DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 16, 2023

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

Re: Reinspection Results
Event ID: KJA012

Dear Administrator:

On November 8, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 21, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 16, 2023

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

RE: CCN: 245414
Cycle Start Date: September 21, 2023

Dear Administrator:

On November 8, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 3, 2023

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

RE: CCN: 245414
Cycle Start Date: September 21, 2023

Dear Administrator:

On September 21, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

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

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 21, 2023 (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).

In addition, if substantial compliance with the regulations is not verified by March 21, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 3, 2023

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

Re: State Nursing Home Licensing Orders
Event ID: KJA011

Dear Administrator:

The above facility was surveyed on September 18, 2023 through September 21, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	09/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 9/18/23 to 9/21/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/18/23 to 9/21/23, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to	F 567		11/2/23

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

Electronically Signed — 10/12/2023

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

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	245414	A. BUILDING _____ B. WING _____	09/21/2023

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F 567	Continued From page 1 manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by:	F 567		

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F 567	Continued From page 2 Based on interview and document review the facility failed to ensure residents had reasonable access to their personal funds after hours and on weekends for 2 of 2 residents (R13, R227) reviewed for personal funds. This had the potential to affect all 52 residents who had personal accounts managed by the facility. Findings include: R13's quarterly Minimum Data Set (MDS) assessment dated 7/7/23, identified R13 was cognitively intact. During an interview on 9/18/23 at 8:34 a.m., R13 stated they went to accounting when they needed money, but it was difficult to get their money and the facility did not have anyone they could get money from on the weekend. R227's annual MDS assessment dated 6/26/23, identified R227 was cognitively intact. During an interview on 9/18/23 at 9:23 a.m., R227 stated they kept money in a facility account and indicated they could not get money on the weekend, and if they wanted money on a Saturday, they would have to ask for it on Friday, or wait until Monday. During an interview on 9/20/23 at 2:08 p.m., nursing assistant (NA)-A stated social services could assist a resident with getting money from their personal facility account, but residents could not get money during the weekend. During an interview on 9/20/23 at 2:40 p.m., licensed practical nurse (LPN)-C stated during the week they would bring a resident to the	F 567	F: 567 It is Viewcrest Health Center's policy to provide reasonable access to their personal funds. Administrator and/or designee will implement corrective action for resident R13 and R227 affected by this practice by: • R13 and R 227 will have access to their personal funds outside of normal business hours. Administrator and/or designee will assess residents having the potential to be affected by this practice including: • All residents who have trust fund accounts have the potential to be affected by deficient practice. Administrator and/or designee will implement measures to ensure that this practice does not recur including: • The residents were notified of having access to their personal funds after hours and on weekends at the resident council meeting on 10/10/2023. • All staff will be educated on residents' access to their personal funds after hours and on weekends at meetings on 10/11 and 10/12/2023. Administrator and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits identifying access to personal funds will be completed by Administrator/designee 1x/week x 4 weeks, and then monthly thereafter beginning the week October 16, 2023.	

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 567	Continued From page 3 accountant to get money, but they did not know if residents could get money during evenings or weekends. During an interview on 9/20/23 at 2:43 p.m., the accountant stated she has been in her position since 6/12/23. Residents knew she left at 4:00 p.m. and that they could access their funds anytime when she was there. The administrator could also disperse money from the resident fund cash box locked in her office. The charge nurse had access to the cash box to get residents money after hours and on weekends, but since she had been at the facility nurses had not accessed the cash box. She could also be called in to get money for a resident, but that had not happened since she started. If a resident wanted money for the weekend, they would get it on Friday. The facility kept $300.00 to $500.00 in cash on hand in the accountant office for residents with personal accounts. During an interview on 9/21/23 at 9:27 a.m., registered nurse (RN)-B stated residents cannot get money in the evening or the weekend. Those that get cash know to ask before the weekend or before the end of the business day. There was petty cash at one time, but they were not sure if there was any anywhere anymore. During an interview on 9/21/23 at 8:49 a.m., RN-E stated normally residents cannot get money in the evening, so they try to have them plan ahead. The money was kept locked in the accountant office and they were not sure if anyone had access to the money on weekends or evenings. On 9/21/23 at 9:31 a.m., RN-D stated the green	F 567	• Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 2, 2023	

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 567	Continued From page 4 valley medication cart had 75 dollars of petty cash in it. RN-D opened the narcotic box and showed a bank bag with a ledger and withdrawal slips for residents to take money out of the petty cash. The resident ledger indicated the last time money had been counted was 3/31/23. RN-D counted a total of 75 dollars in the petty cash bag. The Trust Fund Tally Sheet in the petty cash bag identified the last withdrawal occurred on 3/31/23, and the balance was 75.00 dollars. During a follow-up interview on 9/21/23 at 10:22 a.m., the accountant stated she was not aware the Green Valley medication cart had resident funds petty cash in it and must have been something previously in place. The petty cash was off since she started and indicated the money in the medication cart was not being included in the count and that explained the discrepancy. On 9/21/23 at 10:32 a.m., the accountant reported she spoke with the administrator and found out the money in the medication cart was kept in the cart for the weekend needs of residents. During an interview on 9/21/23 at 12:38 p.m., the director of nursing (DON) stated in the past the facility had had a petty cash box for after hours and weekends and it should contain 100 dollars for residents to access. The cash box should be counted each day to ensure it is balanced. Information about the petty cash would be reviewed with staff and residents at the next resident council meeting to ensure everyone knew resident funds could be accessed outside of business hours and on weekends.	F 567		

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 567	Continued From page 5 During an interview on 9/21/23 at 12:42 p.m., the administrator was unaware there was an issue with residents not being able to get money on the weekends or after hours. The issue likely developed during the transition of an accountant leaving, an interim and a replacement being hired and trained. There will need to be staff and resident education provided so that all are aware residents can access their funds at any time. The facility Trust Fund Monthly Summary, dated 9/1/23 to 9/20/23, identified there were 52 current residents with accounts.	F 567		
F 568 SS=E	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure residents with trust accounts received quarterly accounting statements for 2 of 2 residents (R227, R13) reviewed for resident funds. This had the potential to affect all 52 residents who had	F 568	F: 568 It is Viewcrest Health Center's policy to provide residents/families statements of their trust fund accounts at least quarterly. Administrator and/or designee will	11/2/23

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 568	Continued From page 6 personal accounts managed by the facility. Findings include: R13's quarterly Minimum Data Set (MDS) assessment dated 7/7/23, identified R13 was cognitively intact. During an interview on 9/18/23 at 8:34 a.m., R13 they handled their own finances and had not received a quarterly account balance statement from the facility. R227's annual MDS assessment dated 6/26/23, identified R227 was cognitively intact. During an interview on 9/20/23 at 9:17 a.m., R227 stated they did not know how much money they had in their account, but since they didn't think it was very much. R227 did not identify if they received a quarterly statement. During an interview on 9/20/23 at 2:43 p.m., the accountant recently stated and had not sent out resident trust account statements since she was hired and did not know when they were last sent out. During an interview on 9/21/23 at 12:42 p.m., the administrator stated residents should get quarterly trust account statements if the accountant didn't send residents a trust account statement, then the residents had not received one. It was facility practice to send out regular statements to residents and indicated the gap in sending statements was likely due to the position transitions and orienting processes that were occurring within the accounting department.	F 568	implement corrective action for resident R13 and R227 affected by this practice by: • R13 and R227 will have trust fund statements provided to them by 10/20/2023. Administrator and/or designee will assess residents having the potential to be affected by this practice including: • All residents who have trust fund accounts have the potential to be affected by deficient practice. • All residents/families with trust fund accounts will receive trust fund statements by 10/20/2023. Administrator and/or designee will implement measures to ensure that this practice does not recur including: • The Resident Trust Fund Account policy was reviewed. • The administrator was trained on the policy regarding providing trust fund statements at least quarterly. Administrator and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Audits identifying trust fund statements were provided to residents/families will be completed quarterly beginning in January 2023 for the 4th quarter of 2022. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 2, 2023	

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 _____	09/21/2023

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VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

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F 568	Continued From page 7 The facility Trust Fund Monthly Summary, dated 9/1/23 to 9/20/23, identified there were 52 current residents with accounts.	F 568		
F 570 SS=E	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the surety bond was equal to or greater than the funds entrusted to the facility. This had the potential to impact all 52 current and 47 discharged residents identified as having a trust fund account at the facility. Finding include: The facility Trust Fund Monthly Summary, dated 9/1/23 to 9/20/23, identified the beginning balance on 9/1/23 was16,195.63 and the ending balance for the time period was 15,735.63. The balances were calculated based on account balances for 52 current residents and 47 discharged residents. The Nationwide Mutual Insurance Company dated 9/30/22, identified the facility had a surety bond in the amount of $15,000.00 that went into effect on 10/1/22. During an interview on 9/20/23 at 2:43 p.m., the accountant stated the total account trust balance on 9/20/23, was $15,735.63. The balance was made up of 52 current residents and 47	F 570	F: 570 It is Viewcrest Health Center's policy to provide a surety bond large enough to cover the balance of resident's personal funds. Administrator and/or designee will implement corrective action for all residents affected by this practice by: • A surety bond was requested for $25,000.00 to cover the balance of the resident trust account by 11/01/2023. Administrator and/or designee will assess residents having the potential to be affected by this practice including: • All residents who have trust fund accounts have the potential to be affected by deficient practice. Administrator and/or designee will implement measures to ensure that this practice does not recur including: • The administrator was trained on surety bond requirements and will ensure the surety bond covers the trust fund	11/2/23

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F 570	Continued From page 8 discharged residents. The facility surety bond to cover resident funds at the facility was for $15,000.00 and the current trust account balance had an excess of 735.63 that was not covered by the surety bond. During an interview on 9/21/23 at 12:42 p.m., the administrator stated the resident fund amount should not exceed the surety bond, and the facility should have a surety bond that covered the amount they had in the resident fund account at any given time.	F 570	account balance. Administrator and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Specific audits regarding trust fund balance and surety bond amount will be conducted monthly by the administrator to ensure that the trust fund balance remains below the surety bond amount beginning the week of October 30, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 2, 2023	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		11/2/23

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F 584	Continued From page 9 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the facility provided a home like environment for 1 of 1 residents (R47) reviewed for home like environment. Findings include: During an observation on 9/18/23 at 8:17 a.m., R47 was laying on a bare mattress on her bed. The bed was unplugged and in a low position. During an observation on 9/19/23 at 2:42 p.m., R47 was laying across the foot of the bed and the bed had a flat sheet and incontinence pad and there was not pillow or blanket. The room contained two chairs, and an end table and a call	F 584	F: 584 It is Viewcrest Health Center's policy to provide a safe/clean/comfortable/homelike environment per our resident's plan of care. DON and/or designee will implement corrective action for resident R47 affected by this practice by: • R47's care plan was reviewed on 10/10/2023 and updated to ensure all behaviors were accurate and reflected "hx of" for behaviors not recently noted. • R47 has behavior charting in place for nursing staff to make note of behaviors that occur each shift. Education provided to all staff on documentation of behaviors.	

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F 584	Continued From page 10 light cord hanging from the wall. There was a stuffed animal on the bed and several others on the floor next to the bed. R47's room lacked any personal clothing or items and the bathroom room was locked. During an interview on 9/19/23 at 3:20 p.m., RN-A identified R47 was at the facility for six months. The facility was concerned about hoarding, but R47 had a history of eating things like incontinence briefs and gloves, the facility did not keep things in R47's room. RN-A didn't know why R47 did not have a pillow or a blanket in her room, as many things were put in to place before RN-A started at the facility. On 9/20/23 at 9:02 a.m., nursing assistant (NA)-J assisted R47 with cares. NA-J explained R47 did not have personal care items or clothes in her room because if she did, R47 would put everything in the toilet and flood the room. NA-J indicated R47's clothes were kept in the laundry room and all of her personal care items were kept in the tub room bathroom they used for R47. During an interview on 9/20/23 at 3:15 p.m. regiatered nurse (RN)-A confirmed R47's room was very sparse and identified all items were removed from her room based on her past behaviors and safety needs, even though R10 did not have any currently identfied behaviors. During an interview on 9/21/23 at 9:14 a.m., NA-K stated R47's clothing had been kept in the laundry room for at least a year or more. When R47's needed clothes, they get them from the laundry room. NA-K stated it was not in her scope to determine if R47's room was homelike.	F 584	• R47 behavior interventions will be assessed with each MDS assessment and PRN. Interventions will be brought to IDT meeting to determine if interventions are still appropriate and attempt to reduce current restrictions/interventions with documentation on failed reintroductions. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents with behavioral care plans have the potential to be affected by deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: • Review of Person-Centered Care Planning policy was reviewed and updated as needed. • Education will be given to all staff regarding documentation of behaviors and refusals of treatment at meetings on 10/11 and 10/12/2023. • Continued monitoring of all residents with MDS assessments, care plan updates, and IDT review of all behaviors and interventions with each MDS and PRN. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits of behavioral care plans, current interventions, documentation of behaviors and recent updating of the care plan to reflect recent changes or last failed reintroduction will	

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F 584	Continued From page 11 During an interview on 9/21/23 at 12:38 p.m. the director of nursing (DON) acknowledged that R47 did not have much of a home like environment and identified an attempt had been made to put some decorative paper items in her room but they were removed. The facility Person Centered Care Planning policy dated 3/7/22, identified the care plan should allow for resident choice, honor home like environment, enhance dignity, allow for treatment refusal, and help support achievement of highest practicable level of well-being for the resident.	F 584	be completed by the DON/designee 5x for 1 week, 3x for 2 weeks, then 1 weekly for 2 weeks and then monthly thereafter beginning the week of October 16, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 2, 2023	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		11/2/23

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F 657	Continued From page 12 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. 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 newly assessed needs and services for 1 of 4 residents (R10) reviewed for changes in activities of daily living (ADL); 1 of 2 residents (R61) reviewed for pressure ulcers. Findings include: R10's quarterly Minimum Data Set (MDS) dated 8/10/23, identified R10 had severe cognitive impairment. Diagnoses included dementia, kidney disease, history of stroke and anxiety. R10 required limited assistance with bed mobility, transfers, and toileting. Ambulation and dressing did not occur. R10 was frequently incontinent of bowel and always incontinent of urine. R10's care plan dated 8/23, identified staff were to ambulate R10 daily with assist of one and a full wheeled walker. R10's care plan did not address her assessed need for assistance with bed mobility and dressing. During continuous observation on 9/20/23, from 8:20 a.m. to 11:45 a.m. R20 was observed dressed in a hospital gown lying in bed on her back. R20 did not make any attempt to turn or reposition herself during the 3 hours and 15 minute observation and no staff were observed to offer assistance with bed mobility.	F 657	F: 657 It is Viewcrest Health Center's policy to update our residents care plan as needed. DON and/or designee will implement corrective action for resident R10 and R61 affected by this practice by: • A review of resident R10's care plan on 9/21/23 was reviewed for accuracy and updated with the most accurate information per staff interviews and assessments completed. A tissue tolerance assessment was initiated to determine if a change to the plan of care was appropriate. Care plan revised to show A1 for all repositioning needs. • R10 will be offered T&R Q 2 to 3 hours and PRN. • R10 had a Braden assessment completed on 9/27/23 revealing a score of 14 revealing moderate risk for skin breakdown. Air overlay placed on resident's bed. • A review of R61's care plan on 10/10/23 was reviewed for accuracy and updated with the most accurate information per staff interviews and assessments completed. A Braden assessment was completed on 8/29/23 scoring 15 indicating moderate risk. Care plan revised for A1 with T&R.	

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F 657	Continued From page 13 During subsequent observations on 9/19/23, and 9/21/23, at various times, R20 was observed lying on her back in bed, dressed in a hospital gown. During interview on 9/19/23, at 11:30 a.m. nursing assistant (NA)-G stated they offer to assist R10 to dress but she preferred to remain in a hospital gown. The staff changed the gown and bedding when needed. When interviewed on 9/19/23, at 11:45 a.m. NA-F stated she assisted R10 with her morning cares and R10 refused to dress. R10 preferred to wear her hospital gown and NA-A assisted R10 to put a fresh one on that morning. R10 did not ambulate and only stood and pivoted to the commode at bedside. R10 was able to assist staff with turning and reposition when she was prompted by grabbing onto the bed rail. During interview on 9/20/23, at 2:40 p.m. registered nurse (RN)-F stated R10's care plan did not address dressing because R10 refused to dress. RN-F confirmed bed mobility and dressing were not on the plan of care and should have been. RN-F was aware R10 had not ambulated in over a year as she frequently refused. R10's family member (FM)-F wanted to keep her on the ambulation restorative program, despite her constant refusals. RN-F was responsible to update the care plan and R10's care plan should have been updated as a result of the changes that had occurred with her MDS assessments. Part of the problem was the facility had recently changed their care plan program from one system to another, and he was still struggling with learning the new system. When interviewed on 9/21/23, at 1:30 p.m. the	F 657	• R61's Braden assessment completed PRN for comparison. Score is 13 still indicating moderate risk. • R61 will be T&R Q2H and PRN DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents who are dependent on staff for turning and repositioning have the potential to be affected by this practice. • A Review will be completed of all residents current repositioning schedule for appropriateness. Updated tissue tolerance assessments will be completed for anyone who has not had one completed in the past quarter. DON and/or designee will implement measures to ensure that this practice does not recur including: • Tissue tolerance assessments to be completed with all admissions, quarterly, annual, and significant change assessments. • Person Centered Care Planning, Care Planning & Care Planning Process were reviewed and updated as needed. • All staff will be educated on turning and repositioning policy and updating nursing staff and or management of a residents change in status from baseline at meetings on 10/11 and 10/12/2023. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits of current MDS assessments completed to ensure tissue	

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F 657	Continued From page 14 director of nursing (DON) stated R10's care plan should have been revised to reflect R10's increased care needs. The care plan needed to reflect that R10 refused to dress and preferred to remain in a hospital gown, as she still needed assistance to change the gown daily and bed mobility should be on the care plan as well. R10's refusal to ambulate should be re-evaluated and other interventions attempted and care planned to prevent range of motion decline. R61's quarterly Minimum Data Set (MDS) dated 8/29/23, indicated R61 had moderate cognitive impairment, was an extensive assist of one staff member for bed mobility and was on hospice services. Diagnoses included coronary artery disease, dementia, and cancer. R61's undated care plan identified R61 was independent with bed mobility which included turning and repositioning. During an interview on 9/20/23 at 9:56 a.m., nurse assistant (NA)-B stated R61 was unable to reposition himself and new staff would not be aware based on the care plan. During an interview on 9/21/23 at 10:14 a.m., registered nurse (RN)-C stated once the MDS nurse performed the assessments they would email RN-C to update the care plan if needed. RN-C never received an email to let them know to update the care plan. During an interview on 9/21/23 at 10:30 a.m., the MDS assistant (MDSA) stated the MDS	F 657	tolerance assessments are completed and care plan updated will be completed by DON/designee 5x/week x 1 week, 3x/week x 2 weeks, then once weekly x 2 weeks, and then monthly thereafter beginning the week of October 16, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 2, 2023	

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F 657	Continued From page 15 coordinator would complete the resident MDS based on observations, interviews with staff and medical record review. After the MDS was completed, the nurse manager was responsible for updating the care plan if there were any changes. MDSA stated she would send emails occasionally letting them know when the MDS assessment was completed to help but it was not a requirement. During an interview on 9/21/23 at 10:37 a.m., the DON stated it was the responsibility of the nurse manager to update the care plan based on the MDS assessment, even if the MDS did not notify them there needed to be changes. The DON stated she expected all nurse managers reviewed every resident MDS when completed to see if changes to the care plan were needed. The care plan needed to be updated to match the MDS so the staff new what needed to be done to provide the best care possible to our residents.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with toileting for 1 of 2 residents (R10) reviewed for activities of daily living and who were dependent on staff for their care. Findings include:	F 677	F: 677 It is Viewcrest Health Center's policy to provide ADL care for dependent residents per our resident's plan of care. DON and/or designee will implement corrective action for resident R10 affected by this practice by: • R10 will have toileting offered at 6 am	11/2/23

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F 677	Continued From page 16 R10's quarterly Minimum Data Set (MDS) dated 8/10/23, identified R10 had severe cognitive impairment, required limited assistance with toileting, and was always incontinent of bladder. R10's care plan dated 8/23, identified R10 required assistance to change her brief and provide peri cares after each incontinent episode. Interventiions included: staff to remind and assist R10 to the toilet on arising at 6:00 a.m. and every two to three hours during the day, as well as at bedtime; assist R10 to the commode every day around 9:00 a.m., and after breakfast to promote continent bowel movements. On 9/20/23, R10 was continuously observed from 8:20 a.m. until 11:30 a.m. R10 was lying in her bed with the head of her bed elevated, watching her television. R10 remained lying in her bed watching television and sleeping off and on until nursing assistant (NA)-F offered assistance to the commode and provided assistance with incontinence care at 11:45 a.m. R10's brief was saturated with a large amount of urine R10 was observed for 3 hours and 15 minutes and was not offered assistance with toileting or incontinence care during that time. On 9/20/23, at 11:45 a.m. NA-F stated she was assigned R10's care and R10 required assistance to check and change her brief and provide incontinence care. NA-F had not checked R10 since her morning cares at 6:00 a.m. and confirmed R10's brief was saturated with urine. When interviewed on 9/20/23, at 2:40 p.m. registered nurse (RN)-F stated he was not aware R10 was always incontinent of urine. R10 was care planned to be assisted to the commode	F 677	and Q2H after. • R10's care plan was updated to reflect the toileting schedule. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents who are dependent on staff for toileting have the potential to be affected by deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: • The Person-Centered Care Planning policy was reviewed and updated as needed. • The Urinary incontinence program was reviewed and updated as needed. • All nursing staff will be educated on the importance of incontinence care and toileting schedules. Staff will also be educated on the Individual receiving services choice policy at meetings on 10/11 and 10/12/2023. • All residents who need assistance with toileting will have their care plan reviewed and updated as needed. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits identifying toileting and peri care per resident's care plan will be completed by DON/designee 5x/week x 1 week, 3x/week x 2 weeks, then once weekly x 2 weeks, and then monthly thereafter beginning the week of October 16, 2023.	

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F 677	Continued From page 17 every two to three hours and he would expect staff to check and change R10 or offer toileting assistance in a timely manner. During interview on 9/21/23, at 1:33 p.m. the director of nursing (DON) stated it was her expectation that residents who were incontinent of bladder and needed assistance with toileting be checked and changed every two hours and if increase in incontinence were noted, the nurse should initiate a bowel and bladder assessment. The policy Urinary Incontinence Program dated 4/16/15, indicated each resident who was incontinent would be identified, assessed, and provided appropriate care and services to prevent incontinence related complications to the extent possible.	F 677	• Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 2, 2023	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meaningful activities for 1 of 3 residents (P10) who was dependent on staff for activities.	F 679	F: 679 It is Viewcrest Health Center's policy to ensure that every resident has an ongoing program to support residents in their choices of activities per our	11/2/23

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 _____	09/21/2023

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F 679	Continued From page 18 Findings include: R10's quarterly Minimum Data Set (MDS) dated 8/10/23, identified R10 had severe cognitive impairment and required assistance from staff for most of her activities of daily living (ADLs). R10's Activity Assessment dated 4/22/22, identified current and past activities of fishing, bingo, knitting, watching soap operas, news, a love of animals and birds, and gardening. R10 had children and her previous occupation was office work. R10's care plan dated 8/23, identified she preferred to engage in individual activity. Interventions included 1 to 1 visits two to three times per week, arrange to transport to and from activities of her choice, document attendance and level of participation, and encourage R10 to attend activities. R10 participated in her 1 to 1 visits, occasional bingo, pastoral visits, volunteer visits, music groups and crafts. On 9/19/23 at 2:15 p.m., R10 was observed lying on her back in bed. The television in the room was on and playing a show, Special Victims Unit (SVU), which depicted the investigation of sexual crimes, the sound was muted and closed captioning was on. A music activity was being conducted in the common area down the hall from R10. On 9/19/23 at 6:30 p.m., an unidentified nursing assistant (NA) was observed cutting up R10's food on her dinner tray. NA noticed R10 was just lying in bed looking at her food, so she came in to see if she could help her. R10 was smiling and	F 679	resident's plan of care. Activity Director and/or designee will implement corrective action for resident R10 affected by this practice by: • R10's Care Plan will be reviewed and updated as necessary to reflect their preferences and interests. Activity Director and/or designee will assess residents having the potential to be affected by this practice including: • All residents who are receiving 1:1 visits are potentially affected by this practice. Activity Director and/or designee will implement measures to ensure that this practice does not recur including: • The Activity Charting Policy and procedure will be reviewed and updated as needed. • All residents who receive 1:1's will have their care plans reviewed to assure that accurate information is in place. Updates will be made as needed, quarterly, annually and if resident has a significant change. • All Activity staff will be educated on the activity charting policy and procedure. Activity Director and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits identifying 1:1's per resident plan of care will be completed by the Activity Director and/or designee 5x/week x 1 week, 3x/week x 2 weeks, then once weekly x 2 weeks, and then	

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F 679	Continued From page 19 interacting with NA politely and stated thank you when NA completed her task. During continuous observation on 9/20/23 from 8:20 a.m. to 11:45 a.m., R10 was observed lying on her back in bed. The television in the room was on and playing the show SVU with sound muted and closed captioning on. During the 3 hour and 15-minute observation, one staff entered R10's room to remove her breakfast tray. No social interaction occurred. During observations on 9/20/23 from 11:45 a.m. to 3:00 p.m., R10 was lying in bed. The lights and television was on with the sound muted. There were no interactions from staff aside from required care of delivering and removing lunch tray and incontinence care. During interview on 9/20/23 at 3:00 p.m., activity director (AD)-G stated R10 did not like to come out of her room. She was able to do a couple of crafts with her and R10 loved one to one visits. AD-G had taken in an I-pad on 8/18/23, and they had looked at different animals and farming. AD-G noted television was documented on R10's activity calendar and the activity staff were more than likely doing something else with R10 and not only documenting the television was on. The activity staff did not document what occurred during the activity or the amount of time that was spent with the resident. More specific documentation for the activity aides was something AD-G was just starting to implement. A joint interview on 9/20/23 at 3:40 p.m., was conducted with activity aide (AA)-A and AA-B. AA-A stated they did not do much with R10. They would stop by R10's room and say hi and AA-A	F 679	monthly thereafter beginning the week of October 23, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 2, 2023	

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	245414	A. BUILDING _____ B. WING _____	09/21/2023

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F 679	Continued From page 20 tried to talk with R10, mostly about the decorations in R10's room, but R10 did not like to do much. They could have offered her books or magazines, but the family would have to bring things like a bird book or bird feeder. AA-B stated the times AA-B tried to have one to one visits with R10, R10 was very confused and it was difficult to communicate with R10. For some residents there was just nothing you could do, especially if they were loners and did not want them to visit. They did document activities for R10 on her activity calendar. When TV was written on the calendar, it meant that R10 was watching television. R10 did not get out of bed and the times when AA-A or AA-B tried to talk with R10 they would highlight one to one visit on her activity calendar in yellow. Anything on R10's activity calendar that was highlighted in green, meant R10 was asleep when they looked in on her. R10's Activity Calendar, dated August 2023, identified R10's recorded activities for the month. It listed various daily activities that could be offered to R10, including exercise and chat, catholic mass, lunch and supper club, quarter, dime and prize bingo, crafts, pet therapy, smores outdoors, birthday party and music, dice game, movies and popcorn, evening activity, and 1 to 1 activity. The calendar identified 8 days in which R10 was observed watching television and sleeping when morning and afternoon activities were scheduled, and 31 days when R10 was observed sleeping when morning and afternoon activities were scheduled. The calendar indicated a craft was done with R10 on one day of the month. There were no further recorded offers, attempts, or completed activities, including one to one visits.	F 679		

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F 679	Continued From page 21 R10's Activity Calendar, dated September 2023, identified R10's recorded activities for the month. It listed various activities daily that could be offered to R10, including exercise and chat, catholic mass, lunch and supper club, quarter, dime and prize bingo, crafts, pet therapy, smores outdoors, birthday party and music, dice game, movies and popcorn, evening activity and 1 to 1 activity. The calendar identified 14 days in which R10 was observed watching television and sleeping when morning and afternoon activities were scheduled, and 6 days when R10 was observed sleeping when morning and afternoon activities were scheduled. There were no recorded offers, attempts, or completed activities, including one to one visits. When interviewed on 9/21/23 at 10:20 a.m., AD-G stated the activity aides were new to the department. AD-G instructed them that one to one visits needed to take approximately ten minutes to be sure it counted. When AD-G saw TV documented on R10's calendar, she had thought one to one visits were also occurring. AD-G expected the activity aides to go into R10's room and visit with R10 and planned to re-educate the aides. During interview on 9/21/23 at 1:30 p.m., director of nursing (DON) stated if activities were care planned then the activity staff should be making attempts to try the interventions or to do something else. A facility policy on activities programming, including the assessment and care planning process was requested; however, none was received.	F 679		

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F 684	Continued From page 22	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to recognize positioning needs for 1 of 1 resident (R23) reviewed for positioning; and failed to implement and track a fluid restriction for 1 of 2 residents (R66) reviewed for fluid intake. Findings include: R23's annual Minimum Data Set (MDS) dated 8/14/23, identified diagnoses of hemiplegia and hemiparesis of left non-dominant side (weakness and loss of movement on one side of the body) due to a stroke. R23 had moderate cognitive impairment, required extensive assistance to complete transfers and self-cares, and used a wheelchair. R23's care plan dated 8/22/22, identified R23 used a Broda wheelchair (wheelchair with increased padding on right and left side that can tilt), their left arm was to be supported on an arm rest when in their wheelchair, and they required assistance with wheelchair mobility.	F 684	F: 684 It is Viewcrest Health Center's policy to provide proper positioning and to monitor fluid restrictions per our resident's plan of care. DON and/or designee will implement corrective action for resident R33 and R66 affected by this practice by: · R23 will be positioned upright at all times while in her wheelchair. · R23's care plan was updated to reflect monitoring for posture and updating nursing management if leaning noted. · R23 will express comfort while being up in wheelchair. · R23's received orders for OT for wheelchair positioning on 10/5/2023. · R66's fluid restriction will be followed per the provider order. · R66's care plan was updated to reflect fluid restriction and monitoring on 9/25/2023. · R66 signed an informed consent for her fluid restriction on 9/20/2023 d/t her	11/2/23

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F 684	Continued From page 23 R23's incident report dated 9/13/23, identified R23 had a bruise above their right eyebrow measuring 2 centimeters (cm) x 2 cm and R23 stated they had bumped their head on the bed rail in the night and no staff or other resident hit them. The report identified the resident frequently leans to the right and the root cause of the injury was an unpadded bed rail. The report did not address resident positioning needs or identify a referral to other services. R23's nursing progress note dated 9/14/23, identified R23 hit their head on a bed rail, and they frequently leaned to the right. During an observation on 9/19/23 at 1:35 p.m., R23 was seated in a Broda wheelchair leaning to the right, left arm was propped on a padded arm tray, blanket was in her right arm, and no cushion was visible in the wheelchair. During an observation on 9/19/23 at 5:18 p.m., R23 was in the dining room seated in a Broda wheelchair with a lift sling beneath them and was leaning strongly to the right side of their wheelchair. During an observation on 9/20/23 at 8:24 a.m., R23 was in bed eating breakfast and noticeably leaning to the right. During an observation on 9/20/23 at 9:07 a.m., R23 was in bed leaning to the right with their right arm hanging off the side of the bed. During an observation on 9/20/23 at 3:08 p.m., R23 was seated in a Broda wheelchair, no cushion observed below them, and R23's left arm was sliding off the padded arm tray due to them	F 684	choice to have ice in a mug and salt in her room for seasoning. · Signage has been placed in the resident room noting a fluid restriction with permission, fluid intake monitoring sheets have been placed the nursing station and care plan updated with mL for dietary and nursing. · Dietary tickets have been updated reflecting fluid restriction. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents who utilize a wheelchair and or have a fluid restriction have the potential to be affected by deficient practices. DON and/or designee will implement measures to ensure that this practice does not recur including: • The Person-Centered Care Planning policy, fluid restriction and intake & output policy were reviewed and updated as needed. • All nursing staff will be educated on monitoring residents for proper posture and upright seating while up in wheelchair and when to notify management of a change in condition such as leaning in wheelchair or bed at meetings on 10/11 and 10/12/2023. • All nursing staff will be educated on monitoring residents on a fluid restriction for intake of fluids for both nursing and dietary at meetings on 10/11 and 10/12/2023. • All residents who have a fluid	

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F 684	Continued From page 24 leaning to the right. During an interview on 9/20/23 at 2:58 p.m., occupational therapist (OT)-C stated nursing staff would identify positioning issues and would go about getting orders for therapy when necessary. OT-C identified R23 was last seen by occupational therapy in September of 2022, and at that time R23 was able to maintain midline positioning in a Broda wheelchair. R23's right sided lean would be considered a change based on the occupational therapy notes from September of 2022, and a referral would be expected. During an interview on 9/21/23 at 8:43 a.m., registered nurse (RN)-A stated R23 had occupational therapy in the past and they would now be seeking occupational therapy orders for positioning due to R23 leaning to the right. During an interview on 9/21/23 at 11:55 a.m., director of nursing (DON) stated that based on R23's positioning changes, R23 should be addressed for positioning. The initial intervention should be to get occupational therapy orders to address R23's positioning needs. R66: R66's significant change MDS dated 9/15/23, identified diagnoses of bipolar disorder, chronic diastolic (congestive) heart failure (CHF), and hypertension. R66 was independent with mobility and self-cares and was cognitively intact. R66's care plan dated 8/4/22, identified R66 would be offered food and drink of their preference.	F 684	restriction were reviewed; monitoring, orders and care plans have all been updated to reflect fluid restrictions. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits identifying residents on fluid restrictions for documentation of intake, orders, and monitoring in place will be completed by DON/designee 5 residents/week x 1 week, 3 residents/week x 2 weeks, then one resident weekly x 2 weeks, and then monthly thereafter beginning the week of October 16, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 2, 2023	

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F 684	Continued From page 25 R66's physician orders, dated 8/4/23, identified Torsemide (used to rid of extra fluid in the body) 80 MG one time per day between 7:00 a.m. and 11:00 a.m.. R66's dietary progress note dated 8/10/23 identified R66 had bilateral lower extremity edema with weight fluctuations due to fluid status, CHF, and diuretic use. R66's physician orders dated 9/1/23, identified R66 was placed on a fluid restriction of less than 64 ounces of fluids per day. R66's nursing progress note dated 9/13/23, identified R66 had returned from a cardiology appointment with new orders for 60 MG Torsemide in the afternoon. R66's dietary progress note dated 9/14/23, identified R66 was unaware of her fluid restriction and had been filling her cup with ice multiple times per day. R66's physician orders dated 9/15/23, identified a new afternoon order of Torsemide 60 MG one time per day, every day at 2:00 p.m. R66's weights and vitals tracking log from September 2023, identified the first instance of fluid intake tracking for R66 on 9/19/23, of 830 milliliters (mL). after entrance by the survey team. During an observation on 9/19/23 at 5:33 p.m., R66's meal ticket identified a daily fluid restriction of 1800 cubic centimeters (cc). During an interview on 9/20/23 at 9:41 a.m.,	F 684		

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F 684	Continued From page 26 nursing assistant (NA)-C stated they were not aware of anyone on Hawk Ridge who was on fluid restrictions. If someone were to be on fluid restrictions, they would document the resident intakes in the electronic medical record. During an interview on 9/20/23 at 3:30 p.m., NA-D stated R66 was on a fluid restriction and now has a tracking sheet in her room. Fluid intake should be tracked every shift and the nurse should track it. On 9/20/23 at 3:35 p.m., R66 was observed to have a notebook with fluid intake documented on 9/19/23 and 9/20/23, with no charting prior. R66 stated her fluid intake was not tracked prior to 9/19/23. During an interview on 9/20/23 at 3:38 p.m., NA-E stated they were recently told R66 was started on a fluid restriction. During an interview on 9/21/23 at 11:08 a.m., RN-C stated that staff should be aware of how much fluid R66 should have with each meal and it would be listed on R66's meal tickets. If the total restriction was listed on the meal ticket, nursing staff should be tallying the amounts throughout their shifts. RN-C was not aware of the protocol to track fluid intakes. RN-C was out the beginning of September when the fluid restriction was ordered, and another nurse manager would have been covering their residents. Typically, a fluid restriction was ordered for someone with reduced kidney function or heart failure. If a fluid restriction was not followed, a resident could have fluid overload. All fluid restrictions should be taken very seriously and should be care planned so that nursing assistants are aware of the order.	F 684		

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F 684	Continued From page 27 During an interview on 9/21/23 at 11:18 a.m., RN-F stated if someone were to receive an order for a fluid restriction, dietary and nursing would be expected to split the tracking. If the resident were to eat in their room, nursing would be solely responsible for tracking. During an interview on 9/21/23 at 12:03 p.m., DON stated when a resident received a new order, the health unit coordinator (HUC) was responsible for inputting the order and the nurse would then verify. This is done in electronci medical record and was typically done by the nurse on the cart but can be any done by any nurse. Nursing and dietary should be inputting fluid intakes in their charting on every shift. Nurse managers should be aware of fluid restrictions and be splitting up the orders each shift to monitor intakes. The meal ticket would be better if it were to state the total fluid intake the resident should get at each meal. If fluid restrictions are not followed, residents would be at risk of electrolyte imbalance, fluid overload, and exacerbation of heart failure. The facility Intake and Output policy dated 12/5/11, identified resident intake and output will be accurately recorded over a 24-hour period from 6 a.m. to 6 a.m. and is to be measured in cc's for intake. This may be a physician or nursing order. Nursing assistants are to record intake and output under monitoring for their shift. Each nurse if responsible for making sure the intake/output is recorded and residents on a fluid restriction will have only intake measured for each 8-hour shift. The facility Fluid Restriction policy, undated,	F 684		

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F 684	Continued From page 28 identified the facility must provide each resident with sufficient fluid intake, based on individual needs and physician's ordered fluid restrictions, to maintain proper hydration and health. When a fluid restriction is ordered by a physician or CNP the HUC will notify the food and nutrition services director, the dietitian will visit the resident to agree on preferred beverage choices and how fluid allowance will be divided between meal. It is the responsibility of the dietitian to determine the fluid requirement. Food and nutrition will indicate on the meal ticket allotted fluids for meals and communicate this to nursing staff. The remainder of fluid will be allotted to nursing staff to provide to resident between meals and with medication administration. Large quantities of fluid should not be left at bedside. Nursing staff are to change care guides to indicate fluid restriction in files. Food and nutrition staff will document the resident fluid intake to ensure the total 24-hour period does not exceed the specified, ordered amount. Residents identified with specific physician ordered fluid restrictions or needs, will have individualized care plan including the goal of fluid intake and specific approaches to utilize, as determined by the dietitian/designee. Licensed nursing staff will evaluate intake/output weekly and communicate to the physician or nurse practitioner the resident's ongoing need and/or need to discharge fluid restriction. The dietitian/qualified designee and/or licensed nursing staff will document observations, approaches, interventions in the resident's medical record related to the resident's hydration status and update the care plan as appropriate.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		11/2/23

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	245414	A. BUILDING _____ B. WING _____	09/21/2023

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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 686	Continued From page 29 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement care planned interventions for promoting the healing of pressure ulcers 2 of 2 residents (R61, R23) reviewed pressure ulcers. Findings include: R61: R61's quarterly Minimum Data Set (MDS) dated 8/29/23, identified R61 had moderate cognitive impairment, was at risk for developing pressure ulcers and currently had an unstageable pressure ulcer. Diagnoses included coronary artery disease, dementia, and cancer. R61's Care Area Assessment (CAA) dated 5/31/23 identified pressure ulcer was an area of care that required close monitoring and specialized care. R61's undated care plan, identified R61 was at	F 686	F: 686 It is Viewcrest Health Center's policy to provide treatment/services to prevent/heal pressure ulcers per our resident's plan of care. DON and/or designee will implement corrective action for resident R61 and R23 affected by this practice by: • A review of R61's care plan on 10/10/23 was reviewed for accuracy and updated with the most accurate information per staff interviews and assessments completed. A Braden assessment was completed on 8/29/23 scoring 15 indicating moderate risk. Care plan revised for A1 with T&R. • R61's Braden assessment completed PRN for comparison. Score is 13 still indicating moderate risk. • R61 will be T&R Q2H and PRN • R61's care plan skin interventions were all scheduled to be shown each shift for nursing to review.	

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F 686	Continued From page 30 risk for altered skin integrity related to impaired mobility with interventions of pressure reducing cushion to chair, pressure reducing mattress to bed and float heels while in bed. R61's progress notes from 9/1/23 to 9/20/23 identified the following: - 9/1/23 at 6:25 p.m., R61's left heel was red and boggy. Heels were floated at that time. - 9/11/23 at 9:09 a.m., R61's left heel was red and boggy, heels were floated at that time. During observation on 9/18/23 at 11:56 a.m., R61 was laying flat on the bed and heels were not being floated off the mattress. During observation on 9/20/23 at 9:24 a.m.R61's heels were observed laying flat on the mattress with the heels pushing against the foot board and not floating above the mattress. Nurse assistant (NA)-B was performing a bed bath on R61 along with a brief change. After cares were completed, NA-B left the room without floating R61's heels off the bed. During an interview on 09/20/23 at 9:56 a.m., nurse assistant (NA)-B stated repositioning and floating heels while in bed would be on the resident's care plan. R61 did not need his heels floated and there was nothing on the care plan that indicated they needed to be floated. NA-B reviewed the care plan and acknowledged floating heels was on R61's care plan and stated she was not aware that was on R61's care plan. During an interview on 9/21/23 10:14 a.m., registered nurse (RN)-C stated all interventions	F 686	• R23's received orders for OT for wheelchair positioning on 10/5/2023. • R23 was assessed for proper wheelchair cushion and placed in broda chair, care planned, and orders placed to check Q shift 10/12/2023. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents who are dependent on staff for treatment and services to prevent/heal pressure ulcers have the potential to be affected by deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: • The Person-Centered Care and care planning policies were reviewed and updated as needed. • All nursing staff will be educated on checking for skin and wound updates in the care plan Q shift for new or updated interventions at meetings on 10/11 and 10/12/2023. • Skin and wound interventions will be scheduled for nursing personnel to review at any time during their shift. • All residents who need assistance with repositioning will be reviewed and care plans updated as needed. TT will be completed with admission, quarterly, annual, significant change and PRN. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including:	

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F 686	Continued From page 31 for skin protection are placed in the resident's care plan and was aware R61 had an intervention to float heels when in bed because of a history of reddened heels in bed. During an interview on 9/21/23 at 10:37 a.m., the director of nursing (DON) stated R61 had float heels when in bed as an intervention since the beginning of September when he was found with red heels. Staff were expected to follow the care plan to prevent any kind of skin issues while in the facilities care. R23: R23's annual MDS dated 8/14/23, identified a diagnoses of hemiplegia and hemiparesis of left non-dominant side (weakness and loss of movement on one side of the body) due to a stroke. R23 had moderate cognitive impairment, required extensive assistance to complete transfers and self-cares, and used a wheelchair. R23 was identified to be at risk of skin breakdown with identified treatments of a pressure reducing device for their chair and bed. R23's care plan dated 8/22/22, identified R23 used a Broda wheelchair (wheelchair with increased padding on right and left side that can tilt), a pressure reducing cushion was to be used at all times, their left arm was to be supported on an arm rest when in their wheelchair, and they required assistance with wheelchair mobility. During observation on 9/19/23 at 1:35 p.m., R23 was seated in a Broda wheelchair leaning to the right, left arm was propped on a padded arm tray,	F 686	• Random audits identifying turning and repositioning compliance, skin interventions being utilized as care planned and compliance per resident's care plan will be completed by DON/designee 5x/week x 1 week, 3x/week x 2 weeks, then once weekly x 2 weeks, and then monthly thereafter beginning the week of October 16, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 2, 2023	

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F 686	Continued From page 32	F 686		

blanket was in her right arm, and no cushion was visible in the wheelchair.

During observation on 9/19/23 at 5:18 p.m., R23 was in the dining room seated in a Broda wheelchair with a lift sling beneath them and was leaning strongly to the right. No cushion was observed in the wheelchair.

During observation on 9/20/23 at 3:08 p.m., R23 was seated in a Broda wheelchair, no cushion was observed below them, and R23's left arm was sliding off the padded arm tray due to them leaning to the right.

During interview on 9/20/23 at 2:58 p.m., occupational therapist (OT)-C stated nursing staff would identify positioning issues and would go about getting orders for therapy when necessary. A Broda wheelchair can recline and tilt and was unable to determine if a pressure relieving cushion was necessary.

During interview on 9/20/23 at 3:30 p.m., NA-D was not aware that R23 required a pressure relieving cushion in her wheelchair.

During interview on 9/20/23 at 3:41 p.pm., NA-E was not aware R23 required a pressure relieving cushion and had not observed a cushion in R23's wheelchair, at any time, since NA-E was hired in April of 2023.

During interview on 9/21/23 at 8:43 a.m., RN-A stated they were unsure as to why a pressure reducing cushion was necessary as R23 does not currently have skin breakdown. The previous nurse manager may have care planned for a pressure relieving cushion. If RN-A had time, they

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F 686	Continued From page 33 would review and update the care plan. RN-A identified the care plan should be reviewed for accuracy at care conferences and RN-A missed that a pressure relieving cushion was care planned, therefore R23 did not have a pressure relieving cushion in their wheelchair. During interview on 9/21/23 at 11:55 a.m., director of nursing (DON) stated all care plans should be revised and updated with any change, at quarterly assessments, annual assessments, and with a significant change. The facility policy Care Planning dated 10/23/17, indicated the nurse manager was responsible for adding interventions to the updated care plan and should communicate with staff any changes made. The policy lacked expectations in regards to staff following the care plan set in place.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688		11/2/23

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F 688	Continued From page 34 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed ensure an ordered ambulation range of motion (ROM) program was implemented for 1 of 2 residents (R10) reviewed for rehabilitation and restorative nursing. Findings include: R10's quarterly Minimum Data Set (MDS) dated 8/10/23, identified R10 had severe cognitive impairment, required limited assistance for her daily activities of daily living (ADLs) and ambulation had not occurred. R10's care plan dated 8/23, identified R10 would walk with the use of assistive devices and would not have a decline in walking. Staff were directed to walk R10 with a transfer belt, physical support, and full wheeled walker. R10 was at risk for a decline in ambulation related to her poor balance and cognition. Restorative staff were directed to ambulate R10 50 feet daily with a two wheeled walker and wheelchair follow. During observations on 9/19/23, between 2:15 p.m. and 6:30 p.m. R10 was observed lying on her back in bed. During continuous observation 9/20/23, from 8:20 a.m. to 11:45 p.m. R10 was observed lying on her back in bed. Staff did not approach and offer ambulation or exercise. Subsequent observations between 12:00 p.m. to 3:00 p.m. revealed R10 remained in bed and no attempts were made to assist her to ambulate.	F 688	F: 688 It is Viewcrest Health Center's policy to provide ambulation programs per our resident's plan of care. DON and/or designee will implement corrective action for resident R10 affected by this practice by: • R10's Care Plan will be reviewed and updated as necessary to reflect appropriate functional maintenance program according to most recent physical therapy recommendations. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents who are on a functional maintenance program have the potential to be affected by this deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: • The Restorative nursing policy will be reviewed and updated as needed. • The Restorative nursing policy will be reviewed and updated as needed. • All residents who receive a functional maintenance program will have their care plans reviewed to assure that accurate information is in place to reflect repositioning. Updates will be made as needed. • All nursing staff will be educated on the Restorative nursing policy, Informed	

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F 688	Continued From page 35 When interviewed on 9/20/23 at 11:45 a.m., nursing assistant (NA)-F stated R10 previously was able to self-transfer from her bed to the commode but was now unable. R10 was able to stand and pivot transfer to her commode with assistance. R10 refused to dress and preferred to remain in bed. R10's Physical Therapy Treatment Encounter Note dated 5/10/23, indicated a restorative nursing program was developed and staff were instructed on R10's ambulation program. Written communication was given to initiate the restorative program and R10 was being discharged from therapy. R10's Restorative Nursing Records were reviewed from the start of R10's program 5/10/22 through 9/20/23, and ambulation was only documented 5/31/23. August 2023 indicated ambulation was offered 14 days and refused. September 2023, indicated 9/1/23, through 9/20/23, ambulation was offered 4 days and refused. When interviewed on 9/20/23, at 1:45 p.m., NA-H stated and offered to assist R10 to walk but was refused. NA-H had only got R10 to ambulate one time since NA-H started in May 2023.. The other therapy aide, NA-I, ambulated with R10 one time shortly after R10 was discharged from therapy. R10 only ambulated the two times that she was aware of. Restorative nursing completed range of motion activities for residents as well, but R10 was not getting any ROM exercises from the restorative program. During interview on 9/20/23, at 2:00 p.m., NA-I	F 688	Consent policy, and the proper documentation and follow up for residents right to choose to refuse. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits will be conducted to ensure that residents FMP is being completed per resident plan of care, by DON/designee 5x/week x 1 week, 3x/week x 2 weeks, then once weekly x 2 weeks, and then monthly thereafter beginning the week of October 16, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 2, 2023	

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F 688	Continued From page 36 stated he was in charge of the restorative program. NA-I knew R10 was able to pivot transfer with her cares but R10 refused to ambulate. NA-I reported R10's refusal to ambulate to the registered nurse (RN)-F many times. Whenever a resident refused restorative they reported it to nursing staff. NA-I stated 5/31/23, was the one and only day R10 had ambulated since the restorative program was initiated on 5/10/22. NA-I knew R10's family member (FM)-F wanted them to keep trying, so they continued to offer ambulation two to three times per week. When interviewed on 9/20/23, at 2:45 p.m., RN-F stated R10 spent much of her time in bed and refused to walk. RN-F brought up the refusals to FM-F but FM-F stated he did not want to give up on R10 and wanted them to keep trying. RN-F was not aware R10 was not getting ROM exercises. RN-F was sure that it had been attempted in the past and was unsuccessful, but was unable to find documentation of exercises. The interdisciplinary team discussed R10's refusal to ambulate and tried to discontinue the ambulation program. RN-F contacted FM-A again to discuss risk vs benefits with R10's consistent refusals to ambulate and discussed the plan to discontinue the program, but FM-A was reluctant to sign it. Alternative programs and exercise were not discussed. A physical therapy evaluation to evaluate why R10 was refusing and if alternative interventions could be implemented to maintain and prevent decline had not been discussed. Nursing supervised the restorative program and it was reported to RN-F that R10 refused to ambulate. No other interventions were discussed and that is where RN-F failed. Nursing should try to prevent any decline in function, even	F 688		

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F 688	Continued From page 37 when a patient was refusing. During interview on 9/21/23 at 11:30 a.m., physical therapist (PT)-H stated they completed an evaluation on 10/3/22, because R10 had fallen. R10 had been in a poor mood that day. R10 could stand and transfer to the commode but that was all R10 would do. The restorative staff told PT-H R10 only ambulated two times since the start of the restorative program. PT-H did think if a resident was refusing to ambulate other interventions should be attempted. PT-H was not approached about R10 and did not know R10 was not walking at all. October 2022 to now was a long time to go without restorative exercises. PT-H did just evaluate her abilities and did not see a significant decline in R10's ROM, however, she was weaker. R10 would be appropriate to be seen by therapy to try to set up an alternative program or interventions. When interviewed on 9/21/23 at 1:30 p.m., the director of nursing (DON) stated she felt if a resident was consistently refusing a restorative program, the staff needed to stop and seek a therapy evaluation and reevaluate to identify other more appropriate interventions. The facility policy Restorative Nursing Program dated 4/6/20, indicated the restorative program implemented interventions to promote a residents ability to adapt and adjust to living as independently and safely as possible. The concept actively focused on achieving and maintain optimal physical, mental, and psychosocial functioning. Interventions implemented were those that assist or promote the resident's ability to attain his or her maximum functional potential. If a resident refused	F 688		

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F 688	Continued From page 38 restorative services, the staff would report to the nurse supervisor in a timely manner. Documentation of non-compliance would include reason for refusal and any interventions to promote compliance. If continued refusal an Informed Choice Consent form would be completed by the resident or resident representative. The resident's restorative program would be evaluated at least quarterly and documented. The evaluation would include the resident's progress toward the goal, any barriers that interfered with the resident's progress, interventions attempted to assist the resident to overcome the barriers, an assessment of frequent refusals to participate in the restorative program and the rationale for the decision to revise, continue, or discontinue the restorative program.	F 688		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess for dementia related behaviors and identify the least restictive intervention(s) and provide ongoing reassesment and care planning for 1 of 1 residents (R47) reviewed who had not personal items in their room. Findings include:	F 744	F: 744 It is Viewcrest Health Center's policy to provide treatment and services for residents with dementia per our resident's plan of care. DON and/or designee will implement corrective action for resident R47 affected by this practice by: • R47's Care Plan was reviewed and updated as necessary to reflect	11/2/23

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F 744	Continued From page 39 R47's annual Minimum Data Set (MDS) dated 7/26/23, identified R47 had short and long term memory problems and were unable to complete a cognitive assessment. R47 had no identified behaviors including hallucinations or dellusions. R47 required extensive assistance for most activities of daily living and was incontinent of bowel and bladder. R47 took an antidepressant and an antipsychotic and had a diagnosis of dementia. During an observation on 9/18/23 at 8:17 a.m., R47 was laying on a bare mattress on her bed. The bed was unplugged and in a low position. During an observation on 9/19/23 at 2:42 p.m., R47 was laying across the foot of the bed and the bed had a flat sheet and incontinence pad and there was not pillow or blanket. The room contained two chairs, and an end table and a call light cord hanging from the wall. There was a stuffed animal on the bed and several others on the floor next to the bed. R47's room lacked any personal clothing or items and the bathroom room was locked. R47's care plan dated 8/18/23, included the following interventions: staff to perform room checks for hoarding and to remove any harmful items like glove boxes, briefs, paper towels and toilet paper from her room; encourage R47 to select clothing; and honor choices and support decision making. The care plan did not include R47's bathroom being locked, clothing being stored in the laundry room, or the lack of any personal belongings in R47's room. In addition, the care plan lacked R47's care plan any behavioral interventions for dementia care based on past history or hoarding and using items in	F 744	appropriate interventions according to hx of behaviors d/t dementia. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents who are diagnosed with dementia and/or have behaviors have the potential to be affected by this deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: • The Dementia Care policy will be reviewed and updated as needed. • Orders for documentation of behaviors every shift will be placed to ensure accurate interventions are in place. • All residents who have Dementia will have their care plans reviewed to assure that accurate information is in place to reflect current and appropriate interventions. Updates will be made as needed. • All nursing staff will be educated on the Dementia and Person-Centered Care Plan policies on 10/11 and 10/12/2023. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits to ensure that care plans are being updated and reviewed for intervention effectiveness will be completed by DON/designee 5x/week x 1 week, 3x/week x 2 weeks, then once weekly x 2 weeks, and then monthly	

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F 744	Continued From page 40 inappropriate manner. R47's medical record lacked assessments related to the removal of her personal items and interventions attempted along with mood and behavior monitoring. R47's mood and behavior assessments were requested and not received. R47's documented interdisciplinary meetings and care conferences held between 1/1/23 and 8/31/23 primarily focused on R47's weight which resulted in care plan modifications. The notes did not identify concerns related to R47's behavior or behavioral health, nor identify attempts of less restrictive care measures based on assessments. During an interview on 9/19/23 at 3:20 p.m., registered nurse (RN)-A identified R47 was at the facility for 6 months. The facility was concerned about hoarding, and R47 had a history of eating things like incontinence briefs and gloves, so the facility did not keep things in R47's room. RN-A didn't know why there was no pillow or a blanket in R47 room, as many things were put in to place before RN-A started at the facility. On 9/20/23 at 9:02 a.m., nursing assistant (NA)-J assisted R47 with cares. NA-J explained R47 did not have personal care items or clothes in R47's room because R47 would put everything in the toilet and flood the room. R47's clothes were kept in the laundry room and all of her personal care items were kept in the tub room that R47 used. During an interview on 9/20/23 at 3:15 p.m. RN-A stated R47's room was very sparse and all items were removed from R47's room based on her past behaviors and safety needs. RN-A reviewed R47's medical record and did not find any current	F 744	thereafter beginning the week of October 16, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 2, 2023	

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 _____	09/21/2023

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F 744	Continued From page 41 behaviors documented in the progress notes. Further, there was no notations regarding behaviors in R47's assessments. RN-A had not seen R47 damage anything or eat any non-food items since RN-A began working at the facility. RN-A was not sure why R47 did not have a bedding in the room, but thought they could trial R47 having a blanket that evening, but care items like gloves should continue to be kept out of the room. On 9/20/23, at 3:36 p.m. NA-L joined the interview in progress with RN-A. NA-L stated R47 had a history of ripping pillows and ripped a pillow two weeks ago. R47 no longer shredded sheets, but she are paper recently and about a year and a half ago R47 are some of her brief, but never ate gloves. When R47 still had her clothes in her room, she would wear all of them, and would put stuff in the toilet. Stuffing things into the toilet caused a bad flood at one time. Then they locked the bathroom door. When R47 had a blanket, she stuffed it behind her bed or in a corner. Another time R47 wore all of her clothes and when R47 was incontinent, there were not clothes to change R47 in to. R47 didn't like to give things up and refused cares sometimes. R47 never tried to harm herself and both NA-L and RN-A stated stuffing bedding places or wearing all of her clothing would not harm R47. NA-L stated R47's safety was a priority and that being at a larger facility was too much of an environment for R47 at times. During an observation on 9/21/23 at 8:40 a.m., R47 was no longer in isolation and was laying on her bed. Breakfast was on the side table and there was fleece blanket on the bed.	F 744		

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F 744	Continued From page 42 During an interview on 9/21/23 at 9:14 a.m., NA-K stated R47's clothing was kept in the laundry room for at least a year or more. R47 would wear everything and when R47 was incontinent R47 would not have anything to change into. When R47's needed clothes the staff got them from the laundry room. During an interview on 9/21/23 at 12:38 p.m. the director of nursing (DON) stated R47 did not have much of a home like environment and identified an attempt was made to put some decorative paper items in her room but they had to be removed. R47's plan of care should be based on R47's current behavioral documentation, status, and assessments. Things like turning the water off in her room should not happen. R47's needed to be assessed and then have the care plan updated. They should provide opportunities for R47 to have restrictions lessened and or items reincorporated back into her room/care as long as safety could be maintained and R47's response was favorable. The facility Person Centered Care Planning policy dated 3/7/22, identified the care plan should allow for resident choice, honor home like environment, enhance dignity, allow for treatment refusal, and help support achievement of highest practicable level of well-being for the resident.	F 744		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		11/2/23

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F 757	Continued From page 43 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement anticoagulant side-effect monitoring for 1 of 1 resident (R23) reviewed for anticoagulant use. Findings include: R23's annual Minimum Data Set (MDS) dated 8/14/23, identified a diagnoses of hemiplegia and hemiparesis of left non-dominant side (weakness and loss of movement on one side of the body) due to a stroke. R23 had moderate cognitive impairment and an anticoagulant was used during the last seven days prior to the completion of the MDS. R23's care plan dated 8/22/22, failed to identify R23's interventions related to anticoagulant use. R23's facility incident report dated 9/13/23,	F 757	F: 757 It is Viewcrest Health Center's policy to provide monitoring for residents on anticoagulation therapy per our resident's plan of care. DON and/or designee will implement corrective action for resident R23 affected by this practice by: · R23's Care Plan was reviewed and updated as necessary to reflect appropriate anticoagulant use and orders for monitoring every shift on 9/21/2023. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents who are on anticoagulants have the potential to be affected by this deficient practice.	

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F 757	Continued From page 44 identified R23 was noted to have a bruise above their right eyebrow measuring 2 centimeters (cm) x 2 cm and R23 stated they bumped their head on the bed rail in the night and no staff or other resident hit them. The report identified the resident frequently leans to the right and the root cause of the injury was an unpadded bed rail and did not address R23's anticoagulant use or monitoring following an injury to their head. Incident checklist sections, "added to skin log?", "care plans adjusted for change in level of care needs", and "staff educated/in-serviced" were marked either not applicable or not addressed. R23's nursing progress note dated 9/14/23, identified R23 hit their head on a bed rail, and they frequently leaned to the right. During observation on 9/19/23 at 1:35 p.m., R23 was seated in a Broda wheelchair with bruising noted above right eye. During interview on 9/20/23 at 9:41 a.m., nursing assistant (NA)-C stated the nursing assistants refer to electronic medical record to know how to care for and monitor each resident. NA-C would notify the nurses of any skin changes. During interview on 9/20/23 at 3:30 p.m., NA-D stated that they would notify the nurse of skin changes. During interview on 9/21/23 at 8:43 a.m., registered nurse (RN)-A stated R23 had a similar head injury in the past and R23 suffered a brain bleed at that time. RN-A identified anticoagulant monitoring was not care planned and it should be for staff to be aware. They did verbal education with staff that was on the floor at that moment	F 757	DON and/or designee will implement measures to ensure that this practice does not recur including: • An anticoagulant use policy will be created and updated as needed. • All residents who receive anticoagulants had their care plans reviewed to assure that accurate information is in place to reflect anticoagulant use. Updates will be made as needed. • All nursing staff will be educated on the use of anticoagulants, monitoring and updating providers when an accident or injury occurs to anyone on an anticoagulant at meetings on 10/11 and 10/12/2023. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits identifying that monitoring is in place and resident care plan reflects anticoagulant use will be completed by DON/designee 5 residents/week x 1 week, 3 residents/week x 2 weeks, then one resident weekly x 2 weeks, and then monthly thereafter beginning the week of October 16, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 2, 2023	

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F 757	Continued From page 45 and hoped that they were talking to each other for the next shift to be aware of monitoring. During interview on 9/21/23 at 11:55 a.m., director of nursing (DON) stated if there is an incident with an intervention it should be care planned under safety of skin. Anticoagulants should be care planned for risk of bleeding or bruising to trigger the nursing staff to look at bruising or bleeding and notify the on-call physician if they fall or have an injury. R23's care plan should have been updated to reflect the intervention and address the anticoagulant use and monitoring.	F 757		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization	F 801		11/2/23

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F 801	Continued From page 46 recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or	F 801		

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F 801	Continued From page 47 (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the dietary manager was certified and credentialed to oversee food services. This had potential to affect all 69 residents, staff, and visitors who consumed food from the ktichen. Findings include: During interview on 9/21/23 at 9:53 a.m. dietary manager (DM)-E stated they had not completed the certified dietary manager course, but was working toward becoming enrolled. The facility was helping to enroll them in the course, but was unsure when that would be. The corporate dietary manager was available by email daily. During interview on 9/21/23 at 10:32 a.m., administrator confirmed DM-E did not have their dietary manager certification or state equivalent and DM-E would start the online program for the	F 801	F: 801 It is Viewcrest Health Center's policy to provide qualified dietary staff. Administrator and/or designee will implement corrective action for all residents affected by this practice by: • Dietary Manager was enrolled in the University of North Dakota certified dietary manager program on 09/27/2023. Administrator and/or designee will assess residents having the potential to be affected by this practice including: • All residents have potential to be affected by deficient practice. Administrator and/or designee will implement measures to ensure that this practice does not recur including: • The Dietary Manager will have the CDM training completed by 09/27/2024.	

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F 801	Continued From page 48 dietary manager certification on October 1st. The adminstrator wasnted the dietary manager to get settled in before adding extra work as they are a newer employee. The qualifications of DM-E were requested, but not received.	F 801	• The Dietary consultant will be the Dietary Manager's mentor through the CDM course. Administrator and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Administrator will do monthly audits to ensure Dietary Manager is on track to complete the CDM course on time, beginning the week of October 30, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 2, 2023	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		11/2/23

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F 880	Continued From page 49 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

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F 880	Continued From page 50 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to utilize proper hand sanitization after topical medication administration for 1 of 5 residents (R226) observed for medication administration; failed to ensure staff completed proper hand hygiene and glove use during distribution of snacks and meals. This had the ability to affect all 69 residents as well as staff and visitors who consumed food in the facility. Findings include: MEDICATION PASS During an observation on 9/19/23 at 6:39 p.m., licensed practical nurse (LPN)-B entered R226's room and administered three medications orally. LPN-B then applied gloves and administered a topical medication to R226's left calf. When done, LPN-B removed her gloves, did not complete hand hygiene, walked to the medication cart in the hallway, documented the medication administration, and then returned R226's medication tube to the medication cart after placing the tube in a zip lock bag. Without completing hand hygiene, LPN-B placed a medication cup on the cart and began to touch other resident medication cards in the cart. During an interview on 9/19/23 at 6:47 p.m.,	F 880	F: 880 It is Viewcrest Health Center's policy to use proper hand hygiene when caring for our residents per our resident's plan of care. DON and/or designee will implement corrective action for resident R226 affected by this practice by: • Staff caring for R226 will use proper hand hygiene while providing care and administering medications and/or treatments. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents have potential to be affected by deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: • Handwashing and infection control policies have been reviewed and all nursing staff will be re-educated regarding proper hand hygiene to include washing hands between glove changes, before entering a room, when leaving a room, when handling food items, and as needed at meetings on 10/11 and 10/12/2023. • All nursing staff will be provided	

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F 880	Continued From page 51 LPN-B stated they had not complted hand hygiene since they had removed their gloves in R226's room. Normally they would sanitize their hands after they performed a treatment that required gloves, then LPN-B continued to touch the medication cards without performing hand hygeine. LPN-B confirmed they still had not sanitized their hands, and stated they were going to wash their hands now because it was important to sanitize hands after wearing gloves and between residents for infection prevention. LPN-B then sanitized their hands. During an interview on 9/21/23 at 12:58 p.m., the infection preventionist (IP) stated gloves should be removed immediately after the application of topical medicine and hand sanitization should occur as soon as possible, and before other tasks are performed or other items are touched. Proper glove use and hand sanitization was required to prevent the spread of infection. MEAL SERVICE: On 9/19/23 at 3:35 p.m., activities aide (AA)-A was observed handling cupcakes and administering them to residents on the Hawk Ridge unit. AA-A was wearing the same gloves when entering multiple resident rooms, did not once remove their gloves or complete hand hygiene, and then wiped their nose with their gloved left hand. Prior to continuing to pass cupcakes, AA-A was stopped by the survey team before entering another resident room. AA-A stated that staff was to wear gloves whenever they have contact with residents, handle food or	F 880	information from the CDC on proper hand washing technique and will be competency tested on proper hand washing technique. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Routine audits identifying handwashing will be completed by DON/designee 5x/week x 1 week on all 3 shifts, these audits will continue until we achieve 100% compliance. Audits will begin the week of October 16, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 2, 2023	

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F 880	Continued From page 52 drink, or clean up after a resident. AA-A should not have worn the same gloves between resident rooms. AA-A not aware that they had wiped their nose with a gloved hand. If they had noticed, they would have taken off her gloves and washed their hands. During continuous observation 9/20/23 at 11:42 a.m., dietary manager (DM)-E was assisting with meal preparation by placing silverware on resident trays and loading each individual tray into food warming carts. -11:50 a.m., DM-E changed gloves for a second time and failed to complete hand hygiene between glove changes. Dietary aide (DA)-A was plating food with gloved hands, including bread rolls from a plastic bag. DA-A touched the outside of the bread bag and opened a cooler door with gloved hands and failed to change gloves or complete hand hygiene prior to continuing to plate food. -11:58 a.m., DA-A opened a cabinet door and moved plates on the counter with the same gloved hands and failed to change gloves or complete hand hygiene. Directly following the observation DM-E identified that she touched a door and other items and removed her gloves, failed to completed hand hygiene, and donned a new pair of gloves. The undated facility Hand Hygiene policy identified staff would routinely perform hand hygiene to control the spread of infection. Hands should be washed before and after direct contract with a client, if moving from a contaminated body site to a clean body site during client care, after contact with environmental surfaces or equipment in the immediate vicinity of the client, after removing gloves or gowns, before eating, after	F 880		

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	245414	A. BUILDING _____ B. WING _____	09/21/2023

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F 880	Continued From page 53 using a restroom, and prior to preparing food. The Viewcrest Health Center Infection Control Preventing the Spread of Infections - Hand Washing dated 6/13/12, identified gloves did not replace hand washing and hands should be washed immediately after gloves were removed.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility	F 883		11/2/23

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F 883	Continued From page 54 must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide pneumococcal conjugate vaccine 20 variant (PVC20) education as directed by the Centers for Disease Control (CDC) for 3 of 5 residents (R9, R10, R60) reviewed for immunizations. Findings include: R9's quarterly Minimum Data Set (MDS) dated 7/6/23, identified diagnoses of cerebral palsy(A group of disorders that affect movement, muscle tone, balance, and posture). R9's undated	F 883	F: 883 It is Viewcrest Health Center's policy to provide vaccine education per the CDC guidelines. DON and/or designee will implement corrective action for resident R9, R10, and R60 affected by this practice by: • Residents will be offered the appropriate Pneumococcal vaccine if they choose as ordered by their provider. DON and/or designee will assess residents having the potential to be	

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F 883	Continued From page 55 immunization record, identified R9 received PPSV23 on 7/26/21, and the PCV13 on 3/31/15. R9's medical record failed to provide evidence the PCV20 was offered and/or education was provided in conjunction with the provider to R9/R9's representative. R10's quarterly Minimum Data Set (MDS) dated 8/10/23, identified a diagnosis of vascular dementia. R10's undated immunization record, identified R10 received the pneumococcal 23 (PPSV23) on 6/25/22 and the pneumococcal conjugate vaccine 13 variant (PCV13) on 1/04/16. R10's medical record failed to provide evidence the pneumococcal conjugate vaccine 13 variant (PCV13) and the PCV20 (pneumonia immunization) was offered and/or education was provided in conjunction with the provider to R1/R10's representative. R60's quarterly Minimum Data Set (MDS) dated 8/21/23, identified diagnoses of dementia and diabetes. R60's undated immunization record, identified R18 received PPSV23 on 10/6/99, and the PCV13 on 10/1/15. R60's medical record failed to provide evidence the PCV20 was offered and/or education was provided in conjunction with the provider to R60/R60's representative. During an interview on 9/19/23 at 2:10 p.m., registered nurse (RN)-C stated the MDS coordinator sent out a list of what immunizations should be offered to each resident and filled out a declination form. The clinical manager was responsible to order the immunizations the resident was agreeable to receive and administer the vaccine. The clinical manager then notified RN-C of the vaccine administration and RN-C entered it into each residents record.	F 883	affected by this practice including: • All residents have the potential to be affected by deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: • The Resident Immunization Policy will be reviewed and updated as needed. • All nursing leadership will be educated on the Pneumococcal vaccine protocol according to the CDC recommendations. • All current resident's will be reviewed for appropriate vaccines and offered any pneumococcal vaccines that they are eligible for. • All new admits going forward will be reviewed for appropriate vaccines and offered any pneumococcal vaccines that they are eligible for. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits of resident's pneumococcal vaccination status will be completed by DON/designee 5x/week x 1 week, 3x/week x 2 weeks, then once weekly x 2 weeks, and then monthly thereafter beginning the week of October 16, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 2, 2023	

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F 883	Continued From page 56 During interview on 9/19/23, at 3:00 p.m. RN-F stated the facility just received information related to the PCV20 vaccine. RN-F had not offered P9, P10 or P60 the vaccine yet. During an interview on 9/19/23 at 3:15 p.m., the director of nursing (DON) stated the facility was just starting to update residents pneumococcal vaccinations and have developed a plan to accomplish that. The facility sent out requests to the residents medical providers regarding which residents they wished to have the PCV15 or PCV20 vaccines. They have not offered to any residents at this time as they were just getting started on the necessary steps needed prior to offering the vaccine. The facility policy Resident Immunizations dated 7/18/23, indicated pneumococcal vaccines would be offered to each resident according to the current recommendations from the CDC. The CDC guidance dated 2/9/23, identified "adults 65 and older have the option to get PCV20."	F 883		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/18/23 to 9/21/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not	2 890		11/2/23

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2 890	Continued From page 3 experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed ensure an ordered ambulation range of motion (ROM) program was implemented for 1 of 2 residents (R10) reviewed for rehabilitation and restorative nursing. Findings include: R10's quarterly Minimum Data Set (MDS) dated 8/10/23, identified R10 had severe cognitive impairment, required limited assistance for her daily activities of daily living (ADLs) and ambulation had not occurred. R10's care plan dated 8/23, identified R10 would walk with the use of assistive devices and would not have a decline in walking. Staff were directed to walk R10 with a transfer belt, physical support, and full wheeled walker. R10 was at risk for a decline in ambulation related to her poor balance and cognition. Restorative staff were directed to ambulate R10 50 feet daily with a two wheeled walker and wheelchair follow. During observations on 9/19/23, between 2:15 p.m. and 6:30 p.m. R10 was observed lying on her back in bed. During continuous observation 9/20/23, from 8:20 a.m. to 11:45 p.m. R10 was observed lying on her back in bed. Staff did not approach and offer ambulation or exercise. Subsequent	2 890	Corrected	

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2 890	Continued From page 4 observations between 12:00 p.m. to 3:00 p.m. revealed R10 remained in bed and no attempts were made to assist her to ambulate. When interviewed on 9/20/23 at 11:45 a.m., nursing assistant (NA)-F stated R10 previously was able to self-transfer from her bed to the commode but was now unable. R10 was able to stand and pivot transfer to her commode with assistance. R10 refused to dress and preferred to remain in bed. R10's Physical Therapy Treatment Encounter Note dated 5/10/23, indicated a restorative nursing program was developed and staff were instructed on R10's ambulation program. Written communication was given to initiate the restorative program and R10 was being discharged from therapy. R10's Restorative Nursing Records were reviewed from the start of R10's program 5/10/22 through 9/20/23, and ambulation was only documented 5/31/23. August 2023 indicated ambulation was offered 14 days and refused. September 2023, indicated 9/1/23, through 9/20/23, ambulation was offered 4 days and refused. When interviewed on 9/20/23, at 1:45 p.m., NA-H stated and offered to assist R10 to walk but was refused. NA-H had only got R10 to ambulate one time since NA-H started in May 2023.. The other therapy aide, NA-I, ambulated with R10 one time shortly after R10 was discharged from therapy. R10 only ambulated the two times that she was aware of. Restorative nursing completed range of motion activities for residents as well, but R10 was not getting any ROM exercises from the restorative program.	2 890		

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2 890	Continued From page 5 During interview on 9/20/23, at 2:00 p.m., NA-I stated he was in charge of the restorative program. NA-I knew R10 was able to pivot transfer with her cares but R10 refused to ambulate. NA-I reported R10's refusal to ambulate to the registered nurse (RN)-F many times. Whenever a resident refused restorative they reported it to nursing staff. NA-I stated 5/31/23, was the one and only day R10 had ambulated since the restorative program was initiated on 5/10/22. NA-I knew R10's family member (FM)-F wanted them to keep trying, so they continued to offer ambulation two to three times per week. When interviewed on 9/20/23, at 2:45 p.m., RN-F stated R10 spent much of her time in bed and refused to walk. RN-F brought up the refusals to FM-F but FM-F stated he did not want to give up on R10 and wanted them to keep trying. RN-F was not aware R10 was not getting ROM exercises. RN-F was sure that it had been attempted in the past and was unsuccessful, but was unable to find documentation of exercises. The interdisciplinary team discussed R10's refusal to ambulate and tried to discontinue the ambulation program. RN-F contacted FM-A again to discuss risk vs benefits with R10's consistent refusals to ambulate and discussed the plan to discontinue the program, but FM-A was reluctant to sign it. Alternative programs and exercise were not discussed. A physical therapy evaluation to evaluate why R10 was refusing and if alternative interventions could be implemented to maintain and prevent decline had not been discussed. Nursing supervised the restorative program and it was reported to RN-F that R10 refused to ambulate. No other interventions were discussed and that is where RN-F failed. Nursing	2 890		

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2 890	Continued From page 6 should try to prevent any decline in function, even when a patient was refusing. During interview on 9/21/23 at 11:30 a.m., physical therapist (PT)-H stated they completed an evaluation on 10/3/22, because R10 had fallen. R10 had been in a poor mood that day. R10 could stand and transfer to the commode but that was all R10 would do. The restorative staff told PT-H R10 only ambulated two times since the start of the restorative program. PT-H did think if a resident was refusing to ambulate other interventions should be attempted. PT-H was not approached about R10 and did not know R10 was not walking at all. October 2022 to now was a long time to go without restorative exercises. PT-H did just evaluate her abilities and did not see a significant decline in R10's ROM, however, she was weaker. R10 would be appropriate to be seen by therapy to try to set up an alternative program or interventions. When interviewed on 9/21/23 at 1:30 p.m., the director of nursing (DON) stated she felt if a resident was consistently refusing a restorative program, the staff needed to stop and seek a therapy evaluation and reevaluate to identify other more appropriate interventions. The facility policy Restorative Nursing Program dated 4/6/20, indicated the restorative program implemented interventions to promote a residents ability to adapt and adjust to living as independently and safely as possible. The concept actively focused on achieving and maintain optimal physical, mental, and psychosocial functioning. Interventions implemented were those that assist or promote the resident's ability to attain his or her maximum functional potential. If a resident refused	2 890		

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2 890	Continued From page 7 restorative services, the staff would report to the nurse supervisor in a timely manner. Documentation of non-compliance would include reason for refusal and any interventions to promote compliance. If continued refusal an Informed Choice Consent form would be completed by the resident or resident representative. The resident's restorative program would be evaluated at least quarterly and documented. The evaluation would include the resident's progress toward the goal, any barriers that interfered with the resident's progress, interventions attempted to assist the resident to overcome the barriers, an assessment of frequent refusals to participate in the restorative program and the rationale for the decision to revise, continue, or discontinue the restorative program. SUGGESTED METHOD OF CORRECTION: The DON or designee could audit all residents to ensure ordered ROM and ambulation plans were being implemented. The DON or designee could review the process for implementing the ROM and ambulation and how that is communicated, then educate the staff on the process. The DON or designee could perform audits to ensure the ROM and ambulation were completed as ordered. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 890		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the	2 900		11/2/23

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2 900	Continued From page 8 development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement care planned interventions for promoting the healing of pressure ulcers 2 of 2 residents (R61, R23) reviewed pressure ulcers. Findings include: R61: R61's quarterly Minimum Data Set (MDS) dated 8/29/23, identified R61 had moderate cognitive impairment, was at risk for developing pressure ulcers and currently had an unstageable pressure ulcer. Diagnoses included coronary artery disease, dementia, and cancer. R61's Care Area Assessment (CAA) dated 5/31/23 identified pressure ulcer was an area of care that required close monitoring and specialized care. R61's undated care plan, identified R61 was at	2 900	Corrected	

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	00602	A. BUILDING: _____ B. WING _____	09/21/2023

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2 900	Continued From page 9 risk for altered skin integrity related to impaired mobility with interventions of pressure reducing cushion to chair, pressure reducing mattress to bed and float heels while in bed. R61's progress notes from 9/1/23 to 9/20/23 identified the following: - 9/1/23 at 6:25 p.m., R61's left heel was red and boggy. Heels were floated at that time. - 9/11/23 at 9:09 a.m., R61's left heel was red and boggy, heels were floated at that time. During observation on 9/18/23 at 11:56 a.m., R61 was laying flat on the bed and heels were not being floated off the mattress. During observation on 9/20/23 at 9:24 a.m.R61's heels were observed laying flat on the mattress with the heels pushing against the foot board and not floating above the mattress. Nurse assistant (NA)-B was performing a bed bath on R61 along with a brief change. After cares were completed, NA-B left the room without floating R61's heels off the bed. During an interview on 09/20/23 at 9:56 a.m., nurse assistant (NA)-B stated repositioning and floating heels while in bed would be on the resident's care plan. R61 did not need his heels floated and there was nothing on the care plan that indicated they needed to be floated. NA-B reviewed the care plan and acknowledged floating heels was on R61's care plan and stated she was not aware that was on R61's care plan. During an interview on 9/21/23 10:14 a.m., registered nurse (RN)-C stated all interventions for skin protection are placed in the resident's	2 900		

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2 900	Continued From page 10 care plan and was aware R61 had an intervention to float heels when in bed because of a history of reddened heels in bed. During an interview on 9/21/23 at 10:37 a.m., the director of nursing (DON) stated R61 had float heels when in bed as an intervention since the beginning of September when he was found with red heels. Staff were expected to follow the care plan to prevent any kind of skin issues while in the facilities care. R23: R23's annual MDS dated 8/14/23, identified a diagnoses of hemiplegia and hemiparesis of left non-dominant side (weakness and loss of movement on one side of the body) due to a stroke. R23 had moderate cognitive impairment, required extensive assistance to complete transfers and self-cares, and used a wheelchair. R23 was identified to be at risk of skin breakdown with identified treatments of a pressure reducing device for their chair and bed. R23's care plan dated 8/22/22, identified R23 used a Broda wheelchair (wheelchair with increased padding on right and left side that can tilt), a pressure reducing cushion was to be used at all times, their left arm was to be supported on an arm rest when in their wheelchair, and they required assistance with wheelchair mobility. During observation on 9/19/23 at 1:35 p.m., R23 was seated in a Broda wheelchair leaning to the right, left arm was propped on a padded arm tray, blanket was in her right arm, and no cushion was visible in the wheelchair. During observation on 9/19/23 at 5:18 p.m., R23	2 900		

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2 900	Continued From page 11 was in the dining room seated in a Broda wheelchair with a lift sling beneath them and was leaning strongly to the right. No cushion was observed in the wheelchair. During observation on 9/20/23 at 3:08 p.m., R23 was seated in a Broda wheelchair, no cushion was observed below them, and R23's left arm was sliding off the padded arm tray due to them leaning to the right. During interview on 9/20/23 at 2:58 p.m., occupational therapist (OT)-C stated nursing staff would identify positioning issues and would go about getting orders for therapy when necessary. A Broda wheelchair can recline and tilt and was unable to determine if a pressure relieving cushion was necessary. During interview on 9/20/23 at 3:30 p.m., NA-D was not aware that R23 required a pressure relieving cushion in her wheelchair. During interview on 9/20/23 at 3:41 p.pm., NA-E was not aware R23 required a pressure relieving cushion and had not observed a cushion in R23's wheelchair, at any time, since NA-E was hired in April of 2023. During interview on 9/21/23 at 8:43 a.m., RN-A stated they were unsure as to why a pressure reducing cushion was necessary as R23 does not currently have skin breakdown. The previous nurse manager may have care planned for a pressure relieving cushion. If RN-A had time, they would review and update the care plan. RN-A identified the care plan should be reviewed for accuracy at care conferences and RN-A missed that a pressure relieving cushion was care planned, therefore R23 did not have a pressure	2 900		

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2 900	Continued From page 12 relieving cushion in their wheelchair. During interview on 9/21/23 at 11:55 a.m., DON stated all care plans should be revised and updated with any change, at quarterly assessments, annual assessments, and with a significant change. The facility policy Care Planning dated 10/23/17, indicated the nurse manager was responsible for adding interventions to the updated care plan and should communicate with staff any changes made. The policy lacked expectations in regards to staff following the care plan set in place. SUGGESTED METHOD OF CORRECTION: The DON or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing, and to promote healing of pressure ulcers. The DON or designee could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	2 920		11/2/23

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2 920	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with toileting for 1 of 2 residents (R10) reviewed for activities of daily living and who were dependent on staff for their care. Findings include: R10's quarterly Minimum Data Set (MDS) dated 8/10/23, identified R10 had severe cognitive impairment, required limited assistance with toileting, and was always incontinent of bladder. R10's care plan dated 8/23, identified R10 required assistance to change her brief and provide peri cares after each incontinent episode. Interventiions included: staff to remind and assist R10 to the toilet on arising at 6:00 a.m. and every two to three hours during the day, as well as at bedtime; assist R10 to the commode every day around 9:00 a.m., and after breakfast to promote continent bowel movements. On 9/20/23, R10 was continuously observed from 8:20 a.m. until 11:30 a.m. R10 was lying in her bed with the head of her bed elevated, watching her television. R10 remained lying in her bed watching television and sleeping off and on until nursing assistant (NA)-F offered assistance to the commode and provided assistance with incontinence care at 11:45 a.m. R10's brief was saturated with a large amount of urine R10 was observed for 3 hours and 15 minutes and was not offered assistance with toileting or incontinence care during that time. On 9/20/23, at 11:45 a.m. NA-F stated she was	2 920	Corrected	

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2 920	Continued From page 14 assigned R10's care and R10 required assistance to check and change her brief and provide incontinence care. NA-F had not checked R10 since her morning cares at 6:00 a.m. and confirmed R10's brief was saturated with urine. When interviewed on 9/20/23, at 2:40 p.m. registered nurse (RN)-F stated he was not aware R10 was always incontinent of urine. R10 was care planned to be assisted to the commode every two to three hours and he would expect staff to check and change R10 or offer toileting assistance in a timely manner. During interview on 9/21/23, at 1:33 p.m. the director of nursing (DON) stated it was her expectation that residents who were incontinent of bladder and needed assistance with toileting be checked and changed every two hours and if increase in incontinence were noted, the nurse should initiate a bowel and bladder assessment. The policy Urinary Incontinence Program dated 4/16/15, indicated each resident who was incontinent would be identified, assessed, and provided appropriate care and services to prevent incontinence related complications to the extent possible. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure all activities of daily living are met. The DON or designee could educate all appropriate staff on the policies and procedures.The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 920		

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2 980	MN Rule 4658.0605 Subp. 2 Director of dietary service; Director Subp. 2. Director of dietary service. If a qualified dietitian is not employed full time, the administrator must designate a director of dietary service who is enrolled in or has completed, at a minimum, a dietary manager course, and who receives frequently scheduled consultation from a qualified dietitian. The number of hours of consultation must be based upon the needs of the nursing home. Directors of dietary service hired before May 28, 1995, are not required to complete a dietary manager course. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the dietary manager was certified and credentialed to oversee food services. This had potential to affect all 69 residents, staff, and visitors who consumed food from the ktichen. Findings include: During interview on 9/21/23 at 9:53 a.m. dietary manager (DM)-E stated they had not completed the certified dietary manager course, but was working toward becoming enrolled. The facility was helping to enroll them in the course, but was unsure when that would be. The corporate dietary manager was available by email daily. During interview on 9/21/23 at 10:32 a.m., administrator confirmed DM-E did not have their dietary manager certification or state equivalent and DM-E would start the online program for the dietary manager certification on October 1st. The	2 980	Corrected	11/2/23

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2 980	Continued From page 16 adminstrator wasnted the dietary manager to get settled in before adding extra work as they are a newer employee. The qualifications of DM-E were requested, but not received. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure the dietary manager has the proper qualifications for the position. The administrator or designee could educate all appropriate staff on the policies and procedures and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 980		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to utilize proper hand sanitization after topical medication administration for 1 of 5 residents (R226) observed for medication administration; failed to ensure staff completed proper hand hygiene and glove use during distribution of snacks and meals. This had the ability to affect all 69 residents as well as staff and visitors who consumed food in the facility.	21375	Corrected	11/2/23

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21375	Continued From page 17 Findings include: MEDICATION PASS During an observation on 9/19/23 at 6:39 p.m., licensed practical nurse (LPN)-B entered R226's room and administered three medications orally. LPN-B then applied gloves and administered a topical medication to R226's left calf. When done, LPN-B removed her gloves, did not complete hand hygiene, walked to the medication cart in the hallway, documented the medication administration, and then returned R226's medication tube to the medication cart after placing the tube in a zip lock bag. Without completing hand hygiene, LPN-B placed a medication cup on the cart and began to touch other resident medication cards in the cart. During an interview on 9/19/23 at 6:47 p.m., LPN-B stated they had not complted hand hygiene since they had removed their gloves in R226's room. Normally they would sanitize their hands after they performed a treatment that required gloves, then LPN-B continued to touch the medication cards without performing hand hygeine. LPN-B confirmed they still had not sanitized their hands, and stated they were going to wash their hands now because it was important to sanitize hands after wearing gloves and between residents for infection prevention. LPN-B then sanitized their hands. During an interview on 9/21/23 at 12:58 p.m., the infection preventionist (IP) stated gloves should be removed immediately after the application of topical medicine and hand sanitization should occur as soon as possible, and before other tasks	21375		

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21375	Continued From page 18 are performed or other items are touched. Proper glove use and hand sanitization was required to prevent the spread of infection. MEAL SERVICE: On 9/19/23 at 3:35 p.m., activities aide (AA)-A was observed handling cupcakes and administering them to residents on the Hawk Ridge unit. AA-A was wearing the same gloves when entering multiple resident rooms, did not once remove their gloves or complete hand hygiene, and then wiped their nose with their gloved left hand. Prior to continuing to pass cupcakes, AA-A was stopped by the survey team before entering another resident room. AA-A stated that staff was to wear gloves whenever they have contact with residents, handle food or drink, or clean up after a resident. AA-A should not have worn the same gloves between resident rooms. AA-A not aware that they had wiped their nose with a gloved hand. If they had noticed, they would have taken off her gloves and washed their hands. During continuous observation 9/20/23 at 11:42 a.m., dietary manager (DM)-E was assisting with meal preparation by placing silverware on resident trays and loading each individual tray into food warming carts. -11:50 a.m., DM-E changed gloves for a second time and failed to complete hand hygiene between glove changes. Dietary aide (DA)-A was plating food with gloved hands, including bread rolls from a plastic bag. DA-A touched the outside of the bread bag and opened a cooler door with gloved hands and failed to change gloves or complete hand hygiene prior to continuing to plate food. -11:58 a.m., DA-A opened a cabinet door and	21375		

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21375	Continued From page 19 moved plates on the counter with the same gloved hands and failed to change gloves or complete hand hygiene. Directly following the observation DM-E identified that she touched a door and other items and removed her gloves, failed to completed hand hygiene, and donned a new pair of gloves. The undated facility Hand Hygiene policy identified staff would routinely perform hand hygiene to control the spread of infection. Hands should be washed before and after direct contract with a client, if moving from a contaminated body site to a clean body site during client care, after contact with environmental surfaces or equipment in the immediate vicinity of the client, after removing gloves or gowns, before eating, after using a restroom, and prior to preparing food. The Viewcrest Health Center Infection Control Preventing the Spread of Infections - Hand Washing dated 6/13/12, identified gloves did not replace hand washing and hands should be washed immediately after gloves were removed. SUGGESTED METHOD OF CORRECTION: The DON/IP or designee could develop, review, and/or revise policies and procedures to ensure hand hygiene and glove use is completed as required; they could review and revise polcies as needed; educate all staff; and develop a monitoring program to monitor ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	21375		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring	21540		11/2/23

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21540	Continued From page 20 Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement anticoagulant side-effect monitoring for 1 of 1 resident (R23) reviewed for anticoagulant use. Findings include: R23's annual Minimum Data Set (MDS) dated 8/14/23, identified a diagnoses of hemiplegia and hemiparesis of left non-dominant side (weakness and loss of movement on one side of the body) due to a stroke. R23 had moderate cognitive impairment and an anticoagulant was used during	21540	Corrected	

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21540	Continued From page 21 the last seven days prior to the completion of the MDS. R23's care plan dated 8/22/22, failed to identify R23's interventions related to anticoagulant use. R23's facility incident report dated 9/13/23, identified R23 was noted to have a bruise above their right eyebrow measuring 2 centimeters (cm) x 2 cm and R23 stated they bumped their head on the bed rail in the night and no staff or other resident hit them. The report identified the resident frequently leans to the right and the root cause of the injury was an unpadded bed rail and did not address R23's anticoagulant use or monitoring following an injury to their head. Incident checklist sections, "added to skin log?", "care plans adjusted for change in level of care needs", and "staff educated/in-serviced" were marked either not applicable or not addressed. R23's nursing progress note dated 9/14/23, identified R23 hit their head on a bed rail, and they frequently leaned to the right. During observation on 9/19/23 at 1:35 p.m., R23 was seated in a Broda wheelchair with bruising noted above right eye. During interview on 9/20/23 at 9:41 a.m., nursing assistant (NA)-C stated the nursing assistants refer to electronic medical record to know how to care for and monitor each resident. NA-C would notify the nurses of any skin changes. During interview on 9/20/23 at 3:30 p.m., NA-D stated that they would notify the nurse of skin changes. During interview on 9/21/23 at 8:43 a.m.,	21540		

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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) COMPLETE DATE
21540	Continued From page 22 registered nurse (RN)-A stated R23 had a similar head injury in the past and R23 suffered a brain bleed at that time. RN-A identified anticoagulant monitoring was not care planned and it should be for staff to be aware. They did verbal education with staff that was on the floor at that moment and hoped that they were talking to each other for the next shift to be aware of monitoring. During interview on 9/21/23 at 11:55 a.m., director of nursing (DON) stated if there is an incident with an intervention it should be care planned under safety of skin. Anticoagulants should be care planned for risk of bleeding or bruising to trigger the nursing staff to look at bruising or bleeding and notify the on-call physician if they fall or have an injury. R23's care plan should have been updated to reflect the intervention and address the anticoagulant use and monitoring. SUGGESTED METHOD OF CORRECTION: The DON and consulting pharmacist could review and revise policies and procedures to ensure proper monitoring is conducted to determine medication efficacy. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21540		
21670	MN Rule 4658.1405 A.B.C.D. Resident Units The following items must be provided for each resident: A. A bed of proper size and height for the convenience of the resident, a clean, comfortable mattress, and clean bedding, appropriate for the weather and resident's comfort, that are in good	21670		11/2/23

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21670	Continued From page 23 condition. Each bed must have a clean bedspread. A moisture-proof mattress or mattress cover must be provided for all residents confined to bed and for other beds as necessary. Rollaway type beds, cots, or folding beds must not be used. B. A chair or place for the resident to sit other than the bed. C. A place adjacent or near the bed to store personal possessions, such as a bedside table with a drawer. D. Clean bath linens provided daily or more often as needed. E. A bed light conveniently located and of an intensity to meet the needs of the resident while in bed or in an adjacent chair This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the facility provided a home like environment for 1 of 1 residents (R47) reviewed for home like environment. Findings include: During an observation on 9/18/23 at 8:17 a.m., R47 was laying on a bare mattress on her bed. The bed was unplugged and in a low position. During an observation on 9/19/23 at 2:42 p.m., R47 was laying across the foot of the bed and the bed had a flat sheet and incontinence pad and there was not pillow or blanket. The room contained two chairs, and an end table and a call light cord hanging from the wall. There was a stuffed animal on the bed and several others on	21670	Corrected	

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21670	Continued From page 24 the floor next to the bed. R47's room lacked any personal clothing or items and the bathroom room was locked. During an interview on 9/19/23 at 3:20 p.m., RN-A identified R47 was at the facility for six months. The facility was concerned about hoarding, but R47 had a history of eating things like incontinence briefs and gloves, the facility did not keep things in R47's room. RN-A didn't know why R47 did not have a pillow or a blanket in her room, as many things were put in to place before RN-A started at the facility. On 9/20/23 at 9:02 a.m., nursing assistant (NA)-J assisted R47 with cares. NA-J explained R47 did not have personal care items or clothes in her room because if she did, R47 would put everything in the toilet and flood the room. NA-J indicated R47's clothes were kept in the laundry room and all of her personal care items were kept in the tub room bathroom they used for R47. During an interview on 9/20/23 at 3:15 p.m. regiatered nurse (RN)-A confirmed R47's room was very sparse and identified all items were removed from her room based on her past behaviors and safety needs, even though R10 did not have any currently identfied behaviors. During an interview on 9/21/23 at 9:14 a.m., NA-K stated R47's clothing had been kept in the laundry room for at least a year or more. When R47's needed clothes, they get them from the laundry room. NA-K stated it was not in her scope to determine if R47's room was homelike. During an interview on 9/21/23 at 12:38 p.m. the director of nursing (DON) acknowledged that R47 did not have much of a home like environment	21670		

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21670	Continued From page 25 and identified an attempt had been made to put some decorative paper items in her room but they were removed. The facility Person Centered Care Planning policy dated 3/7/22, identified the care plan should allow for resident choice, honor home like environment, enhance dignity, allow for treatment refusal, and help support achievement of highest practicable level of well-being for the resident. SUGGESTED METHOD OF CORRECTION: The DON or desginee could review policies. Education of appropriate staff could be provided. Room observations/audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: TWENTY-ONE (21) days.	21670		

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	245414	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/18/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/18/2023. At the time of this survey, Viewcreast Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 10/12/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Viewcrest Health Center is a partial 2-story building with only this part having a basement. The original building was constructed in 1960 with 3 additions constructed in 1968, 2002 and 2008. The 1960 and the 1968 building is type II(111) construction. The 2002 building is two (2) story Type II(000), and the 2008 building is Type II(111) 2-story. Since the construction types of the original building and the 3 additions meet the minimum requirements for existing healthcare facilities it was inspected as one building.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 88 beds and had a census of 72 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe	K 321		11/2/23

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K 321	Continued From page 3 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have a isolated impact on the residents within the facility. Findings include: On 09/18/2023, between 9:30am and 12:30pm, it was revealed by observation that canal park housekeeper storage room did not have a self-closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321	K321 VHC will have doors with self-closing devices. In order to comply with NFPA 101 (2012 Edition), Life Safety Code sections 19.3.2.1.3 and 7.2.1.8.1: 1. The Canal Park Housekeeper storage room door had a self-closing device installed on 09/21/2023. 2. The Environmental Service Director completed a tour of the facility and checked all other storage rooms for self-closing devices. The Environmental Service Director and maintenance employee were educated on ensuring all storage room doors have self-closing devices on them. 3. The Environmental Service Director will tour the facility randomly to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 11/02/2023	
K 346 SS=C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service	K 346		11/2/23

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K 346	Continued From page 4 Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility did not properly implement a fire watch protocol for when the fire alarm system is out of service for more than 4 hours in a 24-hour period, according to NFPA 101 2012 edition, Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Finding include On 09/18/2023, 09:30AM and 12:30PM, during documentation review it was revealed that the facility's fire watch policy did not state that the person performing fire watch is the sole duty of that employee. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 346	K346 VHC will have a proper fire watch policy. In order to comply with NFPA 101 (2012 Edition), Life Safety Code sections 9.6.1.6: 1. The Fire Watch Policy was reviewed and updated to include language that the employee on fire watch would not be assigned any other duties on 09/25/2023. 2. The Environmental Service Director and maintenance employee were educated on updated policy. This policy update was reviewed at our AWAIR meeting on 10/10/2023. 3. The Environmental Service Director will review policies with our corporate consultant as part of our mock survey to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 11/02/2023	

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K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		11/2/23

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K 363	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/18/2023 between 09:00 AM and 12:30AM, it was revealed by observation that the resident room door 32 did not latch. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 363	K363 VHC will have doors that latch properly. In order to comply with NFPA 101 (2012 Edition), Life Safety Code sections 19.3.6.3.5: 1. Room 32 door was adjusted so it latched properly on 09/25/2023. 2. The Environmental Service Director completed a tour of the facility and checked all other doors for proper latching. The Environmental Service Director and maintenance employee were educated on ensuring all doors latch properly. 3. The Environmental Service Director will tour the facility randomly to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 11/02/2023	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall	K 372		11/2/23

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K 372	Continued From page 7 be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 09/18/2023, 09:30AM and 12:30PM, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors Mesabi Park. 2) On 09/18/2023, 09:30AM and 12:30PM, it was revealed by observation that there was a penetration running from one smoke compartment to another above north end doors leading into dining room. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 372	K372 VHC will maintain proper smoke barriers. In order to comply with NFPA 101 (2012 Edition), Life Safety Code sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5: 1. The penetration noted above the north doors of the dining room was sealed on 09/20/2022. 2. The Environmental Service Director completed a tour of the facility and checked above other fire doors looking for penetrations that were not sealed. The Environmental Service Director and maintenance employee were educated on ensuring all penetrations between smoke barriers were caulked properly. 3. The Environmental Service Director will tour the facility randomly to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency.	

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K 372	Continued From page 8	K 372	5. Completion Date: 11/02/2023	