All residents have potential to be impacted by this deficient practice. The Recognition of Service Dates policy was reviewed by the IDT and remains appropriate. An audit was conducted of all direct care staff to identify those that had not had a performance evaluation in the past year. All direct care staff will have a performance evaluation completed by 6/21/21. The Human Resources Director or designee will audit direct care staff performance evaluations a minimum of monthly for six months to ensure	6/21/21

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F 730	Continued From page 12 - NA-H whose date of hire was listed as 8/24/16. On 5/13/21, at 2:35 p.m. the administrator stated performance reviews had not been done, but should be done annually. The administrator stated they had to get caught up. The facility policy Recognition of Service Dates amended 7/19, directed performance appraisals to be done annually from the date of hire.	F 730	compliance starting 6/18/21. All audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee.	
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		6/21/21

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F 755	Continued From page 13 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications held for destruction, including narcotics and controlled medications (drugs regulated by the Controlled Substances Act (CSA) in the United States with the potential for abuse and dependence) were stored in a secure manner and area to prevent diversion. This had the potential to affect all residents residing in the facility. Findings include: According to the United States Drug Enforcement Administration (DEA) drugs, substances, and certain chemicals used to make drugs are classified into five (5) distinct categories or schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential. Schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous. Schedule III drugs, substances, or chemicals are defined as drugs with a moderate to low potential for physical and psychological dependence. Schedule IV drugs, substances, or chemicals are defined as drugs with a low potential for abuse and low risk of dependence.	F 755	It is the policy of Viewcrest Health Care Center to ensure that medications are stored per regulations to prevent diversion. On 5/13/21 the ADON pushed the medication cards down the MedSafe and locked the door and it was fixed that same night. All residents have potential to be impacted by this deficient practice. The facility policy and procedure on the Med Safe was reviewed by the IDT and updated. All Licensed nurses (LN) were re- educated on the updated policy. The LN working on Island Lake were the Med Safe is stored is responsible for checking the MedSafe each shift to ensure the MedSafe is not overfilled. All LN are responsible for notifying the DON if the MedSafe becomes full at which time the DON will lock the safe until the pharmacist can be on-site to remove the medications for destruction. The Administrator or designee will audit the MedSafe 3x/week for a minimum of 4 weeks to ensure compliance. All audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee.	

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F 755	Continued From page 14 On 5/13/21, at 3:45 p.m. during observations of medication storage with licensed practical nurse (LPN)-D, LPN-D stated they put medications to be destroyed in the MedSafe (a stainless-steel collection receptacle with a removable inner liner) located on the Island Lake nurses station. LPN-D brought surveyor to the nurses station, and stated she had not yet used it. The MedSafe was located in the unlocked nurses station next to the desk area. The top door was ajar and cards of medication were visible in the back of the medication safe. When attempting to close the door completely, the door was unable to close and there was a sound of the plastic bubbles on medication cards crunching. On 5/13/21, at 4:23 p.m. the assistant director of nursing (ADON) stated the director of nursing (DON) and the pharmacy have keys to the MedSafe. The ADON stated no one would be able to reach the medications in the MedSafe, but when surveyor was able to reach inside the top flip-down door and almost reach the medications, the ADON stated with a device, there was a potential for the medication cards to be reached and pulled out of the MedSafe. The ADON verified there was a lock for the top door of the MedSafe and she did not know why it was not locked. The ADON stated staff, residents and/or visitors could have access to the unsecured medications in the MedSafe. The ADON stated they had reviewed the security of the MedSafe and the placement of the MedSafe when they received it approximately a month ago. The ADON stated she would find out where the keys were and call the pharmacy to have it emptied tonight. The ADON verified the body of the MedSafe door could only be opened with a key the pharmacy had and a key the DON had when	F 755		

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used together.

On 5/13/21, at 4:48 p.m. the ADON stated they pushed the medication cards down in the MedSafe, and closed and locked the door. The ADON stated it would be fixed that same night.

The facility provided the documentation of the medications that had been placed in the MedSafe for destruction. The medications included:
3/24/21:
-Pregabalin (for seizures and nerve pain) 75 milligrams (mg) 4 tablets
-oxycodone (Schedule II controlled narcotic pain medication) 5 mg 28 tablets
4/6/21:
-Oxycodone 5 mg 20 tablets
-Lorazepam 0.5 mg (Schedule IV controlled medication for anxiety) 20 tablets
-Fentanyl (Schedule II controlled narcotic pain medication) 25 micrograms (mcg)/hour (hr) 12 tablets
4/13/21:
-Fentanyl 12 mcg-3 patches
-Lorazepam 0.5 mg -24 tablets
-oxycodone HCl 10 mg/ml-8.5 milliliters (ml)
5/5/21:
-omeprazole (for acid reflux) 40 mg 250 capsules
-zofran (for nausea and vomiting) 8 mg 30 tabs
-trazodone (antidepressant) 100 mg 29 tabs
-levothyroxine (for thyroid) 100 mcg 29 tabs
-paroxetine HCl (antidepressant) 20 mg 29 tabs
-fluticasone prop (for allergies)50 mcg one bottle
-creon (pancreatic enzyme replacement therapy) 12,000 usp units 100 capsules
-Haldol (antipsychotic) 1 mg 23 tablets
-Haldol 2 mg 112.5 tablets
-olanzapine (antipsychotic) 25 mg 20 tablets
-cymbalta (antidepressant) 20 mg 18 tablets

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-temazepam (for insomnia) 15 mg 29 capsules
-scopolamine patch (for nausea and vomiting) 4 patches
-Albuterol sulfate (for obstructive airway disease-to improve breathing) 90 mcg one inhaler
-Humalog Kwik Pen (rapid acting insulin) 1 pen
-divalproex sodium (for seizures or mood stabilizer) 125 mg 196 capsules
-mirtazapine (antidepressant) 30 mg 26 tablets
-quetiapine (antipsychotic) 25 mg 47 tablets
-trazodone 50 mg 30 tablets
-mirtazapine 15 mg 49 tablets
-duloxetine (antidepressant) 60 mg 65 capsules
-gabapentin (for seizures and nerve pain) 300 mg 30 capsules

The facility policy Med Safe-Narcotic Destruction dated 11/20, directed the collection and disposal of unwanted, expired medications including controlled substances would be disposed of with the use of a Med Safe. The policy directed the use of Med Safe according to the manufacturer's instructions. For any unwanted or expired medication including controlled substances, license nursing staff would notify the director of nursing (DON) and two licensed nurses would verify the medication for disposal of all drugs and would be documented in the medical record prior to being placed in the bin. Verification would include the prescription number, patient name, drug name, strength, and quantity remaining. Two licensed nurses would complete and sign the certificate of inventory and destruction of controlled substance form, which was to be filed with the DON. The inside receptacle would be double locked and require tow keys to access with one key kept by the DON and the second key kept by a member of the consulting pharmacy. The inner liner would be replaced and

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mailed for destruction according to the manufacturer's instructions by the DON and assigned pharmacy staff as needed. The policy and procedure lacked the Med Safe manufacturer's instructions.

The Med Safe manufacturer's instructions were requested and not received.

The facility policy Controlled Substances revised 7/16, directed all controlled medications are to be kept locked, and Schedule II controlled substances to be double-locked at all times in a separately locked compartment, permanently affixed to the physical plant or medication cart.

F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		6/21/21

§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

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 ______	C 05/13/2021

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 812	Continued From page 18 by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was completed during food preparation. In addition, the facility failed to ensure dirty dishes were kept away from beverages that were going to be served. This had the potential to affect 64 of 65 residents who ate food prepared in the kitchen. Findings include: On 5/10/21, at 12:39 p.m. dietary aide (DA)-A entered the kitchen without washing his hands and donned clean gloves. On 5/10/21, at 12:42 p.m. DA-B removed her soiled gloves, and without performing hand hygiene, donned clean gloves. DA-B stated serving food to residents. At 1:08 p.m. DA-B stated that she should have washed her hands after removing her soiled gloves, and before donning glean gloves, but she forgot. On 5/10/21, at 5:31 p.m. DA-A put used dirty glasses in the same container with the milk and juice cartons which were on ice. There was liquid still in the dirty glasses. DA-A stated that the milk and juice cartons would be put away in the fridge and used again for meals tomorrow. When asked why he was mixing dirty glasses with milk and juice cartons that were still being used, DA-A stated, "For all the things going on here, this is what you are worried about now?" On 5/10/21, at 5:38 p.m. dietary manager (DM)-G was interviewed and stated she expect dirty dishes would go into tubs specifically for dirty dishes. DM-G stated she would not expect to see	F 812	It is the policy of Viewcrest Health Care Center to ensure that all food is stored, prepared and served in a manner that reduces the risk for food borne illness. DA-A and DA-B were re-educated by the Dietary Manager regarding hand hygiene. DA-A was also re-educated by the Dietary Manager regarding ensuring dirty dishes are kept away from beverages that will be store. All residents who eat food prepared in the kitchen have potential to be impacted by this deficient practice. The facility policy on Dietary Sanitation was reviewed by the IDT and updated. All staff involved in the delivery, clean up or preparation of food will be re-educated on this policy regarding hand hygiene completed during food preparation and ensuring dirty dishes are kept away from beverages that are going to be served by the Dietary Manager. The dietary manager or designee will audit hand hygiene/glove use as well as collection of trays following meals a minimum of three times per week for 4 weeks then weekly for three months starting 6/18/21 to ensure compliance. All audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee.	

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F 812	Continued From page 19 used glasses go into the tubs with milk and juice cartons. On 5/11/21, at 3:49 p.m. DM-G stated she expected staff to wash their hands before entering the kitchen. DM-G stated staff need to wash their hands before they touch the food, and in between tasks. On 5/13/21, at 2:59 p.m. the administrator was interviewed. The administrator verified dirty dishes should be placed in the cart for dirty dishes, and should not be placed in the bin with beverages that will be used again. The facility policy Dishes and Utensils dated 8/2018, lacked direction on keeping dirty dishes separate from beverages that would be used again.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		6/21/21

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F 880	Continued From page 20 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880 Continued From page 21 F 880

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and glove use practices were maintained for 1 of 2 residents (R21) observed during personal cares.

Findings include:

R21's Face Sheet printed 5/12/21, indicated diagnoses which included spastic diplegic cerebral palsy (a subtype of spastic cerebral palsy in which the legs are most affected), and paraplegia (paralysis of the legs and lower body), .

R21's quarterly Minimum Data Set (MDS) dated 3/4/21, indicated R21 was cognitively intact. The MDS indicated R21 required extensive assistance with toilet use and personal hygiene. R21's MDS further indicated R21 was always incontinent of bowel and bladder.

On 5/12/21, at 9:16 a.m. nursing assistant (NA)-E was observed providing personal cares for R21. NA-E performed hand hygiene upon entering, put on gloves, placed a plastic bag at the foot of the bed, removed R21's brief, explaining everything prior to performing the task, wiped R2's perineal

It is the policy of Viewcrest Health Care Center to establish and maintain an infection control program that is designed to help prevent the development and transmission of communicable diseases and infections. Resident R21 remains in the facility and has had no recent infections as a result of the incident on 5/12/21. NA-E was re-educated by the Director of Nursing on proper hand hygiene. This practice could potentially affect all residents in the nursing facility. The care center policy and procedure on hand hygiene was reviewed by the facility Director of Nursing (DON) and Infection Preventionist and was found to meet CDC guidance. Per the directed plan of correction the facilities Quality Assurance and Performance Improvement Committee will conduct a root cause analysis (RCA) to identify the problem(s) that resulted in the deficiency and develop a corrective action plan to prevent reoccurrence. All staff who interact with resident's will be provided re-education on hand hygiene via; instructional education online as well as verbal and written education. Hand hygiene competencies

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F 880	Continued From page 22 area, discarded the wipe, and assisted R21 with rolling on her right side. NA-E wiped R21's rectal area (soft brown stool present). NA-E removed his soiled gloves, and without performing hand hygiene, donned clean gloves. NA-E adjusted R21's incontinent brief, removed his soiled gloves, and moved R21's overbed tray table closer to her. NA-E went to the bathroom and performed hand hygiene. -at 9:28 a.m. NA-E was interviewed. NA-E verified he did not perform hand hygiene between glove changes, but should have. On 5/13/21, at 2:58 p.m. the administrator was interviewed. The administrator verified hand hygiene should be performed between glove changes. The facility policy Hand Hygiene revised 5/8/17, directed staff to use hand sanitizer between glove changes.	F 880	will be reviewed with all staff. The DON, Infection Preventionist or designee will complete audits of infection control on all shifts every day for one week. This will continue to until 100% compliance is achieved. In addition the facility will continue with regularly scheduled infection control audits. The facility Quality Assurance Performance improvement committee will review all elements of the plan of correction to ensure compliance.	
F 943 SS=F	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property	F 943		6/21/21

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F 943	Continued From page 23 §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 6 staff (RN-A, DON, LPN-A) received annual training that included the required components of Alzheimer's/dementia care. This had the potential to affect all 30 residents currently residing in the facility with a diagnosis of Alzheimer's or dementia. Findings include: On 5/13/21, at 10:45 a.m. review of the facility's Alzheimer's/dementia training was done with human resources director (HR)-A. The review indicated the following: -Registered nurse (RN)-A was hired on 1/7/20, and had not completed any of the four required components of Alzheimer's training in the past year. HR-A stated RN-A should have had the training annually. -Director of nursing (DON) was hired on 8/12/19, and had not completed any of the four required components of Alzheimer's training in the past year. HR-A stated DON should have had the training annually. -Licensed practical nurse (LPN)-A was hired on 12/15/15, and had not completed any of the four required components of Alzheimer's training in the past year. HR-A stated LPN-A should have completed the training annually. On 5/13/21, at 11:47 a.m. the administrator stated	F 943	It is the policy of Viewcrest Health Care Center to ensure all staff have completed required training upon hire and annually. RN-A, DON, and LPN-A have all completed the required components of Alzheimer's/Dementia care. All residents with the diagnosis of Alzheimers/Dementia have the potential to be impacted by this deficient process. The care center Dementia Care policy was reviewed by the IDT with no updates needed. The Human Resources Director was re-educated on the Dementia Care policy regarding staff training requirements by the Administrator. An audit was conducted by the Human Resources Director of staff training to identify any staff that were in need of Dementia/Alzheimer's training. All staff who have not completed the required training will complete it by 6/21/21. The Director of Human Resources or designee will audit all employee records a minimum of monthly for six months to ensure compliance with new tracking tool starting on 6/18/21. All audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee.	

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F 943	Continued From page 24 the all staff should have the Alzheimer's or dementia training done annually. The facility policy Dementia Care dated 4/4/16, indicated the facility provided unique services for residents with dementia. Dementia care training for all staff would be conducted upon hire and on an annual basis, with periodic refresher training prn (as needed). The training would have included: -an explanation of Alzheimer's disease and related disorders -assistance with activities of daily living -problem solving with challenging behaviors -communication skills.	F 943		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 4, 2021

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

Re: State Nursing Home Licensing Orders
Event ID: H18G11

Dear Administrator:

The above facility was surveyed on May 10, 2021 through May 13, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 05/13/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/10/21, through 5/13/21, a licensing survey and a complaint survey were conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of	2 000		

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2 000	Continued From page 1	2 000		

correction you have reviewed these orders and identify the date when they will be completed.

The following complaints were found to be SUBSTANTIATED:
H5414085C (MN56214) with a licensing order issued at 4658.1325 Subp.1
H5414089C (MN72128 and MN72106) with a licensing order issued at 4658.0200 Subp.1

The following complaints were found to be SUBSTANTIATED:
H5414083C (MN51933)
H5414084C (MN52659)
H5414086C (MN64804). However, NO deficiencies were cited due to actions implemented by the facility prior to survey.

The following complaints were found to be UNSUBSTANTIATED:
H5414082C (MN60309)
H5414087C (MN68445)
H5414088C (MN68579)

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

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2 000	Continued From page 2 You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia	2 302		6/21/21

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2 302	Continued From page 3 care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 6 staff (DA-A, NA-C, RN-A, DON, LPN-A, and AA-B) received annual training that included all required components of Alzheimer's/dementia care. This had the potential to affect all 30 residents currently residing in the facility with a diagnosis of Alzheimer's or dementia. Findings include: Minnesota state statute 144.6503 for Alzheimer's disease or related disorder training, directed areas of required training for direct care staff and their supervisors included: -an explanation of Alzheimer's disease and related disorders -assistance with activities of daily living -problem solving with challenging behaviors	2 302	See Federal POC	

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2 302	Continued From page 4	2 302		

-communication skills

During interview on 5/13/21, at 8:45 a.m. the assistant director of nursing (ADON) stated Alzheimer's and dementia training needed to be completed annually and as needed.

On 5/13/21, at 10:45 a.m. an interview and facility Alzheimer's/dementia training document review with human resources director (HR)-A reflected the following:

-Dietary aide (DA)-A was hired on 10/22/20, and had not completed any of the four required components of Alzheimer's training in the past year. HR-A stated DA-A should have completed the training annually.

-Nursing assistant (NA)-C was hired on 4/12/21, and had not completed any of the four required components of Alzheimer's training. HR-A stated NA-C was considered "off orientation" and should have completed the training by now.

-Registered nurse (RN)-A was hired on 1/7/20, and had not completed any of the four required components of Alzheimer's training in the past year.

-Director of nursing (DON) was hired on 8/12/19, had not completed any of the four required components of Alzheimer's training in the past year. HR-A stated DON should have had the training annually.

-Licensed practical nurse (LPN)-A was hired on 12/15/15, and had not completed any of the four required components of Alzheimer's training in the past year. HR-A stated LPN-A should have completed the training annually.

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2 302	Continued From page 5 -Activities aide (AA)-B was hired on 4/16/21, and had not completed any of the four required components of Alzheimer's training. HR-A stated AA-B was considered "off orientation" and should have completed the training before working independently. HR-A stated was aware there were staff that had not completed the required training. HR-A had recently started audits and a new process to track completion of the training. During interview on 5/13/21, at 11:47 a.m. the administrator stated the expectation was for all staff to have the Alzheimer's or dementia training done upon hire and annually. The policy Dementia Care dated 4/4/16, indicated the facility provided unique services for residents with dementia. Dementia care training for all staff would be conducted upon hire and on an annual basis, with periodic refresher training prn (as needed). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures related to staff training pertaining to Alzheimer's and dementia. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 375	MN Rule 4658.0200 Subp. 1 Policies Concerning Residents;Visitors	2 375		6/21/21

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2 375	Continued From page 6 Subpart 1. Visitors. A nursing home must provide access to a resident by relatives and guardians, and to any entity or individual that provides health, social, legal, advocacy, or religious services to the resident, subject to the resident's right to deny or withdraw consent at any time. A nursing home must also provide access to others who are visiting the resident with the resident's consent. A nursing home may restrict visits when the visits pose a health or safety risk to a resident or otherwise violate a resident's rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to allow in-person visits for 1 of 1 residents (R30) reviewed for visitation. Findings include: Guidance from the Centers for Medicare & Medicaid Services (CMS) dated 3/10/21, in conjunction with the Centers for Disease Control and Prevention (CDC) reference QSO-20-39-NH indicated facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission. Visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life. Additionally, visitation can be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, outdoors, and for circumstances beyond compassionate care situations. A nursing home must facilitate	2 375	See Federal POC	

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2 375	Continued From page 7	2 375		

in-person visitation consistent with the applicable CMS regulations, which can be done by applying the guidance.

Additional guidance from the CDC titled Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes dated 3/29/21, indicated in most circumstances, quarantine is not recommended for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) and do not have close contact with someone with SARS-CoV-2 infection. Additionally, quarantining residents who regularly leave the facility for medical appointments (e.g., dialysis, chemotherapy) would result in indefinite isolation of the resident that likely outweighs any potential benefits of quarantine.

Review of the facility provided positivity rates for St. Louis county indicated:
- 4/14/21, 5.2% (yellow) level and the facility was to start weekly testing.
- 4/28/21, 5.3% (yellow) level and the facility was to continue weekly testing.
- 5/5/21, 4.6% (green) level and to continue weekly testing due to this being week one of the decrease to green.

R30's quarterly Minimum Data Set (MDS) dated 3/11/21, indicated R30 had moderately impaired cognition. The MDS indicated R30's diagnoses included dementia and depression. Further, the MDS indicated R30 said it was "very important" to have family or a close friend involved in discussions about her care.

R30's care plan dated 4/9/20, directed staff were to encourage R30 to go out on outings such as

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2 375	Continued From page 8 being outdoors, and being engaged in conversations during visits such as family and grandchildren. The care plan further indicated some of R30's favorite activities included visiting with family. The care plan also indicated R30 was at risk for COVID-19. Staff were directed to encourage hand hygiene, social distancing, face mask and to provide reminders and redirect as needed. Staff were supposed to remind R30 of appropriate way to wear face mask. The care plan lacked indication R30 was born without one ear, and had a difficult time wearing a mask, and lacked indication of alternate types of masks. On 4/19/21, at 4:00 p.m. R30 went out for a colonoscopy with son to transport and attend appointment. R30 was gone for approximately 6 hours. The progress note indicated R30 was at high-risk for contracting COVID-19 due to colonoscopy procedure at the hospital, her unvaccinated status, and her diagnosis of dementia. R30 was seen in her son's vehicle without her mask on. R30 placed on droplet precautions for 14 days through 5/2/21, because of her risk for exposure to COVID-19. The progress note also indicated R30 had only one ear, and had difficulty wearing a mask at times because of this. On 5/6/21, at 9:47 a.m. a progress note indicated social worker (SW)-A met with R30 to discuss recent quarantine period due to her recent procedure. R30 stated she had not liked having to stay in her room. SW-A discussed the reasoning behind R30's quarantine. R30 expressed understanding. SW-A discussed since R30 had no signs or symptoms of respiratory issues, she would be able to come out of her room and attend activities, and move about the facility as long as she maintained her mask. R30 expressed	2 375		

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2 375	Continued From page 9	2 375		

understanding.

On 5/10/21, at 2:35 p.m. R30 was interviewed and stated she had been "grounded" for 14 days after having a colonoscopy, and the facility had restricted her visitors. R30 also stated, "I am not grounded anymore, but I never know what I can do and what I can't." R30 stated her family made her very happy, and she enjoyed visiting with them.

On 5/11/21, at 1:56 p.m. family member (FM)-A was interviewed and stated he had tried to schedule a visit with R30 outside in the facility parking lot in the days after R30's colonoscopy, and was told by the facility he could not as R30 was in quarantine due to her unvaccinated status. The facility offered a window visit instead (where R30 would remain in her room by a window, and FM-A could visit outside the window). FM-A stated this was not preferred, as R30 had difficulty hearing people at a distance through their masks. FM-A said he did not agree R30's colonoscopy would have given her a high risk exposure for COVID-19, and he did not agree with her quarantine afterward.

On 5/12/21, at 9:26 a.m. the activities director (AD)-A was interviewed and stated when R30 was on droplet precautions following the colonoscopy, family could not visit her and they had had expressed some "displeasure" with R30's quarantine. AD-A stated the regional director and other corporate staff had made the decision.

On 5/12/21, at 11:36 a.m. licensed practical nurse (LPN)-B was interviewed and stated all residents were screened daily for signs and symptoms of COVID-19. LPN-A stated vital signs were

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2 375	Continued From page 10	2 375		

documented in the electronic medical record (EMR), and if a resident showed any symptoms of COVID-19, those would be documented in a progress note.

Review of R30's progress notes 4/1/21, through 5/12/21, lacked indication R30 had signs or symptoms of COVID-19.

On 5/12/21, at 2:32 p.m. the assistant director of nursing (ADON) who was also the infection preventionist, stated the facility continued testing for COVID-19 weekly, and there were no active cases of COVID-19 in the facility recently. Additionally, the ADON stated greater than 70% of the residents were fully vaccinated.

On 5/13/21, at 1:24 p.m. the administrator, ADON, and corporate nurse practitioner (NP)-A were interviewed together. NP-A stated she was consulted to help determine R30's risk following her colonoscopy on 4/19/21. NP-A and the ADON stated they had not known how long R30 had her mask off for the procedure, nor for how long it was off in the car with her son. The ADON and administrator stated they had not contacted the hospital to determine the risk of the procedure. The administrator stated she was not aware of R30 having any other exposure to COVID-19. The ADON stated when a resident was on quarantine, the facility limited in-house visitation. The administrator stated nobody had asked R30 if she wanted to visit her family. When asked why R30 could not go outside to visit her family in the facility parking lot during quarantine status, the ADON stated it was too high of a risk, but did not elaborate.

The facility policy Coronavirus Prevention, Screening and Identification dated 5/7/21,

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2 375	Continued From page 11 directed indoor, window and patio visits will occur using visitation policy. These types of visits may be placed on hold when a care center has positive cases within it, county case rates are rising, availability of testing is limited, person protective equipment supplies are low (less than a 7 day supply) and/or care center is utilizing the emergency staffing plan. The facility policy Care Center Visitation during COVID-19 Pandemic dated 3/22/21, directed while taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred. Outdoor visits generally pose a lower risk of transmission due to increased space and airflow. All visits should be held outdoors when practicable and should be facilitated routinely. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure families are allowed to visit residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 375		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary	21015		6/21/21

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21015	Continued From page 12	21015		

procedures and conditions must be maintained in the operation of the dietary department at all times.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was completed during food preparation. In addition, the facility failed to ensure dirty dishes were kept away from beverages that were going to be served. This had the potential to affect 64 of 65 residents who ate food prepared in the kitchen.

See Federal POC

Findings include:

On 5/10/21, at 12:39 p.m. dietary aide (DA)-A entered the kitchen without washing his hands and donned clean gloves.

On 5/10/21, at 12:42 p.m. DA-B removed her soiled gloves, and without performing hand hygiene, donned clean gloves. DA-B stated serving food to residents. At 1:08 p.m. DA-B stated that she should have washed her hands after removing her soiled gloves, and before donning glean gloves, but she forgot.

On 5/10/21, at 5:31 p.m. DA-A put used dirty glasses in the same container with the milk and juice cartons which were on ice. There was liquid still in the dirty glasses. DA-A stated that the milk and juice cartons would be put away in the fridge and used again for meals tomorrow. When asked why he was mixing dirty glasses with milk and juice cartons that were still being used, DA-A stated, "For all the things going on here, this is what you are worried about now?"

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On 5/10/21, at 5:38 p.m. dietary manager (DM)-G was interviewed and stated she expect dirty dishes would go into tubs specifically for dirty dishes. DM-G stated she would not expect to see used glasses go into the tubs with milk and juice cartons.

On 5/11/21, at 3:49 p.m. DM-G stated she expected staff to wash their hands before entering the kitchen. DM-G stated staff need to wash their hands before they touch the food, and in between tasks.

On 5/13/21, at 2:59 p.m. the administrator was interviewed. The administrator verified dirty dishes should be placed in the cart for dirty dishes, and should not be placed in the bin with beverages that will be used again.

The facility policy Dishes and Utensils dated 8/2018, lacked direction on keeping dirty dishes separate from beverages that would be used again.

SUGGESTED METHOD OF CORRECTION:

The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all staff receive training on keeping dirty dishes separate from food/drinks that will be used again.
The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.
The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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21015	Continued From page 14 (21) days.	21015		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and glove use practices were maintained for 1 of 2 residents (R21) observed during personal cares. Findings include: R21's Face Sheet printed 5/12/21, indicated diagnoses which included spastic diplegic cerebral palsy (a subtype of spastic cerebral palsy in which the legs are most affected), and paraplegia (paralysis of the legs and lower body), . R21's quarterly Minimum Data Set (MDS) dated 3/4/21, indicated R21 was cognitively intact. The MDS indicated R21 required extensive assistance with toilet use and personal hygiene. R21's MDS further indicated R21 was always incontinent of bowel and bladder. On 5/12/21, at 9:16 a.m. nursing assistant (NA)-E was observed providing personal cares for R21.	21385	See Federal POC	6/21/21

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NA-E performed hand hygiene upon entering, put on gloves, placed a plastic bag at the foot of the bed, removed R21's brief, explaining everything prior to performing the task, wiped R2's perineal area, discarded the wipe, and assisted R21 with rolling on her right side. NA-E wiped R21's rectal area (soft brown stool present). NA-E removed his soiled gloves, and without performing hand hygiene, donned clean gloves. NA-E adjusted R21's incontinent brief, removed his soiled gloves, and moved R21's overbed tray table closer to her. NA-E went to the bathroom and performed hand hygiene.

-at 9:28 a.m. NA-E was interviewed. NA-E verified he did not perform hand hygiene between glove changes, but should have.

On 5/13/21, at 2:58 p.m. the administrator was interviewed. The administrator verified hand hygiene should be performed between glove changes.

The facility policy Hand Hygiene revised 5/8/17, directed staff to use hand sanitizer between glove changes.

SUGGESTED METHOD OF CORRECTION:

The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all staff receive training on hand hygiene and glove use.
The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.
The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.

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21385	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications held for destruction, including narcotics and controlled medications (drugs regulated by the Controlled Substances Act (CSA) in the United States with the potential for abuse and dependence) were stored in a secure manner and area to prevent diversion. This had the potential to affect all residents residing in the facility. Findings include: According to the United States Drug Enforcement Administration (DEA) drugs, substances, and certain chemicals used to make drugs are classified into five (5) distinct categories or schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential. Schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous. Schedule III drugs, substances, or chemicals are	21550	See federal POC	6/21/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21550	Continued From page 17 defined as drugs with a moderate to low potential for physical and psychological dependence. Schedule IV drugs, substances, or chemicals are defined as drugs with a low potential for abuse and low risk of dependence. On 5/13/21, at 3:45 p.m. during observations of medication storage with licensed practical nurse (LPN)-D, LPN-D stated they put medications to be destroyed in the MedSafe (a stainless-steel collection receptacle with a removable inner liner) located on the Island Lake nurses station. LPN-D brought surveyor to the nurses station, and stated she had not yet used it. The MedSafe was located in the unlocked nurses station next to the desk area. The top door was ajar and cards of medication were visible in the back of the medication safe. When attempting to close the door completely, the door was unable to close and there was a sound of the plastic bubbles on medication cards crunching. On 5/13/21, at 4:23 p.m. the assistant director of nursing (ADON) stated the director of nursing (DON) and the pharmacy have keys to the MedSafe. The ADON stated no one would be able to reach the medications in the MedSafe, but when surveyor was able to reach inside the top flip-down door and almost reach the medications, the ADON stated with a device, there was a potential for the medication cards to be reached and pulled out of the MedSafe. The ADON verified there was a lock for the top door of the MedSafe and she did not know why it was not locked. The ADON stated staff, residents and/or visitors could have access to the unsecured medications in the MedSafe. The ADON stated they had reviewed the security of the MedSafe and the placement of the MedSafe when they received it approximately a month ago. The	21550		

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	00602	A. BUILDING: ______ B. WING ______	C 05/13/2021

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21550	Continued From page 18 ADON stated she would find out where the keys were and call the pharmacy to have it emptied tonight. The ADON verified the body of the MedSafe door could only be opened with a key the pharmacy had and a key the DON had when used together. On 5/13/21, at 4:48 p.m. the ADON stated they pushed the medication cards down in the MedSafe, and closed and locked the door. The ADON stated it would be fixed that same night. The facility provided the documentation of the medications that had been placed in the MedSafe for destruction. The medications included: 3/24/21: -Pregabalin (for seizures and nerve pain) 75 milligrams (mg) 4 tablets -oxycodone (Schedule II controlled narcotic pain medication) 5 mg 28 tablets 4/6/21: -Oxycodone 5 mg 20 tablets -Lorazepam 0.5 mg (Schedule IV controlled medication for anxiety) 20 tablets -Fentanyl (Schedule II controlled narcotic pain medication) 25 micrograms (mcg)/hour (hr) 12 tablets 4/13/21: -Fentanyl 12 mcg-3 patches -Lorazepam 0.5 mg -24 tablets -oxycodone HCl 10 mg/ml-8.5 milliliters (ml) 5/5/21: -omeprazole (for acid reflux) 40 mg 250 capsules -zofran (for nausea and vomiting) 8 mg 30 tabs -trazodone (antidepressant) 100 mg 29 tabs -levothyroxine (for thyroid) 100 mcg 29 tabs -paroxetine HCl (antidepressant) 20 mg 29 tabs -fluticasone prop (for allergies)50 mcg one bottle -creon (pancreatic enzyme replacement therapy) 12,000 usp units 100 capsules	21550		

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21550	Continued From page 19	21550		

-Haldol (antipsychotic) 1 mg 23 tablets
-Haldol 2 mg 112.5 tablets
-olanzapine (antipsychotic) 25 mg 20 tablets
-cymbalta (antidepressant) 20 mg 18 tablets
-temazepam (for insomnia) 15 mg 29 capsules
-scopolamine patch (for nausea and vomiting) 4 patches
-Albuterol sulfate (for obstructive airway disease-to improve breathing) 90 mcg one inhaler
-Humalog Kwik Pen (rapid acting insulin) 1 pen
-divalproex sodium (for seizures or mood stabilizer) 125 mg 196 capsules
-mirtazapine (antidepressant) 30 mg 26 tablets
-quetiapine (antipsychotic) 25 mg 47 tablets
-trazodone 50 mg 30 tablets
-mirtazapine 15 mg 49 tablets
-duloxetine (antidepressant) 60 mg 65 capsules
-gabapentin (for seizures and nerve pain) 300 mg 30 capsules

The facility policy Med Safe-Narcotic Destruction dated 11/20, directed the collection and disposal of unwanted, expired medications including controlled substances would be disposed of with the use of a Med Safe. The policy directed the use of Med Safe according to the manufacturer's instructions. For any unwanted or expired medication including controlled substances, license nursing staff would notify the director of nursing (DON) and two licensed nurses would verify the medication for disposal of all drugs and would be documented in the medical record prior to being placed in the bin. Verification would include the prescription number, patient name, drug name, strength, and quantity remaining. Two licensed nurses would complete and sign the certificate of inventory and destruction of controlled substance form, which was to be filed with the DON. The inside receptacle would be double locked and require tow keys to access

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21550	Continued From page 20 with one key kept by the DON and the second key kept by a member of the consulting pharmacy. The inner liner would be replaced and mailed for destruction according to the manufacturer's instructions by the DON and assigned pharmacy staff as needed. The policy and procedure lacked the Med Safe manufacturer's instructions. The Med Safe manufacturer's instructions were requested and not received. The facility policy Controlled Substances revised 7/16, directed all controlled medications are to be kept locked, and Schedule II controlled substances to be double-locked at all times in a separately locked compartment, permanently affixed to the physical plant or medication cart. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure medications including narcotics are destroyed properly. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and	21805		6/21/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21805	Continued From page 21 residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a resident had privacy when using the bathroom for 1 of 3 residents (R22) reviewed for activities of daily living (ADLs). Findings include: R22's Face Sheet printed 5/13/21, indicated R22's diagnoses included Alzheimer's disease, overactive bladder, retention of urine, and urgency of urination. R22's quarterly Minimum Data Set (MDS) dated 3/15/21, indicated R22 was severely cognitively impaired, required supervision with transfers and with toilet use. R22's MDS further indicated R22 was occasionally incontinent of urine, and always continent of bowel. R22's care plan start date 2/9/20, indicated R22's elimination goal was to have one or less accidents per day. Approaches included using incontinent product, toilet R22 upon rising, before or after meals, around noon, at bedtime, and with night rounds. The care plan indicated a toileting program was tried and not effective. R22's care plan dated 2/10/20, indicated she was at risk for bowel incontinence. The care plan indicated R22 often forgot to close the bathroom door, staff were to ensure bathroom door was closed if walking by when resident was in the bathroom.	21805	See Federal POC	

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Continued From page 22

R22's care plan indicated R22 had a history of transferring self to the bathroom. Approaches included staff maintaining a consistent environment and routine, re-orientation and cues as needed, assisting R22 with cleaning her hands after using the bathroom. The goal was for R22 to use the call light appropriately and ask for assistance with bathroom use.

On 5/11/21, at 8:00 a.m. R22 was observed from the hallway seated on the toilet in her bathroom.

On 5/12/21, at 2:45 p.m. R22 was observed from the hallway seated on the toilet in her bathroom.

On 5/13/21, at 8:59 a.m. nursing assistant (NA)-D was interviewed. NA-D stated R22 went to the bathroom by herself every 10 minutes, and would not shut the door.

-at 9:09 a.m. registered nurse (RN)-A was interviewed. RN-A stated it is was not dignified for R22 to be seen seated on the toilet by anyone passing by her room. RN-A stated staff need to perform more frequent checks, and shut R22's door door. RN-A stated this should be addressed in the daily interdisciplinary team (IDT) meeting.

-at 9:21 a.m. R22 was observed from the hallway seated on the toilet, with her pants down around her ankles.

-at 9:54 a.m. R22 was observed from the hallway seated on the toilet wiping herself.

-at 9:55 a.m. RN-B was interviewed. RN-B stated he was aware of R22 leaving the bathroom door open. RN-B stated the facility could not keep R22's door closed because she was a high risk for falls. RN-B stated he was not sure what the

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21805	Continued From page 23	21805		

next step should be. RN-B stated they had not discussed this at their IDT meeting.

-at 11:51 a.m. R22 was observed from the hallway seated on the toilet, with her pants down around her ankles.

-at 2:45 p.m. R22 was observed from the hallway standing in the bathroom with her pants down around her ankles.

-at 2:58 p.m. the administrator was interviewed. The administrator stated it was not dignified for a resident to be seen from the hallway seated on the toilet.

The facility policy Toileting Residents dated 3/12/17, directed staff to assure privacy and dignity for resident, pull privacy curtain and close door.

The facility policy Dignity reviewed/revised 10/23/17, directed staff would be provided guidance on maintaining and enhancing resident's dignity. The policy directed staff would treat each resident with respect and dignity at all times. Staff were directed to promote, maintain and protect resident privacy, including bodily privacy during assistance with personal cares and treatments. In addition the staff were directed to treat cognitively impaired residents with dignity and sensitivity.

SUGGESTED METHOD OF CORRECTION:

The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all staff receive training on resident dignity with bathroom use.
The Director of Nursing or designee could

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21805	Continued From page 24 educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		

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	245414	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/12/2021**

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K 000	INITIAL COMMENTS An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/12/ 2021. At the time of this survey, Viewcrest Health Center Building 01 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. Healthcare Fire Inspections State Fire Marshal Division	K 000		

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

Electronically Signed | | 06/14/2021

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	K 000		

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 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 92 beds and had a

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	245414	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/12/2021**

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K 000	Continued From page 2 census of 67 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
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 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 the automatic fire sprinkler system in accordance with (NFPA 101 2012, Life Safety Code, section 9.7.5 and NFPA 25 2011, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.1. This deficient practice could affect all residents within the room. Findings include:	K 353	It is the policy of Viewcrest Health Care Center to ensure maintenance and testing of sprinkler systems are completed per the NFPA. The two fire sprinkler heads over the washing machines in the laundry room were replaced with new devices. The Maintenance Director or designee will randomly audit sprinkler heads weekly for three months to ensure no other heads have noted corrosion. Results of all	6/14/21

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	245414	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/12/2021**

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K 353	Continued From page 3 On a facility tour between the hours of 10:30 AM and 2:30 PM on 05/12/2021, it was revealed that there were two fire sprinkler heads above washing machines in the laundry room that were showing a large amount of corrosion. This deficient practice was verified by the Facility Maintenance Director at the time of discovery.	K 353	audits will be reviewed by the facility Quality Assurance Performance Improvement committee.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	K 918		6/14/21

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K 918	Continued From page 4 readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain essential electrical systems in accordance with NFPA 99 2012, Health Care Facilities Code, section 6.4.1.1.6.2 and NFPA 110 2010, Standard for Emergency and Standby Power Systems, section 5.6.5.6. This deficient practice could affect all 92 residents. Findings include: On a facility tour between the hours of 10:30 AM and 2:30 PM on 05/12/2021, it was revealed that there was no remote emergency shut-down for the generator. This deficient practice was verified by the Facility Maintenance Director at the time of discovery.	K 918	It is the policy of Viewcrest Health Care Center to ensure all electrical power systems receive the required maintenance and testing per the NFPA. The facility generator was noted to have a remote emergency shut-down installed on 5/20/2021. The facility generator systems will continue to be reviewed for maintenance per current guidelines.	

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	245414	A. BUILDING **03 - FAZE REMODEL** B. WING ____	**05/12/2021**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/12/ 2021. 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 18 New 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	TITLE	(X6) DATE
Electronically Signed		06/14/2021

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 **03 - FAZE REMODEL** B. WING ____________	**05/12/2021**

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K 000	Continued From page 1	K 000		

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.

The facility has a capacity of 92 beds and had a census of 67 at the time of the survey.

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K 918		6/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 3 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain essential electrical systems in accordance with NFPA 99 2012, Health Care Facilities Code, section 6.4.1.1.6.2 and NFPA 110 2010, Standard for Emergency and Standby Power Systems, section 5.6.5.6. This deficient practice could affect all 92 residents. Findings include: On a facility tour between the hours of 10:30 AM and 2:30 PM on 05/12/2021, it was revealed that there was no remote emergency shut-down for the generator. This deficient practice was verified by the Facility Maintenance Director at the time of discovery.	K 918	See Federal POC	