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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: H58P

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/23/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NEII 09/01/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/01/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/26/2015
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5414

On July 23, 2015 a health A Post Certification Revisit (PCR) was completed and on August 27, 2015 a life safety code Federal monitoring PCR was completed at this facility to verify if the facility achieved and maintained compliance with Federal certification requirements. Based on our revisits, we have determoned the facility has achieved compliance with deficiencies issued pursuant to a PCR completed June 10, 2105 and a life safety code FMS completed on June 9, 2015, effective July 13, 2015. As a result of the revisit findings, this Department discontinued the Category 1 remedy of State monitoring, effective July 13, 2015.

In addition, this Department recommended to the CMS Region V Office the following action related to the remedy imposed in the CMS letter of June 23, 2015:

• Mandatory denial of payment for new Medicare and Medicaid admissions (DPNA) effective August 1, 2015 be rescinded, effective July 31, 2015. (42 CFR 488.417 (b))

Since DPNA did not go into effect. The facility would not be subject to a two year loss of NATCEP that was to begin, August 1, 2015.

Refer to the CMS 2567b forms from the July 23, 2015 health PCR and the August 27, 2015 FMS PCR.

Effective July 31, 2015, the facility is certified for 92 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245414

September 1, 2015

Mr. Geoffrey Ryan, Administrator
Viewcrest Health Center
3111 Church Street
Duluth, Minnesota 55811

Dear Mr. Ryan:

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

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

Effective July 31, 2015 the above facility is certified for:

92 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 1, 2015

Mr. Geoffrey Ryan, Administrator
Viewcrest Health Center
3111 Church Street
Duluth, Minnesota 55811

RE: Project Number S5414026, F5414025

Dear Mr. Ryan:

On June 23, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedywas being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 1, 2015. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of June 23, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 1, 2015.

In addition, on July 1, 2015, we informed you that the following Category 1 remedy was being imposed:

- State Monitoring effective July 6, 2015. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on May 1, 2015, Federal Monitoring Survey (FMS) completed on June 9, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on June 25, 2015. The most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On July 23, 2015, the Minnesota Department of Health completed a PCR and on August 27, 2015 the Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to health PCR completed on June 25, 2015 and an FMS completed June 9, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 13, 2015. Based on our visit, we have determined

that your facility has corrected the deficiencies issued pursuant to our PCR, completed on June 25, 2015 and the FMS completed on June 9, 2015, effective July 13, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 31, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of June 23, 2015:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 1, 2015 be rescinded, effective July 31, 2015. (42 CFR 488.417 (b))

Futhermore, in the CMS letter of June 23, 2015, CMS advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 1, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 31, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245414	A. Building B. Wing	7/23/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **07/13/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **07/13/2015**	ID Prefix **F0369** Reg. # **483.35(g)** LSC	Correction Completed **07/13/2015**
ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **07/13/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	CC/mm	09/01/2015	29433	07/23/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/1/2015			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245414	A. Building B. Wing **01 - MAIN BUILDING 01**	8/27/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**
Reg. # **NFPA 101** LSC K0014		Reg. # **NFPA 101** LSC K0018		Reg. # **NFPA 101** LSC K0025	
ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**
Reg. # **NFPA 101** LSC K0027		Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0033	
ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**
Reg. # **NFPA 101** LSC K0045		Reg. # **NFPA 101** LSC K0048		Reg. # **NFPA 101** LSC K0051	
ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**
Reg. # **NFPA 101** LSC K0055		Reg. # **NFPA 101** LSC K0056		Reg. # **NFPA 101** LSC K0062	
ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**
Reg. # **NFPA 101** LSC K0064		Reg. # **NFPA 101** LSC K0069		Reg. # **NFPA 101** LSC K0144	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/mm	09/01/2015	03005	08/27/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245414	A. Building B. Wing **01 - MAIN BUILDING 01**	8/27/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0147	Correction Completed **07/31/2015**				

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/mm	09/01/2015	03005	08/27/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/9/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245414	A. Building B. Wing **02 - VIEWCREST HEALTH CENTER**	8/27/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**
Reg. # **NFPA 101** LSC K0011		Reg. # **NFPA 101** LSC K0012		Reg. # **NFPA 101** LSC K0023	
ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**
Reg. # **NFPA 101** LSC K0025		Reg. # **NFPA 101** LSC K0033		Reg. # **NFPA 101** LSC K0038	
ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**
Reg. # **NFPA 101** LSC K0046		Reg. # **NFPA 101** LSC K0048		Reg. # **NFPA 101** LSC K0051	
ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**	ID Prefix	Correction Completed **07/31/2015**
Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0064		Reg. # **NFPA 101** LSC K0144	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/mm	09/01/2015	03005	08/27/15
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/9/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H58P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00602

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/25/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NEII 07/15/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/18/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/26/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5414

A Post Certification Revisit (PCR) was completed on June 25, 2015 to verify the facility achieved and maintained compliance with Federal certification requirements. Based on our PCR, we determined the facility had not achieved substantial compliance with deficiencies issued pursuant to the May 1, 2015 standard survey. The deficiencies not corrected are as follows:

• F0241 -- S/S: E -- 483.15(a) -- Dignity And Respect Of Individuality
• F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
• F0369 -- S/S: D -- 483.35(g) -- Assistive Devices - Eating Equipment/utensils

In addition, at the time of this revisit, we identified the following deficiency:

• F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

As a result of the revisit findings, this Department is imposing the following Category 1 remedy:

• State Monitoring effective July 6, 2015. (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of June 23, 2015:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective August 1, 2015 remain in effect. (42 CFR 488.417 (b))

As CMS Region V Office notified the facility in their letter of June 23, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), Viewcrest Health Center is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 1, 2015.

Refer to the CMS 2567b, CMS 2567 along with the facilitys plan of correction. Post Certification Revisit (PCR) to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 1621

July 1, 2015

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

RE: Project Number S5414026

Dear Mr. Dahl:

On June 23, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedy was being imposed:

> • Mandatory denial of payment for new Medicare and Medicaid admissions effective August 1, 2015. (42 CFR 488.417 (b))

Also, CMS notified you in their letter of June 23, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 1, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on May 1, 2015 and a Federal Monitoring Survey (FMS) completed June 9, 2015. The most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On June 25, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey completed May 1, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 10, 2015. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our survey, completed on May 1, 2015. The deficiencies not corrected are as follows:

- **F0241 -- S/S: E -- 483.15(a) -- Dignity And Respect Of Individuality**
- **F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being**
- **F0369 -- S/S: D -- 483.35(g) -- Assistive Devices - Eating Equipment/utensils**

In addition, at the time of this revisit, we identified the following deficiency:

- **F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans**

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

As a result of the revisit findings, this Department is imposing the following Category 1 remedy:

- State Monitoring effective July 6, 2015. (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of June 23, 2015:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 1, 2015 remain in effect. (42 CFR 488.417 (b))

As CMS Region V Office notified you in their letter of June 23, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 1, 2015.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

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

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: chris.campbell@state.mn.us
Phone: (218) 302-6151 Fax: (218) 723-2359

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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 1, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

RECEIVED
JUL 13 2015
MN Dept of Health
Duluth

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 _____	R 06/25/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		
{F 241} SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to promote a dignified dining experience by serving continental breakfast on paper plates, and disposable plastic glasses for 5 residents (R19, R96, R63, R2, R92) observed at continental breakfast. This had the potential to effect approximately 50 residents who ate the continental breakfast. Findings include: On 6/23/15, at 8:10 a.m. the continental breakfast service was observed. Residents were eating breakfast served on paper plates, and drinking juice served in disposable plastic cups. Housekeeper (H)-A stated the facility always served continental breakfast with disposable dishware. R19 was observed on 6/23/15, at 8:10 a.m. eating toast off of a disposable plate. R96 was observed on 6/23/15, at 8:10 a.m. eating toast from a disposable plate, and drinking juice out of a disposable plastic glass.	{F 241}	**F241** **VHC promotes care for residents in a manner that maintains each resident's dignity and respect in full recognition of his or her individuality.** All dietary and housekeeping staff will be educated on the use of regular dishware. Continental breakfast will be served for all residents on regular dishware. Dietary manager and/or designee will conduct audits of the continental breakfast meal daily X 1wk, and then 2xwkx2wks and weekly thereafter to ensure the proper dishware and adaptive equipment is being utilized. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion date: 7/13/15 7/15/15 1440 via phone = Bob Dahl: Administrator to audit DM's audits and results to ensure compliance.	

of 7/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Dahl | TITLE: Administration | (X6) DATE: 07/10/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	R 06/25/2015

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 241}	Continued From page 1 On 6/23/15, at 8:50 a.m. the administrator and the director of nursing (DON) were interviewed. The administrator stated he was unaware the facility continued to use disposable dishware at the continental breakfast. On 6/23/15, at 9:35 a.m. dietary aide (DA)-B was interviewed and indicated she was unaware of what type of dishware was served at continental breakfast. DA-B stated she had not received any education on what type of dinnerware was to be used. On 6/23/15, at 9:58 a.m. the dietary manager (DM)-A stated he was unaware the kitchen was to serve continental breakfast on regular dishware. He further stated he was not involved in the plan of correction so was unaware any correction plan had been developed. The facility policy and procedure on Dining - Atmosphere/Environment updated /5/15, directs all meals will be served on regular glassware with regular silverware unless specified on care plan. On 6/23/15, at 8:00 a.m. the continental breakfast service was observed. Residents were eating toast and hard boiled eggs served on paper plates. Cereal was served in paper bowls using plastic spoons, and juice was served in plastic disposable cups. R63 was observed on 6/23/15, at 8:15 a.m. eating continental breakfast at a table in the Mesa dining area utilizing disposable dishes and silverware. R2 was observed on 6/23/15, at 8:15 a.m. eating continental breakfast at a table in the Mesa dining	{F 241}		

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 _____	R 06/25/2015

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

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{F 241}	Continued From page 2 area utilizing disposable dishes and silverware. R92 was observed on 6/23/15, at 8:15 a.m. eating continental breakfast at a table in the Mesa dining area utilizing disposable dishes and silverware. On 6/23/15, at 8:15 a.m. housekeeper (H)-B verified the residents were eating from disposable dishes and silverware. H-B stated the residents were always served continental breakfast on disposable dishes and silverware except hot beverages were served in coffee mugs. "That's what we do and have been doing."	{F 241}		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the use of a continuous positive airway pressure (CPAP) machine as ordered for 1 of 1 residents (R39) reviewed for medical equipment needs. Findings include: R39's face sheet identified diagnoses that included obstructive sleep apnea. The physician's	{F 309}	**F309** **VHC will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.** ***R39 No CPAP on in early morning*** Island Lake Nursing and NAR staff were re-educated on R39s CPAP schedules and to document any refusals. All resident's reviewed for CPAP use to ensure plan of care being followed.	

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 _____	R 06/25/2015

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

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{F 309}	Continued From page 3 order signed 5/13/15, directed CPAP (a medical device, used to treat sleep apnea) every night, all night, and with naps. Document if refusing. R39's care plan dated 7/15/14, directed CPAP every night and during naps, and document if refusing. On 6/24/15, at 7:07 a.m. R39 was observed to be in bed sleeping. The CPAP machine was not applied to R39. On 6/25/15, at 7:11 a.m. R39 was observed to be sleeping in bed, without use of the CPAP machine. On 6/24/15, at 2:10 p.m. registered nurse (RN)-B stated R39 should be wearing his CPAP when he is sleeping. RN-B verified there was no documentation of her refusals. On 6/25/15, at 11:32 a.m. the director of nursing (DON) verified the CPAP was to be used when R39 was sleeping, and staff were to document if he refused. The facility policy and procedure on CPAP/BiPAP Support dated 6/12, directed use of a CPAP to promote resident comfort and safety, and to notify the physician if the patient is refusing.	{F 309}	Random CPAP use audits will be conducted by DON/designee to ensure CPAP being used per care plan and there is documentation of any refusals. Audits to be done daily x 1 week, 3xwkx2, 2xwkx2, and then weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion date: 7/13/15	
{F 369} SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adaptive eating equipment was provided for 2 of 3 residents	{F 369}	**F369** **VHC will provide special eating equipment and utensils for residents who need them** Dietary staff were re-educated on R 19, R21, and all other residents utilizing adaptive eating equipment to ensure individual needs are being met.	

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	R 06/25/2015

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 369}	Continued From page 4 (R19, R21) reviewed for adaptive eating equipment. Findings include: R19's Face Sheet identified diagnoses that included osteoarthritis and pain. The quarterly Minimum Data Set (MDS) dated 4/23/15, indicated R19 had severe cognitive impairment, and was independent with eating after staff set up. R19's care plan dated 5/11/15, directed sippy cups without lids. R19's diet ticket directed sippy cups, no lids. On 6/24/15, at 7:23 a.m. R19 was observed to be eating toast, and drinking juice out of a regular glass, and coffee from a coffee cup. On 6/24/15, at 8:18 a.m. the dietary manager (DM)-A stated R19 could use a regular coffee cup for her coffee, but she should have a sippy cup for her juice. R21's Face Sheet identified diagnoses that included osteoarthritis, osteoporosis and pain. The annual MDS dated 4/23/15, indicated R21 was cognitively intact, and was independent with eating after staff setup. R21's diet ticket directed thin black handle fork, spoon and knife, and dycem lip plate. On 6/24/15, at 12:59 p.m. R21 was observed in her room, just starting her lunch. R21 had a half grilled cheese sandwich, tomato soup, pureed egg and cut up fruit. R21 was not provided with the thin black handle fork, spoon or knife.	{F 369}	Random audits of all residents' with adaptive equipment will be completed by Dietary Manager daily X 1 week, 3xwkx2, 2xwkx2, then weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion date: 7/13/15	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520		

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 _____	R 06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 5 QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to ensure the quality assurance and assessment (QAA) committee identified quality concerns and implemented policies and systems to ensure disposable dishware was not being used for the breakfast meal which had been identified during the recertification survey exited 5/1/15. This had the potential to effect all residents in the facility. Findings include:	F 520	**F520** **VHC maintains a QAPI committee that meets monthly to identify issues with regards to quality assurance and develops and implements appropriate plans of action to correct identified quality deficiencies.** State report of quality deficiencies will be brought to QAPI meeting on 7/10/15 in order to identify and develop appropriate plans of action for correction of quality deficiencies. Audit results for each deficiency (F241, F309, and F369) will be reviewed on a weekly basis by the Correction Committee to ensure compliance. Results from the Correction Committee of the audit results will be brought forward to the QAPI meeting monthly for further review. Completion date: 7/13/15	

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	R 06/25/2015

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

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F 520	Continued From page 6 During the initial survey completed on 5/1/15, the facility was identified to be using disposable dishware at the breakfast meal (see F241, F369). During the revisit survey conducted on 6/23-6/25/15, the facility continued to use disposable dishware for the breakfast meal. This was identified by observation and verified through interview. On 6/25/15, at 11:32 p.m. the director of nursing (DON) stated the facility had a QAA meeting following the initial survey of 5/1/15, but had not reviewed the circumstances identified in F241 and F369. The DON stated the Dietary Manager was responsible for the correction, however she did not know it had been missed by the Dietary Manager.	F 520		

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245414	A. Building B. Wing	6/25/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **06/10/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **06/10/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **06/10/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **06/10/2015**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **06/10/2015**	ID Prefix **F0362** Reg. # **483.35(b)** LSC	Correction Completed **06/10/2015**
ID Prefix **F0365** Reg. # **483.35(d)(3)** LSC	Correction Completed **06/10/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **06/10/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	CC/mm	07/01/2015	29433	06/25/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/1/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: H58P

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

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/01/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (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 :
Susan Frericks, HPR-SWS — 06/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 06/26/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0266

May 19, 2015

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

RE: Project Number S5414026

Dear Mr. Dahl:

On May 1, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: chris.campbell@state.mn.us

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 10, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 10, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 1, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 1, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	05/01/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to promote a dignified dining experience by serving continental breakfast on paper plates and bowls and using plastic utensils and cups for 6 of 8 residents (R25, R23, R92, R39, R56, R29) observed for the use of adaptive equipment at meal time. This had the potential to effect all residents who participated in the continental breakfast. Findings include:	F 241	**F241** **VHC promotes care for residents in a manner that maintains each resident's dignity.** All dietary staff will be re-educated on the use of regular dishware for all meals. Continental breakfast will be served for all residents on regular dishware. Dietary manager and/or designee will conduct audits of the continental breakfast meal daily X 1wk, and then 2xwkx2wks and weekly thereafter to ensure the proper dishware is being utilized. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion date: 6/10/15	06/10/15

6/10/15 OK w addendum sc

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Cahill MHA | TITLE: Administrator | (X6) DATE: 05/28/15

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

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F 241	Continued From page 1 On 4/28/15 at 10:55 a.m., 4/29/15 at 10:50 a.m. and 4/30/15 at 11:10 a.m. the continental breakfast service was observed. Residents were eating toast and muffins served on paper plates. Cereal was served in paper bowls using plastic spoons, and juice was served in plastic disposable cups. R25 was observed on 4/30/15, at 10:34 a.m. was observed in her room eating toast. She had disposable dishes with her continental breakfast. R23 was observed on 4/29/15, at 8:35 a.m eating breakfast at a table in the dining area utilizing disposable dishes. R92 was observed on 4/29/15, at 8:20 a.m. sitting at the dining table eating from disposable dishes. R39 was observed on 4/29/15 at 8:14 a.m.in the dining area eating with disposable dishes. R56 was observed on 4/30/15, at 7:37 a.m. sitting int he dining room utilizing disposable dishes and utensils to eat the continental breakfast. R29 was observed on 4/29/15, at 8:33 a.m. eating the continental breakfast with disposable dishes and utensils. Interview with the dietary manager on 4/30/15 at 8:40 a.m. indicated continental breakfast was always served with disposable products.	F 241		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		06/10/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 2 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was revised to reflect the care and services required to meet the needs for 2 of 5 residents (R92, R29) reviewed for accidents and 1 of 3 residents (R29) reviewed for nutrition. Findings include: R92's bed was observed on 4/27/15, at 4:21 p.m. to have a body pillow tucked under the fitted sheet on the left side of the bed, which occupied approximately one third of the bed. A family member-E, stated the body pillow had been placed there to prevent R92 from rolling out of the left side of the bed.	F 280	**F280** **VHC reviews and revises care plans to ensure the care plan reflects the needs of the residents.** R92's care plan and NAR care guide was updated regarding the body pillow on the bed. R29's care plan was reviewed and updated regarding the call light within reach at all times. R92's Nutritional care plan was reviewed and revised to reflect the resident's care and services regarding his/her swallowing disorder and adaptive equipment. Nursing staff will be re-educated on Care planning for 'Accidents' on 6/1/15. Dietary manager will be re-educated on Care planning for Nutrition on 6/1/15. Care plans for all residents will be audited for both 'Accidents' and 'Nutrition' and will be revised prn. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion date: 6/10/15	

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F 280	Continued From page 3 R92's face sheet, current as of 4/29/15, identified diagnoses including a heart arrhythmia (irregular heart beat), muscle weakness, vertigo (dizziness), and a history of transient ischemic attacks (small strokes). R92's quarterly Minimum Data Set (MDS) assessment dated 1/28/15, indicated R92 had a moderate cognitive deficit, required extensive assistance of one staff with transfers and ambulation, and had an unsteady balance. The MDS further indicated R92 had 2 falls without injury and 2 falls with injuries that were not significant. Review of an incident report dated 12/9/14, at 12:20 a.m. indicated R92 slid out of bed, onto the floor. Fall interventions initiated following the incident included a body pillow on the bed , and a floor mat beside the bed. The incident report dated 12/19/14, at 2:20 a.m. indicated R92 slid out of bed and the body pillow had not been in place on the bed. The current care plan updated on 4/28/15, was silent regarding the body pillow, and the review dated 1/21/15, did not address the body pillow. The current undated nursing assistant care guide for R92 did not address the body pillow. During observations on 4/29/15 at 7:18 a.m. R92's bed had a body pillow tucked under the fitted sheet on the bed. Observations on 4/30/15, at 7:41 a.m. identified R92 lying in bed with the body pillow tucked under the fitted sheet directly behind her back. Her knees were bent, extending her legs beyond the right edge of the bed. During observations on 5/1/15, at 9:15 a.m. R92 was lying in bed. The body pillow was not on the bed.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 4 R92 then stated she didn't think she needed it anymore, and stated she did not want it in the first place. During an interview on 4/30/15, at 7:49 a.m. nursing assistant (NA)-F and NA-G stated R92 frequently tries to get out of bed by herself. NA-F verified R92 had a body pillow under the sheet to try to prevent her from getting out of bed. During an interview on 04/30/15 at 9:58 a.m. RN-A stated the body pillow was no longer care planned and believed it to be R92's preference. RN-A stated R92 had the body pillow because she was falling, but was no longer falling so didn't need it. During an interview on 5/1/15, at 9:52 a.m., the DON stated the care plan was updated at least quarterly and with each significant change. The DON verified the body pillow should have been added to the care plan, and should not have been placed under the sheet. R29's face sheet printed on 4/29/15, identified diagnoses including dementia, and anxiety. R29's annual MDS, dated 3/11/15, indicated R29 had severely impaired cognition and required extensive assistance with bed mobility, and transfers. Review of R29's safety/restrictive devices care plan, with a start date of 6/26/14 identified a problem of risk for falls or injury related to cognitive deficits due to dementia and impaired mobility and a history of self-transfers. Approaches included a bed sensor (used to alert staff, but not as a fall intervention), body pillow under outer edge sheet on bed when laying down and keep call light in easy reach. In addition,	F 280		

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F 280	Continued From page 5 R29's safety/restrictive devices care plan also directed encourage resident to use call light for assistance; and keep call light in easy reach. R29 was observed in bed on 4/27/15, at 6:57 p.m. The bed was positioned against the wall, with R29's left side nearest the wall. The bed was in the lowest position, and a body pillow tucked in under the bottom sheet, on the outside edge of the bed. On 4/27/15, at 6:52 p.m., R29 was observed lying in bed and calling out softly for help. R29's call light was hanging off the side of her ¼ bed rail. The call light was not visible to the resident, nor could she have reached it. On 4/28/15, at 10:37 a.m., R29 was observed sitting in her wheelchair in her room. R29's call light was not within reach, rather it was approximately two feet away from her, out of reach. On 4/30/15, 12:06 p.m., R29 was observed laid back into bed; her call light was hanging off the outside of her side rail, not within sight or reach. In an interview on 4/30/15, at 12:14 p.m. RN-B stated that the body pillow is placed under the bottom sheet to keep R29 safe and ensure that she doesn't climb out of bed as easily. RN-B stated that the body pillow has been in place since sometime before the fall on 4/14/15. RN-B stated that the body pillow acts like "treating the bed as if it were a concave mattress", providing extra support to the side, so that if R29 rolled, she wouldn't just roll out of bed. On 4/27/15, at 6:52 p.m., nursing assistant (NA)-L stated R29 is capable of using her call light. On 4/27/15, at 6:57 p.m., NA-M stated R29's call light was usually put within reach. NA-M stated R29 always called out for help and didn't use her call light. On 4/29/15, at 1:47 p.m. NA-E stated that R29 did press her call light, but she was not sure if	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 6 R29 understands what she's doing. On 4/30/15, at 12:07 p.m., registered nurse (RN)-B was shown the call light out of reach and stated R29 didn't always use her call light but they do leave it within reach. RN-B explained, "That is what the care plan says" and adjusted the call light so that R29 could reach it. R29's annual MDS, dated 3/11/15, indicated R29 had severely impaired cognition and required limited assistance with eating, had no swallowing disorders, and was on a mechanically altered therapeutic diet. R29's weight records indicated R29 weighed 140 pounds on 11/1/14 and 123 pounds on 3/28/15. This was a loss of 17 pounds, a severe weight loss of 12.1% weight loss in 180 days. R29's care plan specified she needed cues, reminders and some assistance with meals. The care plan directed staff to serve R29 in the Fish Lake dining area, provide adaptive equipment, and a regular diet of pureed texture. R29's care plan identified as a problem a history of weight loss and listed as a goal that the resident will have adequate food and fluid intake, with her weight remaining within 7.5% for 90 days. R29's undated Care Card specified the following adaptive equipment: dycem, suction bowls, brown covered mugs, and black handled utensils. On 4/29/15, at 8:33 a.m., R29 was observed at continental breakfast sitting in w/c at a table by herself. R29 was eating cereal (Cheerios in milk), yogurt, and juice. The cereal was in a white disposable bowl, the yogurt was in a small, clear disposable cup and the juice was also in a	F 280		

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F 280	Continued From page 7 disposable cup. R29 was using a disposable white spoon to eat the cereal. No adaptive equipment was provided. No staff consistently provided encouragement to eat. R29 was wheeled out of the dining room area at 8:58 a.m. R29 had eaten approximately 70% of her continental breakfast. In the interview on 4/30/15, at 2:18 p.m., the SLP stated she last saw R29 starting on 7/24/14 and discharged her on a pureed diet and thin liquids because R29 was pocketing a lot of food into both her cheeks. She would chew food, but not swallow it; instead it would "pocket" or stay in her cheeks. The SLP stated that cold cereal, such as "Cheerios" could only be considered pureed if it was soaked in milk long enough become mush, or what they call a "slurry". The SLP stated that R29 receiving regular textured foods was a concern, as R29 could choke, aspirate or get pneumonia from regular consistency food. The facility policy and procedure for Dining Services dated 2/1/15, directed that adaptive equipment will be provided as determined by nursing or OT to assist the resident in maintaining independence with eating. The policy and procedure further directed dietary to wash and sanitize the equipment and return it to the resident each meal.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		06/10/15

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F 282	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure care plan interventions for prevention of skin breakdown were followed for 1 of 1 resident (R107) reviewed for a non-pressure related skin condition and 1 of 3 residents (R39) reviewed for dental care and for risk of pressure ulcers.. Findings include: R107's disease diagnosis and allergies report dated 4/30/15, identified R107's diagnoses as diabetes, hypertension (high blood pressure), cerebral artery occlusion with infarct (type of ischemic stroke), and generalized muscle weakness. R107's quarterly Minimum Data Set (MDS) dated 3/6/15, indicated R107 had moderate cognitive impairment and required extensive assist with dressing. R107's Physician Order Sheet dated 4/30/15, directed staff to make sure R107 had her black ankle sleeves on bilaterally during the day time. R107's nursing assistant care plan [undated] directed the nursing assistant staff to place the black ankle sleeves on her in the morning. R107's Current Care Plan [undated] directed the licensed staff to place black ankle sleeves on R107 due to her history of bumping the outside of her ankles on the wheelchair. On 4/30/15, at 7:08 a.m. R107 was observed seated in her wheelchair in the dining room. R107 was dressed in a short sleeve shirt, capri pants, short white anklet socks, and tied black shoes. R107's ankles lacked the black protective sleeves. On 4/30/15, at 8:50 a.m. R107 was observed with registered nurse (RN)-C. RN-C confirmed R107 was not wearing the black sleeved ankle	F 282	**F282** **VHC will ensure services provided by the facility are provided by qualified persons in accordance with each resident's written plan of care.** Nursing and NAR staff on Canal Park unit were re-educated on **R107s** Care plan regarding her black protective ankle sleeves. Nursing and NAR staff on Island Lake unit were re-educated on **R39's** care plan regarding offloading and repositioning schedule and care plan regarding R39's tooth brushing schedule. Random audits will be conducted by DON/designee for care plans being followed for Repositioning and for Tooth brushing, 3xwkx2, 2xwkx2, and then weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion date: 6/10/15	

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F 282	Continued From page 9 protectors. R107's ankles were checked and there was noted an approximately 1 centimeter (cm) by 1cm reddened and scabbed area on R107's outer aspect of her right ankle. RN-C confirmed R107's care plan should have been followed and R107 should have been wearing the black ankle sleeves. On 4/30/15, at 10:21 a.m. the director of nursing (DON) verified it was her expectation that resident care plans be followed. The Resident Care Policies dated 6/1/2012, indicated a written plan of care would be developed for all residents to address their needs and goals. This care plan would be a part of the resident's permanent record. R39's quarterly Minimum Data Set (MDS) assessment dated 3/30/15, indicated R39 had a short term memory deficit and severely impaired decision-making ability. The MDS indicated R39 required total assistance with bed mobility, toileting needs, and personal hygiene with 2 staff. The certified nurse practitioner (NP) visit note dated 2/19/15, indicated R39's diagnoses included hemiplegia (paralysis on one side of the body), traumatic brain injury (TBI), and speech disorder. The NP note further indicated R39 had an impaired mobility and ADLs and required total assistance with dressing, toileting, bathing and transfers. The progress notes regarding the MDS quarterly assessment, dated 3/23/15, indicated R39 was unable to move self in bed and required total assistance. The addendum to the progress note dated 3/24/15, indicated R39 was dependent on staff for all cares.	F 282		

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F 282	Continued From page 10 The General Nurse's Observation dated 3/23/15, indicated R39 had his own teeth with some missing, but had no pain or discomfort. The documentation indicated R39 had teeth brushed in the morning, at bedtime and after every meal. The currently used, undated nursing assistant care guide indicated R39 required extensive assistance of 1-2 staff for ADLs, 1-2 staff for repositioning, and directed staff to reposition R39 in the wheelchair and in bed, every 3 hours. The care guide directed staff to provide toileting cares every 2 hours. The care guide also directed staff to brush R39's teeth with an electric toothbrush upon rising in the morning and after meals and snacks, and if R39 pushed staff's hands away during oral hygiene, be sure to tell him what they are doing. The care plan reviewed 1/21/15, indicated R39 was dependent on two staff to reposition in bed or required the assistance of 1-2 for repositioning in bed, and was to be repositioned every 3 hours. The care plan directed staff to provide toileting cares every two hours. The care plan further indicated R39 was dependent on staff to provide all grooming/hygiene tasks, and directed staff to brush resident's teeth with a soft tooth brush with morning and bedtime cares, and after each meal. During continuous observations on 4/29/15, from 8:08 a.m. until 11:59 a.m. R39 was not repositioned to relieve pressure from a sitting position. In addition, during the continuous observations, R39 did not receive oral cares. The signed physician orders dated 3/5/15, directed the nurse to check with the NA to ensure	F 282		

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F 282	Continued From page 11 R39's teeth were brushed as indicated on the care card, two times/day during the day and evening. The electronic treatment administration record (eTAR) for 4/29/15, indicated the teeth brushing for R39 was not recorded during the day shift. A Tissue Tolerance-Repositioning Observation (a test used to determine how long a resident can tolerate sitting or lying in one position without pressure relief and without adverse effects) dated 3/18/15 indicated R39 had redness on his coccyx (tailbone) after 3 hours of lying and it was determined R39 required repositioning every 2 hours. The observation for sitting dated 3/19/15, indicated R39 was to be repositioned every 2 hours. An observation on 4/29/15, at 7:37 a.m. revealed a blue and white electric toothbrush was lying on a dry paper towel on the right side of the sink with the bristles facing toward the faucet and the paper towel partially over the head of the toothbrush. During observations on 4/29/15, at 8:08 a.m. R39 was put in the wheelchair, using a hoyer (a machine that completely lifts a resident using a sling). After R39 was in the wheelchair, nursing assistant (NA)-B asked NA-A if she was going to brush R39's teeth. NA-B stated she was going to brush his teeth after breakfast. Continuous observations were initiated. Following the cares provided at 8:08 a.m., continuous observations were initiated and R39 was brought down to the unit dining area and served continental breakfast.	F 282		

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F 282	Continued From page 12 On 4/29/15, at 9:34 a.m. R39 was brought to his room by the nurse, who then administered eye drops and an injection. R39 was left in his room, with the television on. During the continuous observation on 4/29/15, at 10:54 a.m. NA-A entered R39's room and closed the curtain. curtain. Surveyor immediately walked over and entered the room and found NA-A adjusting R39's shirt. NA-A stated she checked his brief and he was dry. NA-A left to get NA-B to help with boosting R39 up in his wheelchair. When they returned, NA-B stated they should use the hoyer so the canvas doesn't slide out. NA-A got the hoyer and they lifted R39 up with the hoyer and immediately sat him right back down, but positioned so he was sitting straighter and higher up in the chair. No oral care was provided. At 11:04 a.m. R39 was brought toward the dining room in Central Park. Continuous observations continued until 11:59 a.m. while R39 ate lunch. RN-A was informed of R39's need for repositioning. At 12:21 p.m., R39 was put into bed. During an observation on 4/29/15, at 2:01 p.m. the blue and white electric tooth brush remained in exactly in the same position, on the dry paper towel, and the suction machine was dry. During an interview on 4/29/15, at 2:09 a.m. NA-A stated she brushed R39's teeth after continental breakfast with toothettes. NA-A stated R39 is sometimes fine with brushing his teeth and sometimes is not. NA-A was informed that continuous observations had been done and oral cares had not been done. NA-A stated she had not yet brushed R39's teeth after lunch.	F 282		

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F 282	Continued From page 13 On 4/30/15, at 8:12 a.m. NA-F had brushed R39's teeth and stated R39 does not mind having his teeth brushed using the electric toothbrush and a small amount of toothpaste. NA-F again stated R39 never minds having his teeth brushed. On 4/29/15, at 12:13 p.m., NA-A stated R39 had been repositioned just before lunch when he was lifted in the hoyer and put back in his wheelchair. NA-A did not know how long R39 should be without pressure on his bottom during repositioning. During an interview on 4/29/15, at 12:15 p.m. RN-A stated repositioning times were determined by the tissue tolerance testing results and stated they start testing at 2 hours; if no redness at 2 hours, then they test the tolerance at 3 hours, both sitting and lying. If there is redness, they go back to reposition every 2 hours. RN-A stated R39 was to be repositioned every 3 hours. During an interview on 4/30/15, at 4:59 p.m. the director of nursing (DON) verified the hoyer canvas still applies pressure on a resident's bottom during transfers with the hoyer. The DON verified lifting R39 from the wheelchair with the hoyer and immediately returning him to the wheelchair, did not provide pressure relief. The DON stated pressure should be relieved for at least one full minute. The DON stated she would expect staff to follow the care plan. During an interview on 5/1/15, at 9:33 a.m. RN-A verified the care plan was not updated to reflect R39's need for repositioning every 2 hours as indicated on the tissue tolerance test, by nodding and saying, "M hm" and said she would have to check into it.	F 282		

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F 282	Continued From page 14 The facility documented on the tissue tolerance test after a copy was requested on 5/1/15. The facility documented the assessment indicated every 3 hours and that every 2 hours was an error, though R39 had redness on the coccyx (tailbone) after 3 hours of unrelieved pressure. The added documentation was not signed or dated. The facility policy and procedure for Skin Ulcer Protocol, updated 2/1/15, indicated the tissue tolerance test results determines an individual's turning and repositioning schedule. The policy and procedure further indicated "off-loading is considered 1 FULL MINUTE of pressure relief and momentary pressure relief followed by a return to the same position is NOT beneficial." The facility policy and procedure for care plans effective 10/10/14, indicated the plan of care would include the identified resident needs and the approach to meeting the identified goals. The approach was to include the care and services that must be provided and the frequency of the services to meet the goals. The care plan is to specify the members of the interdisciplinary team who are responsible for working with the resident to meet the goals.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	**F309** **VHC will provide the necessary care and services to residents in order to attain and maintain their highest practicable well-being.** **R29** No doc *of bruise/scab on top of hand noted on two days during survey* **R107** No *black ankle sleeves, Weekly skin check did not identify R wrist bruise, No doc of 1cmX1cm red, scabbed R ankle* ***R39*** *Teds not on in AM, off HS, No CPAP on during naps*	06/10/15

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F 309	Continued From page 15 This REQUIREMENT is not met as evidenced by: The facility did not ensure the care and services were provided for 3 of 3 residents (R29, R107, R39) reviewed for non-pressure skin conditions and 1 of 1 residents (R39) reviewed with medical equipment needs. Findings include: R29's face sheet printed on 4/29/15, identified diagnoses including dementia, anxiety, and seborrheic dermatitis. R29's annual Minimum Data Set (MDS), dated 3/11/15, indicated R29 had severely impaired cognition. The MDS further indicated that R29 required extensive assistance for activities of daily living (ADLs), and did not have any skin problems during the assessment period. Review of R29's skin log revealed the last reported abnormality was on 12/21/14, with the statement, "scratched calf on bed frame during transfer. Received scratch." R29's current skin integrity care plan, as printed on 4/29/15, stated that R29 was at risk for altered skin integrity and bruising related to impaired mobility and anticoagulation therapy. The care plan identified goals including skin will remain warm, dry, and free of skin tears. On 4/28/15, at 10:36 a.m., a bruise and a scabbed over skin tear were observed on R29's left forearm. On 5/1/15, at 9:43 a.m., the bruise and scab were observed by registered nurse (RN)-B. RN-B	F 309	Nursing and NAR staff were re-educated on 5/29/15 regarding R29s bruise/scab noted on top of R hand. Nursing and NAR staff were re-educated on 5/29/15 regarding R107s Right ankle scab and black ankle sleeves. Nursing and NAR staff were re-educated on 5/29/15 regarding R39s Teds and CPAP schedules. Nursing staff were re-educated on 6/3/15-6/4/15 regarding the facility's Skin protocol regarding Weekly Skin Checks, reporting and documentation of any new skin issue AND offloading and repositioning according to the Tissue Tolerance assessment. Random skin audits will be conducted by DON/designee to ensure accurate documentation of skin issues. 3xwkx2, 2xwkx2, then weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion date: 6/10/15	

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F 309	Continued From page 16 described a bruise on top of R29's hand, an area with discoloration, surrounded by redness and some darker purplish blue within. RN-B described the scab by stating there were lighter scabs and darker scabs-over a discolored area that has some deep purple to blue coloring underneath. RN-B stated it looked like there was slightly pink scarring where it had extended out at some point in time. In an interview during the observation, RN-B, stated she would expect the nursing assistants to let a licensed nurse know about the bruise and the scabbed area. RN-B stated, "I would expect that if there was any new skin abnormality to report to the nurse manager or the nurse on the cart." RN-B stated she could not find any documentation on the scabbed area or the bruise. R107's disease diagnosis and allergies report dated 4/30/15, identified R107's diagnoses as diabetes, hypertension (high blood pressure), cerebral artery occlusion with infarct (type of stroke), and generalized muscle weakness. R107's quarterly Minimum Data Set (MDS) dated 3/6/15, indicated R107 had moderate cognitive impairment and required extensive assist with bed mobility, transferring, and dressing. R107's Physician Order Sheet dated 4/30/15, directed staff to make sure R107 had her black ankle sleeves on bilaterally during the day time. R107's weekly skin assessment dated 4/29/15, indicated no deficit. On 4/29/15, at 7:19 a.m. R107 was observed seated in her wheelchair by the nursing station. She stated she just had had a shower that morning. A one centimeter (cm) round purple bruise was observed on her right wrist area. R107 stated she noticed it a couple of days ago,	F 309		

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F 309	Continued From page 17 however couldn't remember how it happened. On 4/30/15, at 7:08 a.m. R107 was observed seated in her wheelchair in the dining room. R107 was dressed in a short sleeve shirt, capri pants, short white anklet socks, and tied black shoes. The 1 cm round purple bruise was still evident on her right wrist area. In addition, R107's ankles were not covered with black ankle sleeve protectors as directed by her physician. R107's Current Care Plan [undated] directed the licensed staff to conduct weekly skin checks on R107's shower day. In addition, black ankle sleeves should be on bilaterally due to her history of bumping the outside of her ankles on the wheelchair. R107's nursing assistant care plan [undated] directed the nursing assistant staff to place the black ankle sleeves on in the morning. R107's General Nurse's Observation note dated 9/10/14, indicated R107's Braden (skin breakdown risk assessment tool) score indicated she was at moderate risk for skin breakdown. R107's plan of treatment included weekly skin checks on her shower day. On 4/30/15, at 8:41 a.m. registered nurse (RN)-C confirmed the last skin assessment had been completed on 4/29/15, by RN-D, and the documentation identified no skin problems were noted. RN-C confirmed R107 should have on the black ankle sleeves during the day time hours and when she is up in her wheelchair. On 4/30/15, at 8:50 a.m. R107 was observed with RN-C. RN-C confirmed R107 was not wearing the black sleeved ankle protectors. R107's ankles were checked and there RN-C noted an approximately 1 cm by 1 cm reddened and scabbed area on R107's outer aspect of her right ankle and the 1 cm round purple bruise on her right wrist. RN-C stated these should have been identified by RN-D yesterday when she conducted	F 309		

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F 309	Continued From page 18 R107's skin assessment. On 4/30/15, at 10:21 a.m. the director of nursing (DON) verified it was her expectation that resident care plans be followed. A policy on guidelines for conducting, documenting, and implementing interventions to help minimize the risk of skin breakdown was requested but not provided. R39 was not provided with TED (compression stockings that help prevent blood clots and swelling in legs) stockings and continuous positive airway pressure therapy (CPAP) for sleep apnea during naps. The nurse practitioner visit note dated 2/20/15, indicated R39's diagnoses included thrombin gene mutation (a disorder which increases the risk of blood clots), impaired mobility, hemiplegia (paralysis on one side of the body), venous insufficiency, and sleep apnea with CPAP treatment. The quarterly Minimum Data Set (MDS) assessment dated 3/23/15, indicated R39 was dependent in bed mobility, transfers, dressing, and personal hygiene. The care plan reviewed 1/21/15, directed staff to apply TED stockings. The care plan also indicated R39 was to have the CPAP on at bedtime and during naps. The undated resident care guide directed staff to put TED stockings on in the morning and take them off at bedtime. The care guide was silent regarding applying the CPAP during naps. The care guide directed staff to explain things to R39 when he pushes staff's hands away during activities of daily living, brushing teeth, or CPAP application.	F 309		

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F 309	Continued From page 19 The signed physician order sheet, dated 3/5/15, directed staff to ensure CPAP was being used at night and for naps. The physician orders also directed staff to put knee-high TED stockings on in the morning and remove at bedtime. The electronic treatment administration record (eTAR) indicated the CPAP use was not recorded on 4/29/15 during the day shift. The General Nurse's Observation dated 3/23/15, indicated R39 used a CPAP at night for sleep apnea and occasionally refused the CPAP. During an observation on 4/29/15, at 7:19 a.m. R39 was lying in bed on his back and did not have the CPAP on. During an observation of morning cares on 4/29/15, at 7:50 a.m. nursing assistant (NA)-B was looking for the TED stockings for R39. NA-A stated they were usually put on by the night shift, but were not on yet. The TED socks were not found. During an observation on 4/29/15, at 2:01 p.m. R39 was lying in bed on his back. The CPAP was not on. During an interview on 4/29/15, at 10:54 a.m. NA-A stated R39 was to have special TEDs and they were not in the room, so she had assumed they were on order. During an observation on 4/30/15, at 7:07 a.m. NA-F and NA-G did morning cares and transferred R39 into the wheelchair. No TEDs were applied. R39 was not observed to have the CPAP on when in bed. During an interview on 4/30/15, following morning cares, NA-G verified R39 should have TEDs, but they had been missing since last week. NA-G	F 309		

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F 309	Continued From page 20 stated it had been reported to the nurse last week. During an interview on 4/30/15, at 4:59 p.m. the director of nursing (DON) stated it would be expected that staff follow the care plan. "If it is care planned, it is to be done." The facility policy and procedure for care plans effective 10/10/14, indicated the plan of care would include the identified resident needs and the approach to meeting the identified goals. The approach was to include the care and services that must be provided and the frequency of the services to meet the goals. The care plan is to specify the members of the interdisciplinary team who are responsible for working with the resident to meet the goals.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure repositioning was provided to decrease the risk of development of pressure ulcers for 1 of 1 residents (R39)	F 314	**F314** **VHC will ensure repositioning is provided to decrease the risk of development of skin ulcers.** Nursing and NAR staff on Island Lake unit was re-educated on **R39's** care plan regarding offloading and repositioning schedule per the resident's Tissue Tolerance assessment. Nursing staff were re-educated on 6/3/15-6/4/15regarding the facility's Skin protocol regarding Weekly Skin Checks, reporting and documentation of any new skin issue and offloading and repositioning according to the Tissue Tolerance assessment.	06/10/15

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F 314	Continued From page 21 reviewed for pressure ulcers. Findings include: R39 was not repositioned to relieve pressure from a sitting position during continuous observations on 4/29/15, from 8:08 a.m. until 11:59 a.m. The certified nurse practitioner (NP) visit note dated 2/19/15, indicated R39's diagnoses included hemiplegia (paralysis on one side of the body), traumatic brain injury (TBI), speech disorder, and seizure disorder. The NP note further indicated R39 had impaired mobility and ADLs and required total assistance with dressing, toileting, bathing and transfers. R39's quarterly Minimum Data Set (MDS) assessment dated 3/30/15, indicated R39 had a short term memory deficit and severely impaired decision-making ability. The MDS indicated R39 required total assistance of 2 staff with bed mobility and transfers. The MDS further indicated R39 was at risk for skin breakdown. The progress notes regarding the MDS quarterly assessment, dated 3/23/15, indicated R39 was unable to move self in bed and required total assistance. The addendum to the progress note dated 3/24/15, indicated R39 was dependent on staff for all cares. The currently used, undated nursing assistant care guide indicated R39 required extensive assistance of 1-2 staff for ADLs, 1-2 staff for repositioning, and directed staff to reposition R39 in the wheelchair and in bed, every 3 hours. The care guide directed staff to provide toileting cares every 2 hours.	F 314	Random audits will be conducted by DON/designee for care plans being followed for repositioning for residents at risk for development of skin ulcers, 3xwkx2, 2xwkx2, and then weekly hereafter. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion date: 6/10/15	

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F 314	Continued From page 22 The care plan reviewed 1/21/15, indicated R39 was at risk for skin breakdown related to decreased mobility, diabetes, and bladder incontinence. The care plan indicated R39 was dependent on two staff to reposition in bed or required the assistance of 1-2 for repositioning in bed, and directed staff to reposition R39 every 3 hours, check for incontinence and provide cares as necessary every 2 hours. A Tissue Tolerance-Repositioning Observation (a test used to determine how long a resident can tolerate sitting or lying in one position without pressure relief and without adverse effects) dated 3/18/15, indicated R39 had redness on his coccyx (tailbone) after 3 hours of lying and it was determined R39 required repositioning every 2 hours. The observation for sitting dated 3/19/15, indicated R39 was to be repositioned every 2 hours. A copy of the current tissue tolerance result was requested. However, the facility documented on the tissue tolerance results after the request was made on 5/1/15. The facility documented the assessment indicated every 3 hours and the every 2 hours had been an error. R39 had redness on the coccyx (tailbone) after 3 hours of unrelieved pressure. The added documentation from 5/1/15 was not signed or dated. During observations on 4/29/15, at 8:08 a.m. R39 was put in the wheelchair, using a hoyer (a mechanical lift that raises and transfers utilizing using a sling). Continuous observations were initiated. At 8:08 a.m., R39 was served a continental breakfast in the dining room. At 9:34 a.m. during continuous observations, R39 was brought to his room by the nurse to receive	F 314		

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F 314	Continued From page 23	F 314		

medications and watch television. At 10:54 a.m. NA-A entered R39's room and closed the curtain. MDH surveyor immediately entered the room and found NA-A adjusting R39's shirt. NA-A stated she checked R39's brief and he was dry. NA-A left to get NA-B to help with boosting R39 up in his wheelchair. NA-A brought in the lift, they connected the sling, and lifted R39 up from the wheelchair and immediately returned him to the wheelchair. R39's posture was improved sitting up straighter and higher in the chair. Pressure remained on R39's buttocks/hips/coccyx during the lifting process through the use of the sling. At 11:04 a.m. R39 was brought toward the dining room in Central Park. Continuous observations continued until 11:59 a.m. while R39 ate lunch. At that time RN-A was informed of R39's need for repositioning. At 12:21 p.m., R39 was put into bed.

During interview on 4/29/15, at 12:13 p.m., NA-A stated R39 had been repositioned just before lunch when he was lifted in the hoyer and returned to his wheelchair. NA-A did not know how long R39 should be without pressure on his bottom during repositioning.

During an interview on 4/29/15, at 12:15 p.m. RN-A stated repositioning times were determined by the tissue tolerance testing results and stated they start testing at 2 hours; if no redness at 2 hours, then they test the tolerance at 3 hours, both sitting and lying. If there is redness, they go back to reposition every 2 hours. RN-A stated R39 was to be repositioned every 3 hours. RN-A was uncertain how long pressure relief (off-loading) should be provided during the repositioning process. RN-A initially stated about a minute, then stated she was not sure if it was a

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F 314	Continued From page 24 couple of seconds or a minute, but would check. During an observation on 4/30/15, at 7:07 a.m. during morning cares by NA-F and NA-G, R39 had no visible signs of pressure ulcer development. During an interview on 4/30/15, at 4:59 p.m. the director of nursing (DON) verified the hoyer canvas still applied pressure on a resident's bottom during transfers. The DON verified lifting R39 from the wheelchair with the hoyer and immediately returning him to the wheelchair did not provide pressure relief. The DON stated pressure should be relieved for at least one full minute. The DON stated she would expect staff to follow the care plan. During an interview on 5/1/15, at 9:33 a.m. RN-A verified the care plan was not updated to reflect R39's need for repositioning every 2 hours as indicated on the tissue tolerance test, by nodding and stating she would check into it. The facility policy and procedure for Skin Ulcer Protocol, updated 2/1/15, indicated the tissue tolerance test results determined an individual's turning and repositioning schedule. The policy and procedure further indicated "off-loading is considered 1 FULL MINUTE of pressure relief and momentary pressure relief followed by a return to the same position is NOT beneficial."	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323	**F323** **VHC will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.**	06/10/15

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F 323	Continued From page 25 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure care and services were assessed and provided to minimize the risk of accidents for 5 of 5 residents (R92, R39, R29, R66, and R100) reviewed for accidents. Findings include: R92's bed had a body pillow tucked under the bottom sheet on the left side of the bed during observation on 4/27/15, at 4:21 p.m. Family member (FM)-E stated it was to prevent R92 from rolling out of bed. There was no evidence the body pillow had been assessed for appropriateness of use and need or care planned for appropriate implementation. In addition, review of R92's incident reports revealed the analysis did not include determination of the root cause of the falls. R92's face sheet, current as of 4/29/15, indicated diagnoses included a heart arrhythmia (irregular heart beat), muscle weakness, vertigo (dizziness), and a history of transient ischemic attacks (small strokes). R92's quarterly Minimum Data Set (MDS) assessment dated 1/28/15, indicated R92 had a moderate cognitive deficit, required extensive assistance of one staff with transfers and	F 323	R92 lacked an assessment and informed consent for a body pillow which could potentially be a restraint. R39's bed had large spaces between mattress and upper bedrails and facility had not assessed the safety and appropriate fit. R29 was lacking an assessment for a body pillow tucked under the sheet. R66 Fall OOB 4/16/15 – no RCA or IDT FU R100s bed sensor alarm malfunctioning, no system in place to routinely check and replace pressure sensor alarm pads. Nursing staff were re-educated on 6/4/15-6/5/15 regarding safety assessments for potential restraints (R92 and R29) and appropriate fitting of side-rails (R39). RCA of falls re-training completed for nursing staff on 6/3/15-6/4/15. A schedule was put into place to routinely check and replace the sensor alarm pads according to manufacturing recommendations. Maintenance staff will conduct audits of all mattresses on a monthly basis to determine safe and appropriate fit.	

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F 323	Continued From page 26 ambulation, and had unsteady balance. The MDS further indicated R92 had 2 falls without injury and 2 falls with injuries that were not serious. The Review of Indicators of Fall Risk dated 5/8/14, indicated R92 was at high risk for falls due to diagnoses of impaired balance, incontinence, cardiac dysrhythmias, functional decline, cognitive impairment, and medications. The care plan dated reviewed 1/21/15, indicated R92 was independent with bed mobility and required assist of one staff for transfers. The care plan further indicated R92 was at risk for falls or injury related to cognitive deficits. Interventions included: -anti-roll backs on wheelchair, -assist with mobility and transfers as needed, -encourage to use the call light for assistance, -assess fall risk quarterly and with change of condition, -keep call light in easy reach, -provide resident with verbal cues and reminders as needed, -resident does not remember that she needs assistance with transfer or ambulation, anticipate needs, -alarms in bed and wheelchair, alarms are to alert staff of resident transferring, not as a fall prevention. -if restless throughout the night shift and self transferring in and out of bed, have sit up at the nursing station until she is ready to sleep in bed. The undated resident care guide directed staff to implement fall interventions and mirrored the care plan.	F 323	DON/designee will assess any body pillow currently in use by 5/29/15, to ensure are not being used in a way that could potentially be a restraint. FU audits will be conducted by DON/designee on all fall incident Reports to ensure RCA was completed. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion date: 6/10/15	

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F 323	Continued From page 27 The signed physician orders dated 4/21/15, indicated R92 had orders to monitor sleep every night. An incident report dated 12/1/14 at 6:20 a.m.: identified R92 fell out of bed. The cause was identified as R92 attempting to self transfer from bed to wheelchair. R92 was redirected to use the call light and signs were placed in her room to remind to call and don't fall. A review of an incident report dated 12/9/14, at 12:20 a.m. indicated R92 slid out of bed, onto the floor. The corrective measures taken by the facility at 3:39 p.m. indicated the cause of the incident was R92 woke up and was trying to sit at the edge of her bed, and slid out onto the floor. The root cause did not identify the resident's needs at the time of the fall or risk factors. Fall interventions initiated following the incident included a body pillow on the bed , and a floor mat beside the bed. The summary of falls indicated R92 had a recent fall from bed while transferring self from bed to wheelchair, and previous incidents involving rolling out of bed. A review of an incident report dated 12/19/14, at 2:20 a.m. indicated R92 slid out of bed and the body pillow had not been in place on the bed. The post-fall registered nurse (RN) assessment indicated the cause was R92 was repositioning self in bed and fell out of bed. The immediate intervention was the body pillow was placed on the bed and R92 was re-oriented to use the call light. A trend was identified as R92 repositioning and rolling out of bed. A concave mattress was put on the bed for R92 and floor mats on each side of the bed. R92's fall risk score was 20, high risk for falls.	F 323		

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F 323	Continued From page 28 An incident report dated 1/23/15 at 1:25 a.m..indicated R92 fell while transferring herself from bed to wheelchair to clean up the spilled pop on the floor. R92 was not wearing gripper socks. A pressure pad was put in place in bed and wheelchair and monitoring was put in place for sleep pattern at night. An incident report dated 1/30/15 at 8:25 a.m. identified R92 fell while self-transferring from wheelchair to bed. R92 stated she felt weak and couldn't make it all the way to the bed. Referred to physical therapy and occupational therapy to evaluate and treat for transfers and safety. An incident report dated 2/1/15 at 9:30 a.m. revealed R92 fell while sitting on the edge of her bed and slid out onto the floor mat. R92 stated she was reaching for the phone. The concave mattress was discontinued. R92 and family declined to have bed against the wall for safety. A bed rail assessment dated 9/27/14, indicated R92 requires grab bars and was safe to use for repositioning, bed mobility, and transferring. R92 had a history of falls from bed related to self transfers. R92's record lacked an assessment and informed consent for the body pillow. The current care plan updated on 4/28/15, was silent regarding the body pillow, and the review dated 1/21/15, did not address the body pillow. The nursing assistant care guide for R92 did not address the body pillow. During observations on 4/29/15, at 7:18 a.m. R92's bed had a body pillow tucked under the fitted sheet on the bed.	F 323		

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F 323	Continued From page 29 During an observation on 4/29/15, at 8:42 a.m. R92 stood up at the wall and the wheelchair alarm sounded. Staff responded timely to the alarm and calmly asked her to sit and asked if there was something she needed. Resident #92 sat in wheelchair/ and the alarm was checked. During observations on 4/30/15, at 7:41 a.m. R92 was lying in bed with the body pillow tucked under the fitted sheet directly behind her back. Her knees were bent, and they extended beyond the edge of the bed. During observations on 5/1/15, at 9:15 a.m. R92 was lying in bed with her back nearly all the way to the left side of the bed and facing toward the right. The body pillow was not on the bed. R92 stated she didn't think she needed it anymore, and stated she did not want it in the first place. During an interview on 4/30/15, at 7:49 a.m. nursing assistant (NA)-F and NA-G stated R92 frequently tried to get out of bed by herself and that she always tried to get out of bed on the right side toward the doorway. NA-F verified R92 had a body pillow under the sheet to try to prevent her from getting out of bed. During an interview on 04/30/15, at 9:58 a.m. RN-A stated the body pillow was no longer care planned and believed it to be R92's preference. RN-A stated R92 had the body pillow because she was falling, but is no longer falling so doesn't need it anymore. RN-A stated whenever she has talked to R92, she has wanted the pillow there. During an interview on 4/30/15, at 4:59 p.m. the director of nursing (DON), stated R92 liked to hug something and the pillow was falling off so they	F 323		

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F 323	Continued From page 30	F 323		

tucked it in. The DON stated R92 should be able to push it out. The DON also stated R92 liked it so they left it in place.

During an interview on 5/1/15, at 9:52 a.m., the DON if the body pillow was placed above the sheet, it would not need to be assessed because R92 would be able to remove it, but verified it should be assessed if placed under the sheet and she was not able to remove it. The DON further stated the interdisciplinary team (IDT) meets every Tuesday and will discuss incidents, look at the situation, put interventions in place, and look at trending for patterns and the situation of the fall. She indicated the nurse manager will do a post fall follow-up, usually within 24 hours and will determine the recommendations prior to the IDT meeting. The DON stated they do a root-cause analysis and look at medications, what they were doing prior to the fall, look at fall history, pain, restlessness. The nurse manager was to do a follow-up note.

The facility policy and procedure for Falls Protocol dated 1/1/13, indicated the facility will assess the resident for their fall risk and identify interventions to help prevent falls, and will do a root cause analysis if a fall occurs, to identify appropriate interventions to prevent subsequent falls and address the consequences of falling. The IDT would review the falls and interventions to determine their effectiveness, and then make recommendations as necessary for other services to review, such as therapy, the consultant pharmacist, and physician.

The facility policy and procedure for Resident Physical Restraint reviewed/amended on 4/6/15, indicated a physical restraint is "any manual

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VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 31 method or physical or mechanical devices, material, or equipment attached or adjacent to the resident's body that the resident cannot easily remove and that restricts freedom of movement or normal access to his/her body." The purpose of the policy and procedure was to ensure the least restrictive measures were used and that the restraint devices were evaluated for effectiveness and to ensure attempts were addressed to reduce and/or eliminate restraints. The policy and procedure indicated alternatives to restraints, and the resident's needs, problems, conditions, or risk factors must be addressed prior to using any kind of physical restraint. Restrains should be used only with a written order of a physician and after obtaining an informed consent from the resident or the representative. The informed consent must include the risks versus benefits. R39's bed had a large space between the mattress and the upper rails on both sides of the bed when observed on 4/27/15, at 5:41 p.m. R39 was sitting up in his wheelchair. The facility did not assess the safety and appropriate fit of the mattress and siderails placed on the bed. The certified nurse practitioner (NP) visit note dated 2/19/15, indicated R39's diagnoses included hemiplegia (paralysis on one side of the body), traumatic brain injury (TBI), speech disorder, and seizure disorder. The NP note further indicated R39 had impaired mobility and required total assistance with dressing, toileting, bathing and transfers. On 4/27/15, at 6:15 p.m., the space between the mattress and the upper siderails on R39's bed was measured by/with the environmental services director (ESD)-C. There were 9 inches between	F 323		

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F 323	Continued From page 32 the mattress and the upper portion of the right rail, and 6 inches from the bottom portion of the right rail and the mattress. There were 8 inches between the mattress and the upper portion of the left rail, and 6 inches from the mattress and the bottom portion of the left rail. ESD-C stated they had a pressure-relieving mattress on R39's bed and did not have the correct mattress on the bed. The ESD-C stated he would talk to the DON and put extenders on the mattress and put the whole thing into a mattress bag, so it would not separate. ESD-C stated there should not be that space between the mattress and the rail. During an observation on 4/27/15, at 7:15 p.m. R39's bed no longer had a space between the rails and the mattress. The mattress had extenders on the sides with the mattress bag over the whole thing, resulting in the mattress being snug against the rails on both sides. During observations on 4/29/15, at 7:37 a.m. R39 was lying on his back in the center of the bed. The mattress was up against the siderails on both sides of the bed. R39's quarterly Minimum Data Set (MDS) assessment dated 3/30/15, indicated R39 had a short term memory deficit and severely impaired decision-making ability. The MDS indicated R39 required total assistance of 2 staff with bed mobility and transfers. The progress notes regarding the MDS quarterly assessment, dated 3/23/15, indicated R39 was unable to move self in bed and required total assistance. The care plan reviewed 1/21/15, indicated R39 required total assist of up to 2 staff for bed mobility. A bed rail mobility bar assessment	F 323		

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F 323	Continued From page 33 indicated R39 used the side rails to assist with turning side to side, holding self to one side, and supporting self and providing a sense of security. . During an interview on 4/30/15, at 8:58 a.m. ESD-C stated he was very surprised that the wrong mattress had been on the bed for R39. ESD-C stated the normal process was for the nurse manager/nursing to inform him if they need a different mattress on the bed, which did not occur this time. Nursing is to ensure the mattress is the correct one for the bed, but when they inform him, he ensures the mattress fits correctly. On 4/30/15 at 4:46 p.m. ESD-C stated there was no policy and procedure regarding the mattresses. During an interview on 4/30/15, at 4:59 p.m. the DON stated maintenance puts the mattress on the bed and the requests come from nursing or the family. The DON verified the gaps between the mattress and the siderails could have presented a significant risk for R39, and that staff should be alerted to gaps in the mattresses with siderails on the bed. The guidelines for Siderail Entrapment Zones and Dimensional Recommendations dated 3/10/06, indicated the Federal Drug Administration dimensional limit recommendations to reduce the risk of entrapment between the rail and the mattress was less than 4 3/4 inches. R29's face sheet printed on 4/29/15, identified diagnoses including dementia, depression, anxiety, chronic pain, seborrheic dermatitis, and headaches.	F 323		

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F 323	Continued From page 34 R29's annual MDS, dated 3/11/15, indicated R29 had severely impaired cognition. The MDS further indicated that R29 required extensive assistance with bed mobility, transfers, dressing and toileting. R29's 3/12/15, safety assessment listed her fall risk score at 20 (a score over 9 is at risk for falls). Contributing factors as listed on her Care Area Assessment (CAA), printed on 5/1/15 included: antianxiety and antidepressant medications, cardiac dysrhythmias, decline in functional status, visual impairment and dementia. Review of R29's safety/restrictive devices care plan, with a start date of 6/26/14 stated the problem of at risk for falls or injury related to cognitive deficits due to dementia and impaired mobility and a history of self-transfers. The goal was for R29 to be free from falls or injury, with the goal date listed as 7/18/15. Approaches included a bed sensor (used to alert staff, but not as a fall intervention), body pillow under outer edge sheet on bed when laying down and keep call light in easy reach. Review of the undated nursing assistant care card also specified under safety: body pillow at outer edge of bed when residents in bed. According to registered nurse (RN)-B, R29 had an unwitnessed fall on 4/14/15, at 7:30 a.m. The fall was in the morning and there were no injuries. R29 was found sitting on top of her body pillow, which was on top of her blankets, which were on the floor. The bed was in its lowest position. In addition to the fall on 4/14/15, review of the facility's fall log revealed falls on · 10/19/14: transfer to bed, assisted to bed, no	F 323		

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F 323	Continued From page 35 injury · 10/22/14: transfer to bed, PT/OT order, no injury · 12/17/14: self-transfer from w/c to bed, no injury R29 was observed in bed on 4/27/15, at 6:57 p.m. The bed was positioned against the wall, with R29's left side nearest the wall. The bed was in the lowest position, and a body pillow tucked in under the bottom sheet, on the right side (outside edge) of the bed. R29 was also observed lying in bed, with the body pillow tucked under the bottom sheet on: · 4/29/15, from 7:17 a.m. until 7:55 a.m. · 4/29/15, at 1:39 p.m. · 4/30/15, from 6:59 a.m. until 8:07 a.m. · 4/30/15, at 12:06 p.m. and · 5/1/15, at 8:10 a.m. In an interview on 4/30/15, at 12:14 p.m. RN-B stated that the body pillow was placed under the bottom sheet to keep R29 safe and ensure that she doesn't climb out of bed as easily. RN-B stated that the body pillow had been in place since before the fall on 4/14/15. RN-B stated that the body pillow acts like "treating the bed as if it were a concave mattress", providing extra support to the side, so that if R29 rolled, she won't just roll out of bed. RN-B continued, "Some people have used fun noodles" in the same way. In a follow-up interview on 5/1/15, at 9:31 a.m., RN-B stated that there was not an assessment available specifically for the body pillow. R66 did not have fall interventions in place to reduce the risk of falls.	F 323		

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F 323	Continued From page 36 R66's Face sheet identified diagnoses of altered mental status, and hemiplegia of dominant side. The quarterly Minimum Data Set (MDS) dated 4/15/15, indicated R66 was moderately cognitively intact and required extensive assistance of two staff with bed mobility and transfers. The Care Area Assessment (CAA) for fall risk dated 4/15/15, indicated R66 was at risk for falls due to difficulty maintaining standing position, impaired balance during transitions, gait problems, fatigue, loss of arm movement, incontinence, hemiplegia, muscle weakness, and impulsivity or poor safety awareness. R66's Fall Risk Assessment dated 4/16/15, indicated a high risk for falls, no new interventions added to the care plan. On 4/27/15, at approximately 5:00 p.m. R66 was observed in the dining room with a large geenish blue bruise to her forehead and right side of her face extending to her chin. R66 also had black bruises below both eyes. R66's care plan dated 1/30/15, identified a risk for falls or injury, with a goal of being free from falls or injury. The goal date for the care plan was updated to reflect a review with a new goal date of 4/30/15. On 4/30/15, at 11:57 a.m. R66 was observed being transferred by two staff with a gait belt and utilization of the bathroom grab bars. Staff talked R66 through the process. R66 had the following falls: 8/4/14, at 3:20 p.m. R66 fell from wheelchair. No injuries noted. Occupational therapy to evaluate.	F 323		

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F 323	Continued From page 37 No interventions added to the care plan. No root cause identified. 8/8/14, at 8:00 p.m. R66 was found on floor in bedroom in front of wheelchair next to bed. R66 reported she was trying yo use her bed rail to adjust herself in her wheelchair and slid out of her chair. No injuries, Awaiting to hear if occupational therapy is going to follow resident. No interventions added to the care plan. No root cause identified. 9/16/14, at 7:00 p.m. R66 was in recliner and slipped out of the chair. R66 sustained redness to the right elbow. Occupational therapy to access most appropriate intervention. No root cause identified. 4/16/15, at 6:00 a.m. R66 was found in bedroom face down on the floor next to bed with alarm sounding. R66 could not tell what she was doing or where she was going. Noted injuries to bilateral knee caps that were red and a large protruding bruise over right brow. No interventions added to the care plan. No root cause identified. Progress note dated 4/21/15, at 11:55 a.m. summarized interdisciplinary team (IDT) review. Note indicated no new interventions at this time. At the time of fall care plan was being followed. Plan is to follow up in one week. No further mention of a root cause analysis was noted. No further IDT notes were noted. On 4/30/15, at 10:41 a.m. nursing assistant (NA)-K was interviewed and reported there had not been any new interventions for R66 since the most recent fall.	F 323		

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F 323	Continued From page 38 On 4/30/15 at 11:02 a.m. RN-B verified a root cause had not been determined and no new fall interventions had been implemented. On 4/30/15 11:14 a.m. the director of nursing (DON) indicated the team discusses the falls and what happened, review patterns and develop interventions from that discussion. On 5/1/15 at 7:50 a.m. RN-B indicated when a root cause review is done they review what the resident was wearing on their feet, any environmental factors, underlying medical issues, and whats going on at the time. The nurse manager would reveiw the last 3 months for trending but immediate interventions were put in place by the nurse on the floor. R100's Face Sheet dated 4/30/15, identified R100's diagnoses as muscle weakness, status post repair of a recent closed femur fracture, insomnia, and chronic airway obstruction disease. R100's quarterly Minimum Data Set (MDS) dated 3/31/15, revealed R100 had severe cognitive impairment, and required extensive assist with bed mobility and transferring. R100's fall risk assessment dated 4/13/15, indicated R100 was at risk for falls. R100 s current care plan dated 2/6/15, identified that R100 was at risk for falls or injury related to her cognitive deficits and history of falls with a fracture. The approaches put in place included a bed and chair sensor alarm. On 4/29/15, at 8:00 a.m. nursing assistant (NA)-C was observed transferring R100 from her bed to her wheelchair. NA-C escorted R100 into	F 323		

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the bathroom and transferred her on to the toilet. At 8:07 a.m. while R100 was on the toilet and NA-C was in the bathroom assisting her, the sensor bed alarm started to beep (7 minutes later). NA-C stated "that's a little late" (referring to the sensor bed alarm going off).

On 4/29/15, at 8:21 a.m. NA-C confirmed when the bed alarms malfunction like R100's had; it usually just meant the battery needed to be changed in the box. NA-C was unaware if the facility had a schedule for checking the alarms to assure they were functioning properly.

On 4/29/15, at 9:14 a.m. NA-C was observed in R100's room attempting to change out the box for the bed sensor alarm. NA-C stated she had attempted to change out the bed alarm, but the one she tried didn't work either. NA-C had reported it to registered nurse (RN)-C and RN-C had informed her she would get R100 a new set.

On 4/29/15, at 9:31 a.m. RN-C stated at the start and end of each shift the nursing assistants are supposed to go around and do a visual check to assure the alarms are working. They are supposed to be checking to make sure they are attached appropriately, plugged in and that the battery was not low.

On 4/29/15, at 9:37 a.m. NA-C and RN-C stated NA-C had reset the bed sensor alarm when NA-C had transferred R100 to her wheelchair. However, NA-C and RN-C both agreed the bed sensor alarm had malfunctioned.

On 4/29/15, at 2:30 p.m. NA-E and NA-H stated they had never been told to do a routine check of the resident's sensor alarms. NA-D stated she

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F 323	Continued From page 40 thought the nursing assistants on the night shift did this and NA-D provided a copy of an alarm checklist. The checklist had a spot for each shift to sign off that these checks had been completed. However, the majority of the checklist for the current month was empty. On 4/29/15, at 2:45 p.m. RN-C stated the facility did not utilize these checklists and she was unaware of where they came from. On 4/29/15, at 3:25 p.m. the director of nursing (DON) confirmed the checklists were internal documents and the facility wasn't utilizing them. The DON stated they follow their "Use of Alarm Devices" policy. On 4/30/15, at 8:46 a.m. R100's wheelchair sensor pad/alarm was visualized with RN-C. There was a section on the pad to mark the "start date" and "end date". In addition, manufacture guidelines were written on the sensor pad and indicated this pad had a 45 day warranty. RN-C confirmed she was unaware of when R100's sensor pads had been placed in her wheelchair or her bed. RN-C confirmed the facility did not have a schedule to routinely check and replace the pressure sensor alarm pads. On 4/30/15, at 6:00 p.m. the DON provided a copy of the manufacture guidelines for the pressure sensor alarm pads. On 5/1/15, at 7:25 a.m. the DON confirmed the facility did not have a system in place to monitor when the sensor pressure alarm pads are placed or need to be replaced. On 5/1/15, at 9:01 a.m. RN-C verified the	F 323		

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F 323	Continued From page 41 pressure sensor pad alarms for R100 had been an intervention in place since 10/25/14. The Direct Supply Attendant Pressure Alarm owner's manual indicated the "anticipated usable device life" for the pads was 45 days. In addition, the pads should still be inspected/monitored as the device may need to be replaced sooner than anticipated in particular situations. The Use of Alarm Devices policy dated 6/30/15, indicated all alarms utilized would be those manufactured for medical use and the manufacture's recommendations would be followed.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate nutritional intake for 1 of 3 residents (R29), reviewed for nutrition with significant weight loss	F 325	**F325** **VHC will ensure adequate nutritional intake for any resident with weight loss.** R29 had a Nutritional Assessment completed on 5/29/15 and CP and Care Guide were updated accordingly. A Restorative Eating program was put into place for R29 that includes 'ensuring proper meal consistency, setting up with appropriate adaptive eating equipment, cueing and encouraging res to eat and occasionally staff assist to finish meal prn'. Nursing and Dietary staff were re-educated on R29s POC regarding Eating program including meal consistency, adaptive equipment and assistance with meals.	06/10/15

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F 325	Continued From page 42 Findings include: R29's face sheet printed on 4/29/15, identified diagnoses including dementia, depression, anxiety, chronic pain and headaches. R29's annual Minimum Data Set (MDS), dated 3/11/15, indicated R29 had severely impaired cognition. The MDS further indicated that R29 required limited assistance with eating, but extensive assistance for most all other activities of daily living (ADLs), had no swallowing disorders, and was on a mechanically altered therapeutic diet. R29's weight records indicated R29 weighed 140 pounds on 11/1/14; 128 pounds on 1/24/15; and 123 pounds on 3/28/15. This was a loss of 17 pounds, a severe weight loss of 12.1% in 180 days. R29's care plan specified she needed cues, reminders and some assistance with meals. The care plan directed staff to serve R29 in the Fish Lake dining area, provide adaptive equipment, and a regular diet of pureed texture. R29's care plan identified the problem of a history of weight loss and listed as a goal that the resident would have adequate food and fluid intake, with her weight remaining within 7.5% for 90 days. R29's medication orders directed nursing to provide 120 milliliters (ml) of nutritional supplement twice a day at 7:00 a.m. and 7:00 p.m. Review of R29's intake records reveal she consistently drank 100% of her supplements. Review of R29's Meals and Weights report, as printed on 5/1/15, revealed R29 ate during the	F 325	Continental Breakfast will be served to the resident by Dietary staff or trained designee to ensure proper meal consistency and adaptive equipment is provided, and NAR will assist res with eating prn. Dietary manager received re-education on documenting Dietary notes in the EMR on 6/1/15, Random audits of R29s meals and Intakes will be completed by Dietary Manager daily X 1 week, 3xwkx2, 2xwkx2, then weekly thereafter, with a summary note documented on a weekly basis until weight has stabilized X 1 month. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion date: 6/10/15	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 43 continental breakfast meal 14 times out of 30 opportunities during the month of April. Six days were identified as "Asleep" and 10 were blank. R29 ate 75% of many of the lunch and dinner meals in April, but snack opportunities were not documented. In an interview on 4/29/15, at 11:46 a.m., nursing assistant (NA)-E stated meal intakes were recorded by staff that helped at a specific table. Staff wrote a percentage eaten on the cards, which were collected by the dietary staff. On 4/29/15, at 8:33 a.m., R29 was observed at continental breakfast sitting at a table by herself. R29 was eating cereal, yogurt, and juice. No staff encouraged her. At 8:41 a.m., Activities Director (AD)-A sat down with R29 to talk about activities and encouraged R29 to eat. AD-A left and returned a few minutes later. AD-A sat with R29 from 8:46 a.m. until 8:53 a.m. R29 was wheeled out of the dining room area at 8:58 a.m. R29's total time in the dining room was 25 minutes; AD-A sat with her for 10 minutes. R29 had eaten approximately 70% of her continental breakfast. Review of R29's meals and weights recording revealed this meal was recorded at 100% intake. On 4/29/15, at 11:22 a.m., R29 was wheeled to a table in the dining room. A glass of orange juice and a covered brown mug with a straw was placed in front of her. At 11:25 a.m., a staff person took her food order and returned with her tray at 11:31 a.m. NA-E encouraged R29 to eat and talked with others at the table. At 11:42 a.m., R29 was still eating independently with encouragement from NA-E. At 11:47 a.m., NA-E asked R29 if she was done with her meal, marked 25% intake on her card and removed	F 325		

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F 325	Continued From page 44 R29's bowls. R29's brunch meal lasted 16 minutes. Later review of R29's meals and weights form revealed this meal was recorded at 75% intake. On 4/30/15, R29 was observed in bed from 6:59 a.m. until 9:56 a.m. R29 did not attend the continental breakfast, as she was sleeping and/or lying in bed. At 10:12 a.m., nursing assistant (NA)-K filled R29's water pitcher and NA-D got R29 a cup of coffee, which R29 had requested. In an interview on 4/30/15, at 8:52 a.m., licensed practical nurse (LPN)-C stated R29 usually got a morning supplement at "about this time". LPN-C said R29 can drink in bed and drank quickly. On 4/30/15, at 10:02 a.m., LPN-C stated that R29 drank 100% of her supplement and stated, "She always does for me!" In an interview on 4/30/15, at 10:38 a.m., nursing assistant (NA)-D stated that R29 hadn't had any food yet that morning, just the supplement. NA-D stated that when R29 was sleepy she didn't like to eat. She ate well at lunch and enjoyed her coffee in the morning. On 4/30/15 at 10:35 a.m., R29 was wheeled to the Fish Lake dining room. She was given a brown covered mug with a straw. At 10:59 a.m., a dietary aide wheeled a cart to the area and provided residents with beverages; R29 took milk and orange juice, which were in plastic cups with straws. At 11:16 a.m., another resident's family member asked R29 what she would like to eat, took her diet card and went to get her food. The family member returned with R29's tray at 11:26 a.m. R29 quickly grabbed her spoon and began eating her meal: tomato soup, cream of wheat,	F 325		

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F 325	Continued From page 45	F 325		

potato salad, apricots, magic cup and Ensure. R29 sat at the dining room table for over 50 minutes before getting her meal, which was eventually provided to her by another resident's family member.

NA-K sat with R29 from 11:38 a.m. until 11:53 a.m. During this time, NA-K encouraged R29 and another resident at the table with eating. R29 ate independently, but sparingly. At 11:53 a.m., NA-K asked R29 if she was done and wheeled her from the dining room. R29 received a total of 15 minutes of encouragement during that brunch meal. NA-K marked 25% (amount eaten) on R29's diet card. That brunch meal was the first time R29 had eaten that day.

In an interview on 5/1/15, at 9:38 a.m., registered nurse (RN)-B stated dieticians track resident weights. RN-B stated nursing responsibilities included to add supplements to the medication administration record (MAR), provide and track the supplement and to track weekly weights.

In an interview on 5/1/15, at 9:54 a.m., the dietary manager (DM) stated that he kept track of resident weights through involvement in the interdisciplinary team (IDT) process. The DM stated that R29 had been slowly losing weight, a pound or two a month, will be stable for a few weeks and then drop again. The DM stated R29 got Ensure and a magic cup with meals. She was on a pureed diet and got a large portion of mashed potatoes. The DM stated that R29 didn't generally take a snack, as she was sleeping during snack pass. The DM summarized R29's dietary interventions as: 2 magic cups and 2 Ensures each day, a large portion of mashed potatoes and nursing staff to assist her in the

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F 325	Continued From page 46 dining room. The DM stated that he began his current role in January of 2015, he confirmed that he had not made a progress note in R29's record despite her weight loss. The DM stated he did not have any IDT notes on R29. Review of R29's electronic record revealed no IDT or dietary manager notes were made after 2/4/15. Monthly dietician notes were made in January, February and March of 2015. The last dietician note, on 3/17/15, referenced a slow weight loss of 11.33% in the past 180 days, summarized current orders of puree diet, frequent encouragement, magic cup and Ensure at meals and supplement with med pass. R29's weight decline was acknowledged with, "very anxious female who may use large amount of calories with anxious behaviors, very hard to encourage intake at meals." The dietary progress note ended with "continue to monitor". On 5/1/15, from 8:10 a.m. until 9:23 a.m., R29 was observed lying awake in bed. She did not partake in the continental breakfast meal. Review of R29's Dietary Risk Assessment, dated 3/12/15, listed her dietary risk as "moderate." On 5/1/15, at 11:17 a.m., the registered dietician (RD)-F was interviewed and stated that R29 ate fairly well and would probably eat 100% if they [staff] fed her. RD-F stated anxiety played a large portion into her weight loss, but she didn't know if R29 was getting more anxious than previously. RD-F stated, "Her anxiety is the biggest thing." RD-F stated R29 called out for help, "help me, help me," and was dependent on staff for many	F 325		

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F 325	Continued From page 47 things. RD-F didn't want R29 to get more dependent. RD-F stated that R29 responded to staff encouragement, that she would continue to eat independently when staff encouraged her, such as saying, "you can feed yourself, look how good you're doing!". She is fed in the Fish Lake dining room so that staff was available to encourage her to eat. RD-F agreed that 15-20 minutes wasn't much time to eat. RD-F stated they "could stop the weight loss tomorrow if they fed her", but she was balancing the weight loss with R29 maintaining independence and reducing dependency on staff. In an interview on 4/30/15, at 11:52 a.m., family member (FM)-D stated she often got R29 a meal. "She [R29] gets so agitated and they take so long. She's sweet."	F 325		
F 362 SS=F	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not ensure adequate staff was available to provide timely meal service for all residents. This had the potential to affect all 83 residents in the facility. Findings include: A dining observation was made on 4/27/15 at	F 362	**F362** **VHC will employ sufficient support personnel competent to carry out the functions of the dietary service.** Dietary staff will ensure that residents in all dining rooms are served in a timely manner. Random audits of dining room service will be completed by Dietary Manager daily x 1 week, 3x/week x 2 weeks, and then weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion Date: 6/10/15	06/10/15

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F 362	Continued From page 48	F 362		

4:22 p.m. in the atrium dining area. The residents in this area required cueing or feeding assistance. At one table there were four residents seated, a family member was present with one of the residents and was feeding him. The other three residents did not have meals, nor did any other resident in the atrium area. There was another dining area adjacent to the atrium dining room, and a main dining area next to the kitchen where staff was serving meals, several residents had their meals and were eating. At 4:54 p.m. residents in the adjacent area started leaving the dining area. Staff had begun to serve residents in the atrium area at 4:50, the last tray arrived at 5:00 p.m.

Another dining observation was made on 4/29/15 in the atrium dining area. At 11:00 a.m. a family member received a resident's meal and began feeding him. The other three resident's seated at the table did not receive their trays or meal assistance until 11:40 a.m.

Interview with family member (FM)-F on 4/27/15 at 6:00 p.m. indicated she came in every evening to ensure R42 ate. She indicated she had been losing weight, and felt they needed more staff to help with meal time.

Interview with FM-A at 4/29/15 at 11:50 a.m. indicated she came in to feed R109 everyday. She stated sometimes the main dining room would be emptying out, while residents in the back were still waiting to be served, "they wait and wait to be served."

Interview with nursing assistant (NA)-E on 5/1/15 at 9:15 a.m. indicated that weekends were the worst, as there were not as much staff available

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F 362	Continued From page 49 to help with dining on the weekends as there was during the week. She also stated family members take the meal tickets and serve their family member and other residents at the same table. Interview with NA-J on 5/1/15 at 9:20 a.m. indicated Sundays there were no restorative aides available to help with the meals, so mealtimes took longer. Families serve and feed their loved ones, families will bring trays to other residents at the table. Interview with the director of nursing (DON) on 5/1/15 at 10:08 a.m. indicated the dining rooms were staffed using one NA from each unit, and they usually had one or two restorative aides, nurses were to help between medication passes if they were able. Restorative and feeding assistance residents were served last so the NA's could sit with them to help. The DON stated she was aware some residents were sitting there for a long period of time, but wasn't sure what to do about it. On 4/30/15, at 7:25 a.m. family member (FM)-B was observed to be passing beverages to 11 residents in the dining room for continental breakfast. FM-B stated he comes every morning to visit his mother at breakfast time, and he started assisting residents with coffee and beverages when he noticed they had a difficult time pouring themselves coffee. FM-B stated he has been doing this a long time, and is familiar with what each resident prefers to drink. FM-A stated he has continued to serve beverages to residents because the facility is so short handed, and it seemed like they never had enough staff. On 4/30/15, at 2:37 p.m. FM-C was interviewed,	F 362		

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F 362	Continued From page 50 and stated that she came every day to visit her mother and to help serve meals. FM-C continued to state that there are several family members that come daily to help with meals, and although she doesn't mind helping out, she feels like the facility is counting on them to help serve meals. FM-C stated she recently attended a resident council meeting, and complained to the facility that there was not enough staff. R29's care plan specified she needed cues, reminders and some assistance with meals. The care plan directed staff to serve R29 in the Fish Lake dining area, provide adaptive equipment, and a regular diet of pureed texture. R29's care plan identified as a problem a history of weight loss and listed as a goal that the resident will have adequate food and fluid intake, with her weight remaining within 7.5% for 90 days. 4/29/15, at 8:33 a.m., R29 was observed at continental breakfast sitting in w/c at a table by herself. R29 was eating cereal (Cheerios) in milk, yogurt, and juice. No staff encouraged her. At 8:41 a.m., Activities Director (AD)-A sat down with R29 to talk about activities and also encouraged her to eat. R29's total time in the dining room was 25 minutes; AD-A sat with her for 10 minutes. On 4/29/15, at 11:22 a.m., R29 was wheeled to a table in the dining room. A glass of orange juice and a covered brown mug with a straw was placed in front of her. At 11:25 a.m., a staff person took her food order and returned with her tray at 11:31 a.m. NA-E encouraged R29 to eat and talked with others at the table. At 11:42 a.m., R29 was still eating independently with encouragement from NA-E. At 11:47 a.m., NA-E asked R29 if she was done with her meal,	F 362		

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F 362	Continued From page 51 marked 25% intake on her card and took R29's bowls away. On 4/29/15, R29's brunch meal lasted from 11:31 a.m. until 11:47 a.m., or 16 minutes. On 4/30/15 at 10:35 a.m., R29 was wheeled to the Fish Lake dining room. She was given a brown covered mug with a straw. At 10:59 a.m., a dietary aide wheeled a cart to the area and provided residents with beverages; R29 took milk and orange juice, which were in plastic cups with straws. At 11:16 a.m., another resident's family member (FM)-D asked R29 what she would like to eat, took her diet card and went to get her food. FM-D returned with R29's tray at 11:26 a.m. R29 sat at the dining room table for over 50 minutes before getting her meal, and then it was provided to her by another resident's family member. R29 received a total of 15 minutes of encouragement during that brunch meal. In an interview on 4/30/15, at 11:52 a.m., FM-D stated she often got R29 a meal. "She [R29] gets so agitated and they take so long. She's sweet." On 4/27/15, at 3:42 p.m. family member (FM)-C reported there were a lot of staffing problems in the dining room. FM-C or another family member came in daily to feed her spouse the noon and evening meals. FM-C felt her spouse would not be fed fed in a timely manner without family help. FM-C reported she observed residents leaving the dining room without ever receiving food due to having to wait too long to be served.	F 362		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides	F 365		06/10/15

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F 365	Continued From page 52 food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility did not ensure food was served in the proper consistency for 2 of 5 residents (R29, R109) who were reviewed for therapeutic diets. Findings include: R29's face sheet printed on 4/29/15, identified diagnoses including dementia, depression, anxiety, chronic pain and headaches. R29's annual Minimum Data Set (MDS), dated 3/11/15, indicated R29 had severely impaired cognition. The MDS further indicated that R29 required limited assistance with eating, had no swallowing disorders, and was on a mechanically altered therapeutic diet. R29's care plan specified she needed cues, reminders and some assistance with meals. The care plan directed staff to serve R29 in the Fish Lake dining area, provide adaptive equipment, and a regular diet of pureed texture. R29's care plan identified as a problem a history of weight loss and listed as a goal that the resident will have adequate food and fluid intake, with her weight remaining within 7.5% for 90 days. Review of an undated diet card for R29 specified "pureed" diet. Review of progress notes revealed a 1/13/15 dietary manager note that stated, "resident is on a puree textured diet which	F 365	**F365** **VHC will ensure food is served at the proper consistency for residents on therapeutic diets.** R29 had a Nutritional Assessment completed on 5/29/15 and CP and Care Guide were updated accordingly. Nursing and Dietary staff were re-educated on R29s POC regarding Eating program including meal consistency. Continental Breakfast will be served to the resident by Dietary or trained designee to ensure proper meal consistency. Random audits of R29s meals will be completed by Dietary Manager daily X 1 week, 3xwkx2, 2xwkx2, then weekly thereafter, with a summary note documented on a weekly basis until weight has stabilized X 1 month. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion date: 6/10/15	

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F 365	Continued From page 53 remains appropriate." Following that was a 1/20/15 dietary manager note stating that the resident has had weight loss, with most noted when the resident's family was switching R29's diet texture back and forth from puree to regular. "resident's family is now OK with the puree texture and resident accepts puree texture well." Registered dietician (RD) progress notes dated 1/15/15, 2/24/15, and 3/17/15 also confirmed that R29 was on a pureed diet. On 4/29/15, at 8:33 a.m., R29 was observed at continental breakfast sitting in wheelchair, at a table by herself. R29 was eating cereal (Cheerios) in milk, yogurt, and juice. In an interview on 4/30/15, at 2:18 p.m., with the speech language pathologist (SLP), stated nursing can downgrade a diet automatically, but there are no upgrades without a swallow evaluation. The SLP stated only speech, a resident's physician or the resident/family can upgrade a resident's diet consistency. The SLP explained she was usually able to evaluate a resident immediately when she received a referral. In the interview on 4/30/15, at 2:18 p.m., the SLP stated she saw R29 starting on 7/24/14 and discharged her on a pureed diet and thin liquids. R29 was pocketing a lot of food into both cheeks. She would chew food, but not swallow it; instead it would "pocket" or stay in her cheeks. The SLP stated that cold cereal, such as "Cheerios" could only be considered pureed if it was soaked in milk long enough become mush, or what they call a "slurry". The SLP stated that R29 receiving regular textured foods was a concern, as R29 could choke, aspirate or get pneumonia from regular consistency food. R109's Dietary Communication slip dated	F 365		

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F 365	Continued From page 54 4/21/15, indicated the resident was to have a pureed diet. On 4/30/15 at 11:33 a.m. R-109 was seated in his room with a nursing assistant (NA). There was a bowl of Cheerios cereal and a regular cup with juice in front of him. The NA stated she did not know what type of diet the resident should have, the NA looked at her assignment sheet, then indicated he was on a pureed diet. The resident stated he was not on a pureed diet. Interview with the dietary manager (DM) and dietary aide (DA)-B on 4/30/15 at 8:40 a.m. indicated the residents diets and special utensils were available on a sheet for staff to use when serving foods and the sheet was updated weekly. The sheet dated April 27-May 3 for the continental breakfast was reviewed. It indicated R109 should have pureed food. The DM indicated the resident should not have received Cheerios.	F 365		
F 369 SS=E	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to ensure adaptive eating utensils were provided as ordered for 5 out of 8 residents reviewed (R29, R56, R21, R109, R36). Findings include:	F 369	**F369** **VHC will ensure adaptive eating utensils for residents as ordered.** R29 had a Nutritional Assessment completed on 5/29/15 and CP and Care Guide were updated accordingly. Nursing and Dietary staff were re-educated on R29s POC regarding Eating program including adaptive eating equipment.	06/10/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 369	Continued From page 55 R29's face sheet printed on 4/29/15, identified diagnoses including dementia, depression, anxiety, chronic pain and headaches. R29's quarterly Minimum Data Set (MDS,) dated 3/11/15, indicated R29 had severely impaired cognition. The MDS further indicated that R29 had no swallowing disorders and was on a mechanically altered therapeutic diet. R29's care plan specified she needed cues, reminders and some assistance with meals. The care plan directed staff to serve R29 in the Fish Lake dining area, provide adaptive equipment, and a regular diet of pureed texture. R29's undated Care Card specifies the following adaptive equipment: dycem, suction bowls, brown covered mugs, and black handled utensils. On 4/29/15, at 8:33 a.m., R29 was observed at continental breakfast sitting in w/c at a table by herself. R29 was eating Cheerios in milk, yogurt, and juice. The cereal was in a white disposable bowl, the yogurt was in a small, clear disposable cup and the juice was also in a disposable cup. R29 was using a disposable white spoon to eat the cereal. No adaptive equipment was provided. R56's diagnoses according to his most quarterly MDS dated 3/31/15, included stroke, hypertension, diabetes and depression. The MDS further indicated R56 was cognitively intact and independent with eating. R56's nutritional status care plan specifies he is to eat with adaptive equipment (start date of 4/21/14). The adaptive equipment enabled him to eat more independently. Specifically, his orders indicated he was to utilize a big black handled teaspoon and a rocker knife.	F 369	Continental Breakfast will be served to the resident by Dietary or trained designee to ensure proper adaptive eating equipment is provided. (Nosey cup, thin black handled fork and lipped plate w dycem under it). Random audits of R29s meals will be completed by Dietary Manager daily X 1 week, 3xwkx2, 2xwkx2, then weekly thereafter, with a summary note documented on a weekly basis until weight has stabilized X 1 month. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion date: 6/10/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 369	Continued From page 56 On 4/30/15, at 7:28 a.m., R56 was observed sitting at a table in the Fish Lake Dining Room with four other residents. R56 was eating rice krispies with banana in a plastic disposable bowl and a white disposable plastic spoon. In an interview on 5/1/15, at 10:29 a.m., occupational therapist (OT)-G stated that he was one of the people who did assessment for adaptive silverware. OT-G stated that he never wrote a recommendation that would not be used for all meals. He expected the recommendations to be used for all meals. R21's quarterly Minimum Data Set (MDS) assessment dated 1/26/15, indicated R21 was cognitively intact, had a mechanically altered therapeutic diet and received supervision with eating. R21's face sheet printed 4/30/15, identified diagnoses including dysphagia. The Review of Indicators of Nutritional Status dated 4/27/15, indicated R21 fed herself with adaptive equipment, had an intake of 75%-100% of her meals, and had a stable weight. The Nutritional Care Plan Summary used in the kitchen for each resident's meal ticket indicated R21 was to receive a thin black handled fork and lip plate with dycem at each meal. The annual care conference note dated 4/29/15, indicated R21 fed herself with adaptive equipment and a regular diet, with pureed vegetables and meats per her preference. On 4/30/15, at 10:44 a.m. R21 stated she ate pureed foods, most of the time. R21 kept most of her meal tickets and pulled out the ticket for 4/24/15, which indicated R21 was to have a thin	F 369		

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F 369	Continued From page 57 black handled fork. R21 stated she did not always receive the adaptive utensils. R21 did not receive an adaptive fork at brunch on 4/30/15, but did have dycem under the lip plate. When she didn't get what she should get, R21 highlighted it on the card. During an interview on 5/1/15, at 12:22 p.m. occupational therapist (OT)-G stated R21 had not received therapy recently. OT-G stated OT usually makes recommendations for adaptive equipment and would write and communication slip, and then it would be added to the care plan. The facility policy and procedure for Dining Services dated 2/1/15, directed that adaptive equipment would be provided as determined by nursing or OT to assist the resident in maintaining independence with eating. The policy and procedure further directed dietary to wash and sanitize the equipment and return it to the resident each meal. R109 had a Dietary Communication slip dated 4/21/15, that indicated the resident was to have a nosey cup (a cup with an area cut out for the nose) for all liquids and a pureed diet. On 4/30/15 at 11:33 a.m. R109 was seated in his room with a nursing assistant (NA). There was a bowl of Cheerios and a regular cup with juice in front of him. Interview with the dietary manager (DM) and dietary aide (DA)-2 on 4/30/15, at 8:40 a.m. indicated the resident diets and special utensils were on a sheet that staff used when serving foods and the sheet was updated weekly. The	F 369		

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F 369	Continued From page 58 sheet dated April 27-May 3 for the continental breakfast was reviewed. It indicated R109 should have small cut out glasses. The DM indicated the resident should not have received a regular cup. R36's Face Sheet identified diagnoses that included paralysis agitans (Parkinson's disease). The quarterly MDS dated 3/9/15, indicated R36 was cognitively intact, independent with eating (after staff assist with set up), and did not have a swallowing disorder. R36's care plan dated 6/10/14 directed R36 was independent with meals after set up and adaptive equipment provided. The nursing assistant care guide lacked information on adaptive utensils. The dietary progress notes dated 3/9/15, indicated R36 ate meals in main dining room with adaptive silverware in place. On 4/30/15, at 8:10 a.m. R36 was observed to be eating breakfast in the dining room. R36 was observed to be eating cold cereal with a white disposable spoon. On 4/30/15, at 8:15 a.m. housekeeper (H)-A was serving breakfast, and was interviewed. H-A verified R36 did not have adaptive utensils, and stated all residents get plastic utensils at the breakfast meal.	F 369		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**F371** **VHC will ensure a safe and sanitary kitchen related to proper refrigerator temperatures, and food labeled with expiration dates when stored in the refrigerator.**	06/10/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 59 This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure a safe and sanitary kitchen related to refrigerator temperatures above normal range and food not labeled with expiration dates. This had the potential to affect all 83 residents in the facility who received meals prepared in the kitchen. Findings include: An initial kitchen tour was conducted 4/27/15 at 11:50 a.m. with the dietary manager (DM) and dietary aide (DA)-A. There was a three door refrigerator in the main kitchen area, the outside gauge indicated the temperature was 50 degrees Fahrenheit. DA-A indicated the temperature should be 40 or below, and the current temperature was high. The DA-A indicated the door had been opened often during meal preparation, and the staff should use the thermometer inside the refrigerator. The staff was unable to locate a thermometer inside the refrigerator at that time. There was a temperature log on the front of the refrigerator for April 2015, the recorded p.m. temperatures ranged from 39 to 45 degrees. The three door refrigerator was checked again 30 minutes later and the temperature was 43 degrees. Another observation on 4/30/15 at 10:14 a.m. the temperature was 42 degrees. There was another refrigerator in the back of the	F 371	Dietary staff were re-educated on 5/29/15 regarding proper labeling of food that was placed in the refrigerator and appropriate range for refrigerator temperatures (32-42 degrees.) Audits of the refrigerator temperatures/logs will be conducted on a daily basis x2wks, then 2xwkx2 and weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion date: **6/10/15**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 60 kitchen. The thermometer inside read 44 degrees. There was a temperature log on the front of the refrigerator for April 2015, the recorded p.m. temperatures ranged from 41 to 44 degrees. On 5/1/15 at 12:44 p.m., the small refrigerator was observed again with DA-B, the inside temperature gauges both indicated 46 degrees. Interview with the DM during the initial kitchen tour indicated that the refrigerator temperatures should be kept at 40 degrees or below. A policy regarding refrigerator temperatures was requested but not received. Also during the initial kitchen tour on 4/27/15, at 11:50 a.m. food was observed in the refrigerator in the back of the kitchen. There was a sign on the front of the refrigerator that indicated, "Food items are dated with the expiration date- not the date made." There was an open bag of lettuce dated 4/23, the lettuce was slightly browned. There was a container or bologna spread dated 4/26, and a package of bacon dated 4/26. DA-A stated the foods were labeled with the date they were opened or made, and it was good for five to seven days after that. The cook confirmed the bologna spread had been made the previous day. Interview with the DM on 4/27/15, at 12:30 p.m. indicated food should be dated with the expiration date, not the open on date. He indicated the above items were not labeled correctly.	F 371		

VHC Revised Plan of Correction

F241

VHC promotes care for residents in a manner that maintains each resident's dignity.

All dietary staff will be educated on the use of regular dishware and adaptive equipment for all meals.

Continental breakfast will be served for all residents on regular dishware and with adaptive proper specified adaptive equipment.

Dietary manager and/or designee will conduct audits of the continental breakfast meal daily X 1wk, and then 2xwkx2wks and weekly thereafter to ensure the proper dishware and adaptive equipment is being utilized.

Audit results will be brought to the QAPI Committee for review and further recommendations.

Completion date: 6/10/15

F280

VHC reviews and revises care plans to ensure the care plan reflects the needs of the residents.

R92's care plan and NAR care guide was updated regarding the body pillow on the bed.

R29's care plan was reviewed and updated regarding the call light within reach at all times.

R92's Nutritional care plan was reviewed and revised to reflect the resident's care and services regarding

his/her swallowing disorder and adaptive equipment.

Nursing staff will be re-educated on Care planning for 'Accidents' on 6/1/15.

Dietary manager will be re-educated on Care planning for Nutrition on 6/1/15.

Care plans for all residents will be reviewed and updated for both 'Accidents' and 'Nutrition' and will be revised prn.

Random care plan audits on 'Accidents' and 'Nutrition' will be conducted by DON/designee 3xwkx2, 2xwkx2, and then weekly thereafter.

Audit results will be brought to the QAPI Committee for review and further recommendations.

Completion date: 6/10/15

F282

VHC will ensure services provided by the facility are provided by qualified persons in accordance with each resident's written plan of care.

Nursing and NAR staff on Canal Park unit were re-educated on **R107s** Care plan regarding her black protective ankle sleeves.

Nursing and NAR staff on Island Lake unit were re-educated on **R39's** care plan regarding offloading and repositioning schedule and care plan regarding **R39's** tooth brushing schedule.

All nursing and NAR staff were also re-educated on proper repositioning techniques as well as need to follow care cards regarding repositioning

schedules, tooth brushing schedules, and skin protective devices.

Random audits will be conducted by DON/designee for care plans being followed for Repositioning and for Tooth brushing, 3xwkx2, 2xwkx2, and then weekly thereafter.

Audit results will be brought to the QAPI Committee for review and further recommendations.

Completion date: 6/10/15

F309

VHC will provide the necessary care and services to residents in order to attain and maintain their highest practicable well-being.

R29 No doc *of bruise/scab on top of hand noted on two days during survey*

R107 No *black ankle sleeves, Weekly skin check did not identify R wrist bruise, No doc of 1cmX1cm red, scabbed R ankle*

R39 *Teds not on in AM, off HS, No CPAP on during naps*

Nursing and NAR staff were re-educated on 5/29/15 regarding R29s bruise/scab noted on top of R hand.

Nursing and NAR staff were re-educated on 5/29/15 regarding R107s Right ankle scab and black ankle sleeves.

Nursing and NAR staff were re-educated on 5/29/15 regarding R39s Teds and CPAP schedules.

All care plans and care cards were reviewed to ensure Teds and CPAP schedules matched.

All residents at high risk for non-pressure areas reviewed for skin issues and care plans/care cards updated.

All resident's reviewed for CPAP use and no other residents use a CPAP device.

Nursing and NAR staff were re-educated on 6/3/15-6/4/15 regarding the facility's Skin protocol regarding Weekly Skin Checks, reporting and documentation of any new skin issue AND offloading and repositioning according to the Tissue Tolerance assessment as well as following care cards regarding Teds Stocking and CPAP schedules. Staff was also educated that if special equipment is not available or missing that a replacement needs to be retrieved when it is noted to be missing or not available.

Random skin audits will be conducted by DON/designee to ensure accurate documentation of skin issues to be done 3xwkx2, 2xwkx2, and then weekly thereafter.

Audit results will be brought to the QAPI Committee for review and further recommendations.

Completion date: 6/10/15

F314

VHC will ensure repositioning is provided to decrease the risk of development of skin ulcers.

Nursing and NAR staff on Island Lake unit was re-educated on **R39's** care plan

regarding offloading and repositioning schedule per the resident's Tissue Tolerance assessment.

All current tissue tolerance assessments were reviewed for accuracy and errors. A new tissue tolerance assessment was completed if errors were noted.

All care plans and care cards were reviewed to ensure repositioning schedules matched.

All residents with pressure ulcers were reviewed to ensure care plans/care guides reflect appropriate treatment/services.

Nursing and NAR staff were re-educated on 6/3/15-6/4/15regarding the facility's Skin protocol regarding Weekly Skin Checks, reporting and documentation of any new skin issue and offloading and repositioning according to the Tissue Tolerance assessment.

Random audits will be conducted by DON/designee for care plans being followed for repositioning for residents with pressure ulcers and also residents at risk for development of skin ulcers, 3xwkx2, 2xwkx2, and then weekly hereafter.

Audit results will be brought to the QAPI Committee for review and further recommendations.

Completion date: 6/10/15

F323

VHC will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate

supervision and assistance devices to prevent accidents.

R92 lacked an assessment and informed consent for a body pillow which could potentially be a restraint. Resident and resident's son stated they no longer wanted the body pillow for comfort and it was removed. Care plan and care card were reviewed and updated.

R39's bed had large spaces between mattress and upper bedrails and facility had not assessed the safety and appropriate fit. Spacers were placed on side of mattress to make it appropriate for the bed resident is in.

R29 was lacking an assessment for a body pillow tucked under the sheet. Resident's safety was assessed and body pillow was removed as resident has not been restless in bed. Care plan and care card were updated.

R66 Fall OOB 4/16/15 – no RCA or IDT FU- Corporate nurse did root cause analysis training with nursing staff after survey. Resident was referred back to therapy since fall and hasn't had any further falls. IDT review follow-up note was placed in computer on 4/21/15.

R100s bed sensor alarm malfunctioning, no system in place to routinely check and replace pressure sensor alarm pads. Alarm was replaced after fall. NARs check alarms when placing a resident on them and nurses also check all of a resident's alarms weekly for functioning. Alarms are replaced when not functioning.

All residents were reviewed to assess for potential restraints. All resident beds were assessed to ensure proper fit

for safety. All alarms were checked for functioning.

Nursing staff were re-educated on 6/4/15-6/5/15 regarding safety assessments for potential restraints and appropriate fitting of side-rails/mattresses. RCA of falls re-training completed for nursing staff on 6/3/15-6/4/15.

Nursing and NAR staff re-educated on policy to check alarms when placing resident on them throughout the day and to notify nurse if not functioning. Nursing staff to check all alarms weekly for functioning and to replace if needed.

Maintenance staff will conduct audits of all mattresses on a monthly basis to determine safe and appropriate fit.

DON/designee will assess any body pillow currently in use by 5/29/15, to ensure are not being used in a way that could potentially be a restraint.

FU audits will be conducted by DON/designee on all future fall incident reports to ensure RCA was completed.

Audit results will be brought to the QAPI Committee for review and further recommendations.

Completion date: 6/10/15

F325

VHC will ensure adequate nutritional intake for any resident with weight loss.

R29 had a Nutritional Assessment completed on 5/29/15 and CP and Care Guide were updated accordingly.

A Restorative Eating program was put into place for R29 that includes 'ensuring proper meal consistency, setting up with appropriate adaptive eating equipment, cueing and encouraging res to eat and occasionally staff assist to finish meal prn'.

Nursing and Dietary staff were re-educated on R29s POC regarding Eating program including meal consistency, adaptive equipment and assistance with meals.

All residents' nutritional statuses were reviewed to assess for any other individual potential weight loss/gain issues.

Continental Breakfast will be served to the resident by Dietary staff or trained designee to ensure proper meal consistency and adaptive equipment is provided, and NAR will assist res with eating prn.

Dietary manager received re-education on documenting Dietary notes in the EMR on 6/1/15,

Random audits of R29s meals and Intakes will be completed by Dietary Manager daily X 1 week, 3xwkx2, 2xwkx2, then weekly thereafter, with a summary note documented on a weekly basis until weight has stabilized X 1 month.

Audit results will be brought to the QAPI Committee for review and further recommendations.

Completion date: 6/10/15

F362

VHC will employ sufficient support personnel competent to carry out the functions of the dietary service.

Fish Lake dining room will be served at approx 11:30 am for brunch or 5:00 pm for supper meals depending on when other dining rooms are finished being served. This will allow residents eating in Fish Lake to be served at same time. Families of residents who eat in Fish Lake who wish to feed their resident and don't want to wait until 11:30 am or 5:00 pm serving time will be provided a space in Mesa Park for the resident and themselves. The resident will continue to keep a designated spot in Fish Lake dining area for when family is not present so that resident will receive staff assistance with eating.

Random audits of dining room service will be completed by Dietary Manager daily x 1 week, 3x/week x 2 weeks, and then weekly thereafter.

Audit results will be brought to the QAPI Committee for review and further recommendations.

Completion Date: 6/10/15

F365

VHC will ensure food is served at the proper consistency for residents on therapeutic diets.

R29 had a Nutritional Assessment completed on 5/29/15 and CP and Care Guide were updated accordingly.

Nursing and Dietary staff were re-educated on R29 and R109 POC regarding Eating program including meal consistency.

All resident's care plans/care cards were reviewed to ensure correct proper consistency of diets noted.

Continental Breakfast will be served to all residents by Dietary or trained designee to ensure proper meal consistency.

Random audits of R29 meals will be completed by Dietary Manager daily X 1 week, 3xwkx2, 2xwkx2, then weekly thereafter, with a summary note documented on a weekly basis until weight has stabilized X 1 month.

Random audits of R109 and other resident meals will be completed by Dietary Manager daily x 1 week, 3xwkx2, 2xwkx2, then weekly hereafter to ensure proper consistency of diet.

Audit results will be brought to the QAPI Committee for review and further recommendations.

Completion date: 6/10/15

F369

VHC will ensure adaptive eating utensils for residents as ordered.

R29 had a Nutritional Assessment completed on 5/29/15 and CP and Care Guide were updated accordingly.

Nursing and Dietary staff were re-educated on R29s POC regarding Eating program including adaptive eating equipment.

R56, R21, R109, and R36's current nutritional status was reviewed for any issues. All other residents' current nutritional statuses were also reviewed and all care plans/care cards were

reviewed to ensure all adaptive equipment noted.

Continental Breakfast will be served to all residents by Dietary or trained designee to ensure proper meal adaptive eating equipment is used.

Random audits of R29s meals will be completed by Dietary Manager daily X 1 week, 3xwkx2, 2xwkx2, then weekly thereafter, with a summary note documented on a weekly basis until weight has stabilized X 1 month.

Random audits of R56, R21, R109, and R36 and other resident meals will be completed by Dietary Manager daily x 1 week, 3xwkx2, 2xwkx2, then weekly hereafter to ensure proper adaptive eating equipment is being used.

Audit results will be brought to the QAPI Committee for review and further recommendations.

Completion date: 6/10/15

F371

VHC will ensure a safe and sanitary kitchen related to proper refrigerator temperatures, and food labeled with expiration dates when stored in the refrigerator.

Dietary staff were re-educated on 5/29/15 regarding proper labeling of food that was placed in the refrigerator and appropriate range for refrigerator temperatures (32-42 degrees.)

Audits of the refrigerator temperatures/logs will be conducted on a daily basis x2wks, then 2xwkx2 and weekly thereafter.

Audit results will be brought to the QAPI Committee for review and further recommendations.

Completion date: **6/10/15**

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	245414	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/28/2015**

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K 000	INITIAL COMMENTS Building #1 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division . At the time of this survey, Viewcrest Health Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Building #1 Viewcrest Health Center, Building #1, is a 1-story building with a partial basement. The original building was constructed in 1960 with additions constructed in 1968, 2002 and 2008. The 1960 and the 1968 building is type II(111) construction. The 2002 building is two (2) story Type II(000), and the 2008 building is Type II(11) 2-story. Therefore, the 1960, 1968, and 2002 building was inspected as one building to Type II(000) construction. The 2008 building was inspected as a separate building. The building is fully protected by automatic fire sprinklers. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 92 beds and had a census of 82 at the time of the survey.	K 000		

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

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K 000	Continued From page 1 The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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	245414	A. BUILDING **02 - VIEWCREST HEALTH CENTER** B. WING _____	**04/28/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Building #2 THIS INSPECTION ONLY COVERS THE 2008 ADDITION TO VIEWCREST HEALTH CENTER. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division . At the time of this survey Viewcrest Health Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 NEW Health Care. The 2008 addition, building #2, to the Viewcrest Health Center is a two (2) story building with no basement. The construction type is determined to be Type II(111) The building is separated from the rest of the facility by 2 hour fire rated construction , with a 1 & 1/2 hour rated fire door. The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The entire facility has a licensed capacity of 92 beds, and the addition has a capacity of 22 beds that were all in use at the time of inspection. The requirement at 42 CFR Subpart 483.70(a) is met.	K 000		

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

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