#### CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALT			D CERTIFIC	CATION A	ND TRANSMITTAL	IEDICARE & MEI	ID: O2WN
	PART I	- TO BE COMP	LETED BY T	THE STAT	E SURVEY AGENCY		Facility ID: 00602
1. MEDICARE/MEDICAID PROVIDIO (L1) 245414 2.STATE VENDOR OR MEDICAID NO (L2) 892028100		3. NAME AND ADDRESS OF FACILITY (L3) VIEWCREST HEALTH CENTER (L4) 3111 CHURCH STREET (L5) DULUTH, MN			(L6) 55811	4. TYPE OF ACTI 1. Initial 3. Termination 5. Validation	ON: 7 (L8)  2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF C (L9) 6. DATE OF SURVEY <b>06/0</b>	OWNERSHIP 06/2018 (L34)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual	PPLIER CATEGO 05 HHA 06 PRTF	ORY 09 ESRD 10 NF	02 (L7) 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit  8. Full Survey After FISCAL YEAR END	
8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE	09/30	INO DATE. (E33)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds	<b>92</b> (L18)	Compliand	nce With Requirements ce Based On: Acceptable POC		And/Or Approved Waivers Of T  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural SN  5. Life Safety Code	6. Scope of 7. Medical l	Services Limit Director Doom Size
13.Total Certified Beds	<b>92</b> (L17)		mpliance with Prog and/or Applied Wa	_	* Code: A	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF 92		ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)  16. STATE SURVEY AGENCY REM.	(L39) ARKS (IF APPLICABL	(L42) E SHOW LTC CANCE	(L43) ELLATION DATE	Ε):			
17. SURVEYOR SIGNATURE		Date:			18. STATE SURVEY AGENCY	APPROVAL	Date:
Susan Frericks, HPR	- SWS	06/14/	2018	(L19)	Alison Helm, Enforcement Specialist 06/14/2018		
	PART II - TO BE	COMPLETED	BY HCFA R	EGIONAL	OFFICE OR SINGLE ST	FATE AGENCY	
<ol> <li>DETERMINATION OF ELIGIBIL</li> <li>_X 1. Facility is Eligible to</li> <li> 2. Facility is not Eligible</li> </ol>	Participate		IPLIANCE WITH GHTS ACT:	I CIVIL		ancial Solvency (HCFA-25 rol Interest Disclosure Stmt ve:	
2. Tacinty is not English	(L21)						
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEN	MENT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION <b>01/01/1987</b>	BEGINNING	DATE	ENDING DA	ГЕ	VOLUNTARY 01-Merger, Closure		<u>UNTARY</u> o Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursen		o Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV  A. Suspension	VE SANCTIONS of Admissions:	(1.44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER	der Status Change
(L27)	B Rescind Sus	nension Date:	(L44)			00-ACIIV	

(L45)

30. REMARKS

DETERMINATION APPROVAL

(L31)

29. INTERMEDIARY/CARRIER NO.

32. DETERMINATION OF APPROVAL DATE

03001

06/01/2018

(L28)

(L32)

28. TERMINATION DATE:

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245414

June 14, 2018

Ms. Katie Collins, Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

Dear Ms. Collins:

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

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

Effective June 4, 2018 the above facility is certified for:

92 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 14, 2018

Ms. Katie Collins, Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

RE: Project Number S5414029

Dear Ms. Collins:

On May 10, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective May 15, 2018. (42 CFR 488.422)
- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective July 15, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on April 26, 2018. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On June 6, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 7, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 26, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 4, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 26, 2018, as of June 4, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 4, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of May 10, 2018:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective July 15, 2018 be rescinded as of June 4, 2018. (42 CFR 488.417 (b))

In our letter of May 10, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP)

Viewcrest Health Center June 14, 2018 Page 2

for two years from July 15, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 4, 2018 the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health

Minnesota Department of Health P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 14, 2018

Ms. Katie Collins, Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

Re: Reinspection Results - Project Number S5414029

Dear Ms. Collins:

On June 6, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 26, 2018, with orders received by you on May 21, 2018. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Alison Helm, Enforcement Specialist

Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

cc: Licensing and Certification File

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: O2WN

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I	- TO BE COMP	LETED BY T	THE STAT	TE SURVEY AGENCY		Facility ID: 00602
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245414  2.STATE VENDOR OR MEDICAID NO.     (L2) 892028100  5. EFFECTIVE DATE CHANGE OF OWNERSHIP		3. NAME AND ADDRESS OF FACILITY (L3) VIEWCREST HEALTH CENTER (L4) 3111 CHURCH STREET (L5) DULUTH, MN			(L6) <b>55811</b>	4. TYPE OF ACTION  1. Initial  3. Termination  5. Validation  7. On-Site Visit	2. Recertification 4. CHOW 6. Complaint
<ul> <li>5. EFFECTIVE DATE CHANGE OF OW (L9)</li> <li>6. DATE OF SURVEY 04/26.</li> <li>8. ACCREDITATION STATUS:</li> </ul>		7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct	PPLIER CATEGO 05 HHA 06 PRTF 07 X-Ray	ORY 09 ESRD 10 NF 11 ICF/IID	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC	8. Full Survey After 0	
0 Unaccredited 1 TJC 2 AOA 3 Other	_	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):				S:	And/Or Approved Waivers Of Th2. Technical Personnel3. 24 Hour RN	ne Following Requirements: 6. Scope of Se 7. Medical Dir	rvices Limit
12.Total Facility Beds	<b>92</b> (L18)	1. /	Acceptable POC		4. 7-Day RN (Rural SNF	_	
13.Total Certified Beds	<b>92</b> (L17)		mpliance with Prog and/or Applied Wa	-	5. Life Safety Code  * Code: <b>B*</b>	9. Beds/Room (L12)	
14. LTC CERTIFIED BED BREAKDOW	/N				15. FACILITY MEETS		
18 SNF 18/19 SNF 92	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMAR	RKS (IF APPLICABL	E SHOW LTC CANCI	ELLATION DATE	Ε):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL	Date:
Susan Frericks, HPR Socia	•	iist	05/30/2018	(L19)	Douglas S. Larson, Enfo		t 05/31/2018 <sub>(L2)</sub>
P	ART II - TO BE	COMPLETED	BY HCFA R	EGIONAL	OFFICE OR SINGLE ST.	ATE AGENCY	
DETERMINATION OF ELIGIBILIT     1. Facility is Eligible to Page 1.			IPLIANCE WITH GHTS ACT:	I CIVIL		ncial Solvency (HCFA-2572 of Interest Disclosure Stmt (F ::	
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEN	MENT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION <b>01/01/1987</b>	BEGINNING	DATE	ENDING DA	ΓE	VOLUNTARY 00 01-Merger, Closure		TTARY Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme		Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI  A. Suspension	VE SANCTIONS  n of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	er Status Change
(L27)	B. Rescind Sus	pension Date:	(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/0	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (	OF APPROVAL I	DATE			

(L33)

DETERMINATION APPROVAL

(L32)



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 10, 2018

Ms. Katie Collins, Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

RE: Project Number S5414029 and H5414055

Dear Ms. Collins:

On April 26, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) as evidenced by the attached CMS-2567, whereby significant corrections are required. In addition, at the time of the April 26, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5414055 that was found to be unsubstantiated.

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

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 6 months after the survey date;

Appeal Rights – the facility rights to appeal imposed remedies; and

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

Please note, it is your responsibility to share the information contained in this letter and the results of

this visit with the President of your facility's Governing Body.

#### DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us

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

#### NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.12, Freedom from Abuse, Neglect, and Exploitation, 42 CFR 483.24, Quality of Life, or 42 CFR 483.25 Quality of Care; <u>OR</u>
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) <u>AND</u> has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

• State Monitoring effective May 15, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective July 15, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective July 15, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 15, 2018.

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

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 15, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

#### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

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

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

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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 their respective deficiencies (if any) is acceptable.

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 July 15, 2018, the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 26, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### APPEAL RIGHTS

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

#### Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

#### INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections

> Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

PRINTED: 06/20/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′				E SURVEY PLETED
		245414	B. WING				C <b>26/2018</b>
	PROVIDER OR SUPPLIER	R		3111	EET ADDRESS, CITY, STATE, ZIP CODE I CHURCH STREET LUTH, MN 55811	, , , , , , , , , , , , , , , , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		ΕO	000			
F 000	Emergency Prepare conducted on 4/23/ recertification surve	iance with CMS Appendix Z edness Requirements, was 18, through 4/26/18, during a ey. The facility is in compliance Z Emergency Preparedness	F 0	000			
	through 4/26/18, an	rvey was conducted 4/23/18, and complaint investigation(s) and at the time of the standard					
		urvey, an investigation of l55 was completed and was tantiated.					
	as your allegation on Department's accept enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required of first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 550 SS=D	on-site revisit of you validate that substa regulations has bee your verification. Resident Rights/Ex		F 5	550			6/4/18
	self-determination,	nt Rights. right to a dignified existence, and communication with and and services inside and					

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

Electronically Signed 05/30/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245414	B. WING		04	C / <b>26/2018</b>	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP 3111 CHURCH STREET DULUTH, MN 55811		20,2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 550	outside the facility this section.  §483.10(a)(1) A fawith respect and oresident in a man promotes mainter her quality of life, individuality. The promote the rights §483.10(a)(2) The access to quality severity of conditi must establish an practices regarding provision of service residents regardles §483.10(b) Exerce The resident has rights as a reside or resident of the §483.10(b)(1) The resident can exercite interference, coerfrom the facility.  §483.10(b)(2) The free of interference reprisal from the frights and to be sexercise of his or subpart.  This REQUIREMIND.	acility must treat each resident dignity and care for each ner and in an environment that nance or enhancement of his or recognizing each resident's facility must protect and sof the resident.  The facility must provide equal care regardless of diagnosis, on, or payment source. A facility and maintain identical policies and the ces under the State plan for all less of payment source.  The facility is careful to exercise his or her not of the facility and as a citizen	F 5	DON and/or designee will	implement		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION	COM	E SURVEY PLETED
		245414	B. WING			C 26/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
\//E\\/OD		- <b>n</b>		3111 CHURCH STREET		
VIEWCR	EST HEALTH CENTE	:K		DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 550	Continued From pa	age 2	F 550			
F 550	provided during careviewed for activit the facility failed to by ensuring a urina for 1 of 1 residents catheter.  Findings include:  R46's Face Sheet diagnoses that include weakness, and spir R46's quarterly Mir 2/23/18, indicated required extensive with activities of dause.  R46's care plan darequired extensive toilet use and personal hygiene.  On 4/25/18, at 7:34 was observed go in door open. From the total approach R46 and change R46's incorequested to be chincontinent brief with the side of the service of t	tres for 1 of 1 residents (R46) ties of daily living. In addition, ensure dignity was maintained ary drainage bag was covered (R296) reviewed for urinary dated 4/26/18, identified luded generalized muscle	F 550	affected by this practice by: -NA-A was verbally educated on regarding need to ensure doors/are closed prior to performing cares/toileting with resident in ord provide for privacyDON met with R46 on 5/1/18 to that resident did not have any dis related to NA-A not closing door completely during toiletingR296's catheter was permanent removed per MD orderDON met with R296 on 5/1/18 to that resident did not have any dis related to incidents of her not had catheter bag covered. DON and/or designee will assess residents having potential to bein affected by this practice includingAll residents have potential impacted by this practice All residents with catheters potential to be impacted by this practice All residents with catheters potential to be impacted by this practice All residents with catheters potential to be impacted by this practice Consider this practice reoccur including: -Education will be provided to all Staff by DON or designee by 6/4 our Dignity Policy and Catheter Consideration of the provide bodily privacy during ass with personal cares and treatment procedures and on ensuring cathers.	curtains der to ensure stress dy o ensure stress ving her sig g to be have oractice. hent does not Nursing /18 on Care need to istance nt	
	lowered the bed, c hands and left the interviewed. NA-A	continent brief. NA-A then overed R46, washed her hands room. At 7:38 a.m. NA-A was stated she was not able to shut a privacy while providing cares,		<ul> <li>bags are not visible from the hall</li> <li>Nurse Managers to review all reresidents with catheters to ensur have proper coverage of cathete dignity by 6/4/18. All resident's v</li> </ul>	esiding e they r bag for	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	COME	E SURVEY PLETED
		245414	B. WING			04/2	C 26/2018
	PROVIDER OR SUPPLIE			31	REET ADDRESS, CITY, STATE, ZIP CODE 11 CHURCH STREET ULUTH, MN 55811	1 0-112	0,2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 550	as the E-Z stand acknowledged the to provide for privious on 4/25/18, at 10 would be embarrasee her from outs On 4/25/18, at 1:3 (DON) was intervexpect the staff to door during cares. The facility's Dign directed staff to president privacy, i assistance with procedures. In adhelp avoid things residents such as urinary catheter b. R296's Face Shediagnoses that inc. R296's care plan was at risk for coninfections due to i urinary retention. empty the cathete and keep the cathete and keep the cathete and keep the cathete and keep the cathete on 4/24/18, at 8:4 from outside of the uncovered urinary.	lift was in the way. NA-A e door should have been closed acy.  :50 a.m. when R46 stated it assing if someone was able to side the room.  37 p.m. the director of nursing iewed and stated she would provide privacy by shutting the state of the provide privacy by shutting the state of the provide privacy during ersonal cares and treatment dition, the policy directed staff to that could be demeaning to the shelping the resident to keep ags covered.  et printed 4/26/18, indicated cluded chronic kidney disease dated 4/24/18, indicated R296 mplications such as urinary tract indwelling catheter use for R296's further directed staff to be bas using aseptic technique, neter bag below the level of the plan lacked direction on	F 5	550	catheters will have their care plans care cards reviewed for accuracy to Nurse Managers and updated to reference to the hallway by 6/4/18.  DON and/or designee will monitor corrective actions to ensure effection of these actions including:  Random audits of staff providing personal cares and treatment processor to watch that they provide bodily provided by the sax of the	edures veness edures veness edures vecy ot done week of and	

	OF DEFICIENCIES OF CORRECTION			OATE SURVEY COMPLETED		
		245414	B. WING_		04	/26/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 550	Continued From p On 4/24/18, at 2:2 from outside of the uncovered urinary outside of the bed urine. On 4/25/18, at 6:5 from outside of the uncovered urinary outside of the bed urine. On 4/25/18, at 9:2 from outside of the uncovered urinary outside of the bed urine. On 4/26/18, at 8:5 from outside of the bed urine. On 4/26/18, at 8:5 from outside of the bed urine. On 4/25/18, at 10: stated they asked catheter bag, and uncovered.	,	F 58	DEFICIENCY)		
	when a resident w On 4/26/18, at 9:3 (DON) stated she be covered whether	neter bags were not covered as in their room.  1 a.m. the director of nursing would expect catheter bags to er a resident was in their room resident stated they did not				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		OATE SURVEY COMPLETED
		245414	B. WING		C 04/26/2018
	PROVIDER OR SUPPLIER	R	;	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 CHURCH STREET DULUTH, MN 55811	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC 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 550	Continued From pa	ige 5	F 550		
		-	F 641		6/4/18
	resident's status. This REQUIREMEI by: Based on observa review, the facility f Minimum Data Set reviewed for dental Findings include: On 4/23/18, at 12:2 tooth was visible w "I have a chipped of They dropped it in f R40's annual Minin 3/2/18, identified di hemiplegia or hemi paralysis on one sid (difficulty swallowin indicated on Sectio teeth or tooth fragn lacked indication R full or partial dentur uncleanable or loos R40's care plan da both upper and low	NT is not met as evidenced tion, interview, and document ailed to accurately code the for 1 of 3 residents (R40) concerns.  O p.m. a chipped front denture then R40's spoke. R40 stated, enture tooth in the upper jaw. The bathroom."  num Data Set (MDS) dated agnoses that included paresis (weakness or de of the body) and dysphagia g). In addition, the MDS on L that R40 had no natural thents, however the MDS 40 had "Broken of loose fitting te (chipped, cracked,		DON and/or designee will implement corrective action for R40 affected by this practice:  -Coding for Section L on the MDS with ARD of 3/2/18 was corrected on 5/15/18 to note the chipped tooth on R40s denture.  - RN-D was re-educated on 5/17/18 ensure accuracy of MDS coding. DON and/or designee will access residents having potential to being affected by this practice:  -All residents have the potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does recoccur including: -MDS coordinators will receive education by 6/4/18 on need to properly code all sections of the MDSAll sections of current residents' most recent MDS will be reassessed by the MDS Coordinators to ensure accuracy coding by 6/4/18.  DON and/or designee will monitor corrective actions to ensure effectiveness.	to  e  not  n

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	l` 'co		E SURVEY IPLETED
		245414	B. WING _			C <b>26/2018</b>
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHURCH STREET DULUTH, MN 55811	<u> </u>	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 641	R40 had both upper did not indicate the On 4/25/18, at 8:45 the staff about the cassisted her twice cas with the same they were chiphad been chipped fin the last year where assistants was brust when they dropped On 4/25/18, at 9:44 (the MDS coordinate completed R40's Monthat assessment MDS indicating it with MDS should have be chipped denture too MDS should have be chipped the actual or On 12/7/17, R40's Comprehensive Prohad full upper and I was broken, and so getting fixed.  On 4/25/18, at 1:35 (DON) stated she wassessments to be	ment dated 3/1/18, indicated and lower dentures however, denture had a chipped tooth.  a.m. R40 stated she had told chipped tooth, and the staff daily with the dentures and ped. R40 stated the dentures or, "Awhile" and thought was none of the nursing shing/cleaning them at the sink them.  a.m. registered nurse (RN)-C for) stated RN-D had DS assessment, and based at, RN-C had signed off on the last accurate. RN-C verified the last accurate. RN-C verified the losen coded to included the losen coded accurately to all status of R40.  Resident Summary with logress Notes indicated R40 lower dentures, the front tooth local services was looking into p.m. the director of nursing would expect all resident MDS coded accurately to reflect the	F 64	of these actions including: -Random audits of sections of th will be completed 3x/week x 2 w starting the week of 5/21/18, the weekly x 2 weeks, then weekly the by DON or facility designee to en accuracy of codingMonitoring will be reported to Queonmittee quarterly and as need QAPI committee will make recommendations for ongoing meaning and the second se	eeks n 2x nereafter sure API led. The	
		tus and care needs. for Dependent Residents 2)	F 67	77		6/4/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	<u> </u>		SURVEY ETED
		245414	B. WING		04/26	/2018
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHURCH STREET DULUTH, MN 55811	1 0-1120	,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE C	(X5) COMPLETION DATE
F 677	§483.24(a)(2) A resout activities of dail services to maintain personal and oral had the services to maintain personal and oral had the services to maintain personal and oral had the services to maintain personal observation review, the facility for the services of the	sident who is unable to carry y living receives the necessary n good nutrition, grooming, and hygiene; NT is not met as evidenced tion, interview, and document ailed to offer oral cares for 1 of eviewed for personal cares.	F 677	·	by this lucated al care cares  by ent does not  by and sidents ng AM eeded. tiveness eing 4 1/18, eekly	
		a.m. until 7:15 a.m. R89 was ved. R89 was in bed. asleep.		offered/completedMonitoring will be reported to QA Committee quarterly and as need QAPI will make recommendations	ed.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			E SURVEY IPLETED
		245414	B. WING _			C <b>26/2018</b>
	PROVIDER OR SUPPLIER	२		STREET ADDRESS, CITY, STATE, ZI 3111 CHURCH STREET DULUTH, MN 55811		20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 677	room to assist R89 Continuous observa occurred until 9:20 breakfast to R89 in or provide oral care continued until 11:3 to the dining room f observations resum wheeled R89 from fair, where R89 brothe hair dresser car nor NA-D offered or On 4/25/18, at 12:5 hadn't offer oral car have any teeth, so in On 4/25/18, at 1:13 stated she would exwith no teeth mouth cares.  On 4/25/18, at 1:29 (DON) stated she expressed brush around in a remorning, at night, at the facility's Oral H directed to cleanse to prevent infection mucous membrane	g assistant (NA)-C entered the with getting up for the day. ations of R89's morning cares a.m. when NA-C brought her room. NA-C did not offer s to R89. Observations 9 p.m. when NA-C took R89 for lunch. Continuous and at 12:13 p.m. when NA-D the dining room to the book with with the dining room to the book with and got R89. Neither NA-C reprovided R89 with oral cares.	F 67	ongoing monitoring.		
		akfast, and at bedtime.	F 68	34		6/4/18
	3 403.23 Quality Of	Cale				

			` ´сом	3) DATE SURVEY COMPLETED C		
		245414	B. WING _			26/2018
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	applies to all treath facility residents. B assessment of a rethat residents rece accordance with propractice, the composare plan, and the This REQUIREME by: Based on observareview, the facility of develop care plannersidents (R89) reversidents of daily livindicated R89 had R89's care plan data history of skin tearinsulin, and a history of skin tearinsulin and a history of skin tearinsulin and a history of skin tearinsulin and a h	fundamental principle that ment and care provided to assed on the comprehensive esident, the facility must ensure ive treatment and care in rofessional standards of rehensive person-centered residents' choices.  NT is not met as evidenced tion, interview, and document failed to assess for causes and red interventions for 1 of 1 viewed with skin tears.  printed on 4/26/18, identified uded: chronic obstructive (COPD), and diabetes.  num Data Set (MDS) dated R89 had moderately impaired aired extensive assistance with ring (ADLs). The MDS further skin tears.  ted 7/1/15, indicated R89 had ars due to a history of falls, ry of bumping into objects by was for R89 to be free from rations included safety ded/ordered, and update the ed.  ursing assistant care guide) R89 required an assist of 2	F 68	DON and/or designee will imple corrective action for R89 affection practice by: -NA-C, NA-D, and RN-E were on 5/1/18 on need to be observed during ADLs and treatments. Note that NA-D were educated on 5/1/18 notify nurse immediately of any or blood noted during cares R89 left elbow skin tear was at on 4/25/18 and a skin incident in completed. Currently almost he DON and/or designee will asseresidents having potential to be affected by this practice includingAll residents have potential impacted by this practice. DON and/or designee will implemeasure to ensure this practice. DON and/or designee will implemeasure to ensure this practice. DON and/or designee will implemeasure to ensure this practice. DON and/or designee will implemeasure to ensure this practice. The Accident/Incident Policy and Documentation Policy by 6/4/18 the need to be observant during and treatments and to notify nuimmediately of any incident regor any blood noted during cares.	educated rant of skin A-C and on need to skin issue assessed report was aled. ss ing ng: all to being ement edoes not cated on d Skin B, including g cares rse arding skin B.	
		vith a sit-to-stand lift.		DON and/or designee will moni	tor	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/20/2018 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			U	MR NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245414	B. WING			C <b>04/26/2018</b>	
NAME OF F	PROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	•	
		_		31	I11 CHURCH STREET		
VIEWCR	EST HEALTH CENTE	R		DI	ULUTH, MN 55811		
(VA) ID	SHIMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From pa	ige 10	F 6	684			
	On 4/25/18 at 6:59	a.m. R89 was continuously			of these actions including:		
		a.m. nursing assistant (NA)-C			-Random audits of NAR cares/nurs	e	
	and NA-D were obs	served to enter R89's room to			treatments will be done 3x/week x	4	
	perform morning cares. NA-C and NA-D lowered R89 onto the toilet with the assistance of a sit-to-stand lift with NA-D on R89's left, and NA-C on R89's right. The wall and several grab bars were also on R89's left. As NA-C and NA-D lowered R89 onto the toilet, R89 called out, "Ow!" NA-D stated, "Did you hit your elbow." Once R89				weeks starting week of 5/21/18, the		
					weekly x 2 weeks, then weekly then		
					by DON or facility designee to ensu		
					incidents/issues are assessed/repo -Monitoring will be reported to QAP		
					committee quarterly and as needed		
					QAPI committee will make	1. 1110	
	was seated on the toilet, NA-D left to go to another room and NA-C left to get supplies. R89				recommendations for ongoing mon	itorina.	
					3 3	3	
		bumped when she came in the					
		ırt at the time, but didn't any					
		bright red drops of blood were					
		o the left of R89. At 7:52 a.m.					
		lood and commented, "Oh,					
		t know what that is from." R89's skin, but continued to					
		ares which included taking off					
		n and putting a dress over					
		, including the one that was					
		m. NA-D returned to assist					
	with R89's transfer	off the toilet. Once R89 was					
		tear was visible on R89's arm,					
		elbow. NA-D was in a position					
		, but did not say anything.					
		ort sleeves, and did not cover					
		6 a.m. registered nurse					
		9's room to check her blood give her insulin. RN-E					
		s insulin in her left arm,					
		ches above the visible skin					
		NA-C entered R89's bathroom					
	,	no idea where that came					
		been there." (in reference to					
		or), and went to wipe it up.					
		d not hear R89 call out "Ow"					

during the transfer, did not know R89 had

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	, COV	(X3) DATE SURVEY COMPLETED		
		245414	B. WING _	B. WING		C <b>04/26/2018</b>	
NAME OF PROVIDER OR SUPPLIER  VIEWCREST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHURCH STREET DULUTH, MN 55811		20/2010	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	incurred a skin tear source of the blood On 4/26/18, at 10:3 should let the nurse on the floor. RN-F swipe it up, they sho nurse.  On 4/26/18, at 12:0 (DON) stated she was the stated her expectate addressed.  The facility Accident directed an incident tears with known on 12/19/13, directed staily with cares, an any skin alterations Treatment/Svcs to CFR(s): 483.25(b)(1) Pres Based on the compresident, the facility (i) A resident receive professional standar pressure ulcers and ulcers unless the indemonstrates that it (ii) A resident with precessary treatment.	s, and did not look for the  5 a.m. RN-F stated the NAs e know if they saw blood drops stated they should not just uld investigate first and tell the  6 p.m. the director of nursing would expect NAs to tell a ood on the floor. The DON ion is that the blood would be  1/2 treport is completed for skin runknown origin.  1/3 cumentation policy dated staff to observe resident's skin d notify a licensed nurse with a noted.  1/4 Prevent/Heal Pressure Ulcer 1/(i)(iii)  1/4 egrity sure ulcers.  1/5 preventive assessment of a	F 68			6/4/18	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245414	B. WING			C 26/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0-1/2	20/2010
				3111 CHURCH STREET		
VIEWCR	EST HEALTH CENTE	ER .		DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 686	Continued From page	age 12	F 686	3		
	new ulcers from de This REQUIREME by:	NT is not met as evidenced				
	Based on observareview, the facility implement interver development and of for 1 of 3 residents ulcers. This resulted developed a pressibility findings include:  Pressure Ulcer stares are ulcer and Stage 2 Pressure Ulcer Additional stages and may also ruptured serum-fill visible and deeper Granulation tissue present. These injutation of the service of the facility of the facility in the facility	oss of skin with exposed d bed is viable, pink or red, so present as an intact or ed blister. Adipose (fat) is not tissues are not visible.  , slough and eschar are not uries commonly result from		DON and/or designee will impler corrective action for R33 affected practice by:  -A new RCA was completed to the skin alteration of the skin alteration of the skin alteration of the new RCA and the Assessment, skin Alteration to conclude the total changed to a pressure ulcer on 5 and updated tissue tolerance test and w/c was completed on 5/2/18 5/3/18, indicating every 3 hour repositioning when in bed and evenours positioning while sitting Care Sheets and Care Plan were updated these times.  -NP assessed/reviewed wound of the pressure ulcer to coccyx a continued treatment as ordered to R33 Care Plan was reviewed or for appropriate skin interventions promote wound healing and preventions.	by this by the ation to  NP ccyx was /15/18. in bed 3 and ery 2 re ted to n 5/4/18 and by MD. n 5/2/18 to ent	
	Stage 3 Pressure Full-thickness loss is visible in the ulcepibole (rolled wou Slough and/or esc of tissue damage vareas of significan wounds. Undermi Fascia, muscle, te	ate and shear in the skin over ar in the heel.  Injury: Full-thickness skin loss of skin, in which adipose (fat) er and granulation tissue and und edges) are often present. The har may be visible. The depth varies by anatomical location; that adiposity can develop deep ning and tunneling may occur. Indon, ligament, cartilage of exposed. If slough or eschar		further skin breakdown with no chemade except for change in repositimes.  - NA-G and NA-E were re-educated 5/1/18 to ensure following R33 repositioning schedule per her can DON and/or designee will assess residents having potential to bein affected by this practice including -All residents with shearing in pressure ulcers.  DON and/or designee will implemate measures to ensure that this practice.	ed on re plan. g : ijuries or	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD		<del></del>	C	
		245414	B. WING	B. WING		04/26/2018	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-0.2010
VIEWOD	EST HEALTH CENTE	:D		3	111 CHURCH STREET		
VIEWCR	EST HEALTH CENTE	:K		D	ULUTH, MN 55811		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (X		
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE
F 686	Continued From pa	age 13	F 6	86			
	obscures the exter	nt of tissue loss this is an			does not reoccur including:		
	Unstageable Press	sure Injury.			-All current residents with shearing		
					injuries or pressure ulcers will be		
		sure Injury: Obscured			reassessed for correct identification		
	full-thickness skin				skin alteration and to ensure appro		
		and tissue loss in which the mage within the ulcer cannot			treatments and interventions are in to promote wound healing by 6/4/18		
		use it is obscured by slough or			-Education of all management nurs		
		or eschar is removed, a Stage			regarding corporate skin protocol a		
		ure injury will be revealed.			identification of pressure ulcers will		
		dry, adherent, intact without			completed by 6/4/18.		
	erythema or fluctua	ance) on the heel or ischemic			-All Nursing Staff will be educated of	on the	
	limb should not be	softened or removed.			Care Plan Policy, in regards to ens		
					the care plan interventions are beir		
		printed 4/26/18, indicated			followed in regards to for skin by 6/	4/18.	
		cluded dementia with			DON and/or designee will monitor corrective actions to ensure effective	(ODOOO	
		inces, encephalopathy (brain jury), restlessness and			of these actions including:	/611622	
		etes mellitus type 2.			-Random audits of nursing skin		
	agitation, and diab	otoo momao typo 2.			assessments will be done 3x/week	x 4	
	R33's quarterly Mir	nimum Data Set (MDS) dated			weeks starting week of 5/21/18, the		
		33 had severe cognitive			week x 2 weeks, then weekly there		
	impairment, and ha	ad no rejection of cares during			by DON or facility designee to ensu	ıre skin	
		eriod. The MDS further			assessments/treatments are		
		ired extensive assistance of			appropriate/effective.		
		obility, and total assist of two			-Random audits of ensuring reside	nts	
		R33's MDS further indicated			care plan is being followed for skin	uook v	
		/ incontinent of bladder and of bowel, was at risk for			interventions will be completed 5x/v 2 weeks, starting the week of 5/21/		
		ad no unhealed pressure			then 4x/week x 2 weeks, then 3x/w		
	•	pisture associated skin			weeks, then 2x/week x 2 weeks, th		
		indicated R33 had a pressure			weekly there after.		
		the chair and in bed, and was			-Monitoring will be reported to QAP	1	
	treated with ointme	ents.			committee quarterly and as needed QAPI committee will make		
	R33's Care Area A	ssessment (CAA) for a			recommendations for ongoing mon	itorina.	
		MDS dated 12/4/17, indicated					
		k for skin breakdown per a					
		core (tool used to assist in					

PRINTED: 06/20/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
						С	
		245414	B. WING			04/2	26/2018
	PROVIDER OR SUPPLIER  EST HEALTH CENTE	R		3	TREET ADDRESS, CITY, STATE, ZIP CODE 111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	identifying risk for p Tolerance Test (TT determining the abi endure the effects of effects) indicated R every 4 hours in the hours when lying. I dated 11/29/17, throindicated R33 had if functional ability. To pressure injury to the that was healed upo 9/7/17. The CAA in assist with toileting problem for friction Hoyer (mechanical) was used to assist shearing. The CAA exposed to inconting but wore an inconting moisture away from and changed or toil needed. The CAA in diarrhea related to noted to refuse cardindicated R33 had a on the chair, and promattress on the beat TTT results, and was help keep her dry. cream applied with incontinent episode wick excess moistures to boots (a pressure-recompromised mobilipressure sores at the	ressure ulcers). R33's Tissue T, a tool used to assist in lity of the skin and tissues to of pressure without adverse 33 tolerated repositioning wheelchair, and every 3 R33's most current TTT was ough 11/30/17. R33's CAA in mpaired mobility and he CAA noted R33 had a ne gluteus when in the hospital on admission to the facility on idicated R33 required staff and repositioning, had a and shearing, but used a lift for transfers, and a pad with boosting to avoid a further indicated R33 was ence of bowel and bladder, ment brief to wick excess in the skin, and was checked eted every two hours, and as andicated R33 was at risk for medications, and R33 was es at times. The CAA also a pressure reduction cushion ressure redistributing/relieving d, was repositioned per the last toileted every two hours to R33 was to have a barrier any noted redness after s, an adult incontinent brief to re away from the skin, Prafo elief boot for patients with lity and at risk of developing	F	386			

was at risk for skin breakdown related to impaired

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245414	B. WING			C I/ <b>26/2018</b>	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY 3111 CHURCH STREET DULUTH, MN 55811	, STATE, ZIP CODE	120/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	mobility and refus and incontinence. remain free of predirected staff to indaily with cares, pup in chair, and a the chair. On 4/4 updated to including refused or was respositioning. R3 turn and reposition results to help predicted the use of mattress, turn side position with a pill bed was not elevate eating or drinking R33 was to be to every two hours at R33's current uncassistant care guing reposition R33 every two hours are card further change every two heating or drinking On 4/25/18, during beginning at 7:41 room, R33 had beginning at 7:41 room, R33 room room room room room room room ro	als of turning and repositioning, The goal was for R33 to assure ulcers. R33's care plan aspect skin weekly and observe brovide Prafo boots on feet when pressure reducing cushion on /18, R33's care plan was a: reapproach when R33 sistive to turning and 3's care plan directed staff to a per the tissue tolerance event skin breakdown. In are plan was updated on I shearing to the coccyx, and of an alternating pressure a to side with repositioning, and fow, and ensure the head of the ated beyond 45 degrees unless and treat per physician orders. leted or checked and changed and as needed.  lated Care Card (nursing de) directed staff to turn and arey two hours, position side to when in bed, and Prafo boots and in the wheelchair. The a directed staff to check and a hours and ensure the head of agher than 45 degrees unless	Fé	686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245414	B. WING _		04	C /26/2018
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP O 3111 CHURCH STREET DULUTH, MN 55811	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 686	bed up to approximal administered mediof the bed to approcontinued to lay in right with the head degrees until 10:30 without repositionin nursing assistant to time. NA-E has her up. When inforce apositioned at 7:4 reposition her, and the room.  On 4/25/18, at 10:3 entered R33's roor incontinent brief was NA-E. NA-E cleans cleansing wipe. R33 was turned to the dressing from I had a small amour odor. RN-B cleans cleanser, and meacm x 0.3 cm. The except from 6 o'clowound bed was cir slough covering it. ulcer would be a Swound with lodofor with an Allevyn dre R33 and got her up alternating pressur.  On 4/25/18, at 11:0	nately 90 degrees. RN-B cations, then returned the head eximately 30 degrees. R33 her bed tilted slightly to the of her bed at approximately 30 a.m. (2 hours and 49 minutes ag) when surveyor stopped a coask about R33's repositioning stant (NA)-G stated she een repositioned about 8:30 ad changed her and washed rmed R33 was last 0 a.m. NA-G stated she would called a nurse to meet her in a sewet, and was opened by sed R33's perineal area with a say's right hip had no redness. The right, and RN-B removed R33's right hip had no redness. The right, and RN-B removed R33's coccyx. The dressing at of clear pink drainage without sed R33's ulcer with wound sured the ulcer at 0.5 cm x 0.5 wound edges were regular, ack to 10 o'clock, and the cular with yellow/white stringy RN-B stated the pressure tage 3. RN-B packed the coular with yellow/white stringy RN-B stated the pressure tage 3. RN-B packed the macking strip, and covered ssing. NA-E finished dressing on in the wheelchair. R33 had an elemattress on her bed.	F 68	6		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245414	B. WING				C <b>04/26/2018</b>	
	PROVIDER OR SUPPLIER			3111	EET ADDRESS, CITY, STATE, ZIP CODE  1 CHURCH STREET  LUTH, MN 55811	1 04/	20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 686	approximately 45 d changed and repositioned R33 ti.  On 4/25/18, at 10:5 previous statement pressure ulcer was be Unstageable precovering the wound should be repositioned R33 repressure mattress,  On 12/28/17, at 2:3 indicated R33 had the beginning of the R33 was agitated at Resident yelled out asked where she h Resident was laid of preference, and on ended and she resindication if R33's stime.  On 1/10/18, a phys R33's skin had not skin), vitiligo (skin to suspicious lesions; concerns.  On 1/18/18, R33's Condition/Wound Fhad multiple areas	egrees. NA-E stated she had sitioned R33 at 7:40 a.m. that d R33 should be repositioned A-E verified she had not mely.  If a.m. RN-B stated her regarding the staging of R33's incorrect, and stated it would essure ulcer with the slough d bed. RN-B verified R33 ned every two hours, and repositioned R33 when she ications earlier. RN-B stated eceived the alternating	F6	886				

1	(X3) DATE SURVEY COMPLETED  C 04/26/2018	
NAME OF PROVIDER OR SUPPLIER  VIEWCREST HEALTH CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  3111 CHURCH STREET  DULUTH, MN 55811	20/2010	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686 Continued From page 18 area on the coccyx. R33's open area was identified as an abrasion. The progress note indicated R33 was incontinent of bowel and bladder, and frequently refused cares and repositioning. A note was left in the rounding book for the physician.  On 1/19/18, R33's Skin Condition/Wound Progression note indicated R33's coccyx open area was changed to a moisture lesion in the anal cleft. R33's wound measured 0.5 centimeters (cm) x 0.3 cm and was very superficial, and wound base was shiny granulation tissue (new connective tissue that forms when the wound is healing) with white surrounding skin. R33 was noted to be frequently incontinent of bowel and bladder, had loose stools at times, and refused cares at times, which "Could have contributed to an increase of moisture on the skin and lead to skin breakdown." An emollient barrier cream was intitated with incontinent cares, and R33 was to be checked and changed every 2 hours and as needed.  On 1/23/18, R33's Skin Condition/Wound Progression note indicated R33's moisture lesion was more irregularly shaped, and measured 0.5 cm x 0.8 cm, was very superficial, and had shiny granulation tissue. The wound edges had no white tissue and were normal skin colored.  On 1/23/18, R33's nurse practitioner progress note indicated R33's an up sitting in the dining room, and was waiting for lunch. The note lacked any skin concerns.  On 2/1/18, R33's Skin Condition/Wound Progression note indicated R33's coccyx wound		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245414	B. WING			C <b>04/26/2018</b>	
	PROVIDER OR SUPPLIER	R		311	REET ADDRESS, CITY, STATE, ZIP CODE 11 CHURCH STREET 11 LUTH, MN 55811	1 041	20/2010
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	measured 0.8 cm x base continued to k with white tissue so wound edges were blanchable.  On 2/5/18, R33's S Progression note in was circular shaped measuring 0.6 cm x tissue (yellow devits stringy or thick, and in the wound base, skin color and blancontinued to be the On 2/16/18, R33's S Progression note in was circular shaped was very superficial tissue on the wound normal skin color, a On 2/16/18, R33's progress not purple linear areas were not open. The through the rounding to provide side to slay her down after in note, indicated and evaluation of the wirequested.	kin Condition/Wound adicated tissue, that can be adherent on the tissue bed) Wound edges were normal chable. R33's treatment same.  Skin Condition/Wound adicated R33's treatment same.  Skin Condition/Wound adicated tissue, that can be adherent on the tissue bed) Wound edges were normal chable. R33's treatment same.  Skin Condition/Wound adicated 33's coccyx wound add, measured 0.8 cm x 1.0 cm, I, though it had white slough d bed. The wound edges were	F6	86			
	R33's risk for press	sure injuries had increased to a increased moisture.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245414	B. WING			C <b>04/26/2018</b>	
	PROVIDER OR SUPPLIER	R		3111	EET ADDRESS, CITY, STATE, ZIP CODE CHURCH STREET .UTH, MN 55811	1 0 41.	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	On 2/19/18, R33's prequired extensive toileting, and was frand bladder. The moisture associated was checked and cas necessary, whice appropriate. R33's speaking with the Filmanager] she had importance of follow every 2 hrs [hours] improved with staff again after the rechanges were made time.  On 2/22/18, R33's Serogression note in had some depth, and the company of the company o	orogress note referencing the essment, indicated R33 to total assist of two staff for requently incontinent of bowel note indicated R33 had a d lesion to her coccyx, and she hanged every two hours and h was determined to remain documentation noted, "After RN [registered nurse] MGR re-educated staff on the wing the care card/care plan of toileting and lesion had then compliance (when looking ducation completed)." No e to R33's care plan at that  Skin Condition/Wound adicated R33's coccyx wound and measured 1 cm x 1.2 cm x red as "Kissing ulcers." These moist wound base, and the normal skin colored and buttocks were noted to have and peeling skin along with d areas. The wound care is skin on that date, and ion of 50/50 Calazime (helps is aper rash, wet and cracked cream to the buttocks with The note further indicated the was to be updated with ders the following day.  kin Condition/Wound adicated R33's, "Moisture is one open area and	F6	86			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		245414	B. WING_		C <b>04/26/2018</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 3111 CHURCH STREET DULUTH, MN 55811	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 686	measured 1 cm x obase was pink and macerated looking macerated areas was treatment was consumplified. On 3/7/18, R33's pindicated R33 had or suspicious lesionskin concerns.  On 3/15/18, R33's Progression note in measured 1.1 cm obapeared less mois R33's wound edge macerated and irrespective of the concerns of clock to 6 o'clock remainder measured 1.1 cm obcorrespink and dry, a irregular, and slight plan was updated to side to side only.  On 3/28/18, an occolischarge summar treated from 3/1/18 positioning equipmed R33 would be prowing the distribution, upright posture, and chance of further sonted that R33 had according to the consultation of the consultation	1.2 cm x 0.1 cm. R33's wound red and moist, with white and irregular edges. R33's other were healed. The same tinued.  hysician progress notes no hyperpigmentation, vitiligo, ns. The note lacked any other  Skin Condition/Wound adicated R33's coccyx wound to 0.8 cm x 0.1 cm, and st with a pink-red sound base. s were white or pink,	F 68	36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245414	B. WING				C <b>26/2018</b>
NAME OF PROVIDER OR SUPPLIER  VIEWCREST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  3111 CHURCH STREET  DULUTH, MN 55811			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 686	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 6	86			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		245414	B. WING		C <b>04/26/2018</b>	
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP O 3111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 686	Progression note in "Moisture lesion" mcm with a pink, dry irregular, macerate appeared to be sca On 4/20/18, R33's Progression note in lesion" measured 0 pink wound base the white, macerated a edges. R33's note updated with a requorders. The physic ordered, "Cleanse and pat dry. Pack strips [used to absordered [sic] [footong [twice daily] & prn [coff."  On 4/23/18, R33's Progression note in was changed to a swound measured 1 undermining prese around the entire cobase was pink with serosanguinous dra and wound base. In macerated, and irresolution of the complex of the c	dicated R33's coccyx reasured 0.8 cm x 0.7 cm x 0.5 base, with white, firm, d appearing edges, that in tissue.  Skin Condition/Wound redicated R33's "Moisture reducted R33's wound reducted R33's "Moisture reducted R33's "	F 68			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245414	B. WING		04	C / <b>26/2018</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 3111 CHURCH STREET DULUTH, MN 55811	•	723/2010
(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 CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 686	R33 had been obsordown in bed, and a over to the right side plan were updated the head of the bed she was eating or or remained the same R33's progress not R33's resistance to On 4/25/18, at 12:4 ulcer was moisture shearing injury. RN injury was a pressure shearing injury. RN injury was a pressure getting better. RN-whether staff had be off, and then notice RN-G stated the he elevated too high, a developed more dehad moisture assorather then shearing undermining of a p shearing. RN-G st pressure mattress, repositioning progradetermined that R3 pressure. RN-G ve and repositioned e facility had been do about three to four on that unit had co	erved to be scooting herself attempting to swing her legs de. R33's Care Card and care to direct staff to not elevate de beyond 45 degrees unless drinking. All other interventions described beyond 45 degrees unless drinking. All other interventions described beyond 45 degrees unless drinking. All other interventions described because and repositioning.  At p.m. RN-B stated R33's degreed that a shearing are related injury.  At p.m. RN-G confirmed she is pressure ulcer because it so she recommended a degree of the wound. Described been rubbing the barrier creamed undermining of the wound. Dead of R33's bed had been and the pressure ulcer had depth. RN-G stated R33 initially ciated skin damage (MASD), and RN-G stated that ressure ulcer was classic atted R33 had an alternating	F 6	86		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			7. BOILE			С	
		245414	B. WING			04/	26/2018
	PROVIDER OR SUPPLIER EST HEALTH CENTI			31	REET ADDRESS, CITY, STATE, ZIP CODE I11 CHURCH STREET ULUTH, MN 55811	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	root cause analysi them, and R33's NRN-G stated the fadocuments appea faxes the informat physician group ta  On 4/26/18, at 11:: (NP)-E was intervilooked at R33's prhad not been notificed depth of the pressurated she went by the nurses. NP-Expressure injury. Nothing the pressure ulcer unstageable. NP-informed of the wasted she went by the identified correlappropriately. NP-a physician had or wound, and did not looked at the would of the depth of the work of the pressure ulcer, and looked at the would of the pressure ulcer appropriately. NP-a physician had or wound, and did not looked at the would of the pressure ulcer, was incompared to be for the pressure ulcer.  On 4/26/18, at 11:: ointments would not the pressure ulcer.  On 4/26/18, at 11:: ointments would not the pressure ulcer.	s, and the doctor signed off on MD had signed off on hers. acility does measurements, rance, drainage, treatment, and ion to the physician. The kes pictures of the wounds.  32 a.m. the nurse practitioner ewed and verified she had not essure ulcer, and stated she ied of the worsening and the ure ulcer. NP-E stated she was s a, "Hole" and an ulcer, and y the information provided by verified shearing can cause a P-E stated if there is slough, would be considered E stated she expected to be orsening and condition of the d verified she would need to citly, so it can be treated E stated she was unaware that dered the packing of the tknow if the physician had not.  34 a.m. RN-G stated R33 had ontinent, and her bed had been R33's pressure ulcer was from moisture and shearing.	F	686			

CLIVILI	13 I ON MEDICANE	A MEDICAID SERVICES				IND INC.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		LE CONSTRUCTION		E SURVEY IPLETED
						(	С
		245414	B. WING	·		04/	26/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	P		3	111 CHURCH STREET		
VILVOIN	LOI IILALIII OLIVIL	IX.		[	DULUTH, MN 55811		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	•	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF		COMPLETION DATE
IAG	REGOLATOR ON E	SO BENTI TINO IN ONWATION	IAG		DEFICIENCY)	TW/ CI L	
F 686	Continued From pa	age 26	F	686			
	manager does a ro	ot cause analysis of skin					
	impairments, and o	letermines what the injury					
	could be caused from	om. It was determined R33's					
	coccyx wound was	from moisture, and then on					
		en worse. R33's Braden score					
		the head of her bed was noted					
	at 90 degrees, cau						
		en asked about the increased					
		oted in R33's wound in					
		stated it was not pressure					
	'	om sliding down in bed. The					
		me it was noted R33's Braden					
		I, and an alternating pressure					
		emented. The DON stated					
		on R33's repositioning, and					
		ning had been done on time.					
		acility determined R33's					
		ring injury. The DON stated 33's bed was elevated at 90					
		as sliding down. The DON					
		id not feel R33's pressure ulcer					
		ed. The DON was asked about					
		e pressure ulcer and if barrier					
		riate to treat the pressure					
		plied the nurse manager noted					
	, , ,	ed to be changed, and new					
		ed. Their wound nurse looked					
		ommendations. When asked					
		and if the barrier cream was					
		that, the DON replied the					
	physician and nurs	e practitioner addressed it and					
	agreed to the treati	ment, and the NP stated it had					
		he DON stated they have					
		und certified and are trained					
		I stated the staff are to follow					
		that is what they have access					
	to. The DON stated	d skin assessments should be					
		a new open area. The DON					
	stated R33 had bee	en resistive to reposition and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245414	B. WING_		04	C / <b>26/2018</b>	
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP C 3111 CHURCH STREET DULUTH, MN 55811			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 686	cares in the past, be DON stated resisting documented, and for the Resident Asset User's Manual date ulcers occur when a bony prominence addition to pressur important contributed development. The resident's soft tissue shear force, or frict tissue. Skin and so with aging, illness, and malnutrition in ulcers. Additional excess moisture, a feces, can increase ulcer development trochanters, ischial areas, such as bor braces, and skin sis shear or friction, and ulcers.  The facility policy a Documentation day who enters the facinot develop a pression to develop a pression directed nursing to Tissue Tolerance Tadmission, quarter significant changes	out was less resistive now. The we behaviors should be	F 68	36			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245414	B. WING _			C <b>26/2018</b>
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHURCH STREET DULUTH, MN 55811	<u> </u>	20/2010
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	The nurse manage impaired skin integrited healing and would of factors, and implement to prevent skin alternation prevent skin alternation. The nurse update all necessar factors associated primary care physic hours of any new structure to any new structure of a	r would assess risk factors for rity and/or delayed wound document the identified risk nent appropriate interventions rations and/or promote wound manager was to would be partments of any risk with that department. The sian would be notified within 24 kin alterations, except when ests to be notified on routine all wound would be reviewed the interdisciplinary team essary, wound nurse or nurse ess all pressure ulcers, other wounds of concern aprovement with wounds within a treatment would be tried if g staff to document any the resident with the eventions and education dent.  Indicated that it is the eff would follow the resident's e plan.  Intinence, Catheter, UTI 1)-(3)  The ence.  Facility must ensure that tinent of bladder and bowel on services and assistance to express the or her clinical ences such that continence is	F 69			6/4/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING (X3)			B) DATE SURVEY COMPLETED	
		245414	B. WING _			C <b>04/26/2018</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 3111 CHURCH STREET DULUTH, MN 55811			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 690	§483.25(e)(2)For a incontinence, base comprehensive as ensure that- (i) A resident who indwelling catheter resident's clinical or catheterization wa (ii) A resident who indwelling catheter is assessed for reras possible unless demonstrates that and (iii) A resident who receives appropriate prevent urinary tracontinence to the office states and (iii) A resident who receives appropriate prevent urinary tracontinence to the office states and (iii) A resident who receives appropriate restore as much and possible. This REQUIREMED by:  Based on observations.	a resident with urinary ed on the resident's esessment, the facility must enters the facility without an is not catheterized unless the condition demonstrates that is necessary; enters the facility with an or subsequently receives one moval of the catheter as soon at the resident's clinical condition catheterization is necessary; is incontinent of bladder atte treatment and services to ct infections and to restore	F 69	,			
	cares were provide (R33) reviewed for Findings include: On 4/25/18, during beginning at 7:41 a	ed timely for 1 of 3 residents r pressure ulcers.  g continuous observations a.m. when staff exited R33's		practice by: -NA-E and NA-G were verb on 5/1/18 on need to follow individualized schedule for residentsR33's toileting plan was re resident appropriate for che	pally educated resident's toileting viewed with eck and change		
	Findings include: On 4/25/18, during beginning at 7:41 aroom, R33 had be	g continuous observations		on 5/1/18 on need to follow individualized schedule for residentsR33's toileting plan was re	resident's toileting viewed with eck and chan e Plan and		

STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/SAND PLAN OF CORRECTION IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245414	B. WING			C <b>04/26/2018</b>	
	PROVIDER OR SUPPLIER	R		3	TREET ADDRESS, CITY, STATE, ZIP CODE 111 CHURCH STREET DULUTH, MN 55811	<u> </u>	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	approximately 30 d registered nurse (R give oral medication bed up to approximadministered medic of the bed to appronot check if R33 haincontinent. R33 coslightly to the right approximately 30 d hours and 49 minut changed) when ask stated she thought washed her up at a R33 was last reposnot been checked on NA-G stated she withe room.  On 4/25/18, at 10:3 entered R33's room incontinent brief was NA-E. NA-E cleans cleansing wipe. NA got her up in the whole R33's face Sheet R33's diagnoses in behavioral disturbadisease or brain injugitation, and diabeted R33's quarterly Min 3/2/18, indicated R31's quarterly M31's qu	egrees. At 8:31 a.m. RN)-B entered R33's room to ns, and raised the head of the nately 90 degrees. RN-B cations, then returned the head ximately 30 degrees. RN-B did not dileting needs, or if she was ontinued to lay in her bed tilted with the head of her bed at egrees until 10:30 a.m. (2 tes without being checked and ked, nursing assistant (NA)-G NA-E had changed R33 and about 8:30 a.m. When informed ditioned at 7:40 a.m. and had or changed since that time, ould call a nurse to meet her in the reposition her. R33's as wet, and was opened by sed R33's perineal area with a a-E finished dressing R33 and	F	690	accuracy on 5/2/18.  DON and/or designee will assess residents having potential to being affected by this practice:  -All residents who require assistant toileting have the potential to be imby this practice.  DON and/or designee will impleme measure to ensure this practice do occur by:  -All nursing staff will be educated of Care Planning Policy and need to fresidents' care plan for toileting residents' care plan for toileting residents' care plan for toileting residents of these actions including:  -Random audits of ensuring residential toileting plans are being followed with done 5x/week x 2 weeks starting with 5/21/18, then 4x/week x 2 weeks, then 2x/week x 2 weeks, then 3x/week x 2 weeks, then 3x/week x 2 weeks, then 3x/week x 3x/w	nt es not n the ollow ident veness nt ill be eek of hen (2 DON or el d. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245414	B. WING _		04	C / <b>26/2018</b>
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP 3111 CHURCH STREET DULUTH, MN 55811	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 690	associated skin dal R33's Care Area As 12/4/17, indicated Is and functional ability with toileting. The Coexposed to inconting but wore an inconting moisture away for to changed or toileted needed. R33's CA risk for diarrhea rel to have a barrier or redness after incor incontinent brief to from the skin. R33's care plan inity was at risk for skin mobility refusals of incontinence. The coor or check and chang needed. R33's care to include R33 had staff to check and of R33's Care Card (r undated, directed severy two hours.  On 2/19/18, R33's R33's risk for press to a moderate risk R33's progress not R33's resistance to	· •	F 69			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING	COMPLETED
<b>245414</b> B. WING	04/26/2018
NAME OF PROVIDER OR SUPPLIER  VIEWCREST HEALTH CENTER  STREET ADDRESS, CITY, STATE, ZIP CO 3111 CHURCH STREET DULUTH, MN 55811	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 690 Continued From page 32 and stated she had not checked R33 when she had given her medications earlier.  On 4/25/18, at 11:07 a.m. NA-E brought R33 out of her room in her high back reclining Broda (brand name)wheelchair, at approximately 45 degrees. NA-E stated she had changed and repositioned R33 at 7:40 a.m. and stated R33 should be changed every two hours. NA-E verified she was late.  On 4/25/18, at 2:14 p.m. RN-G stated R33 initially had moisture associated skin damage (MASD).  On 4/26/18, at 2:00 p.m. the director of nursing (DON) stated staff were to follow the Care Cards, as that is what they have access to.  The facility policy Care Planning revised 10/17, directed that it was the expectation that staff would follow the resident's comprehensive care plan.  F 755 Pharmacy Srvcs/Procedures/Pharmacist/Records SS=D CFR(s): 483.45(a)(b)(1)-(3)  §483.45 Pharmacy Services The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	6/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ULTIPLE CONSTRUCTION  _DING		(X3) DATE SURVEY COMPLETED  C 04/26/2018	
		245414	B. WING				
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP C 3111 CHURCH STREET DULUTH, MN 55811	•	20/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 755	Continued From participation of the province o	age 33 ministering of all drugs and the needs of each resident.  Consultation. The facility tain the services of a licensed ides consultation on all rision of pharmacy services in blishes a system of records of tion of all controlled drugs in enable an accurate ermines that drug records are in account of all controlled drugs beriodically reconciled.  NT is not met as evidenced tion, interview, and document failed to ensure Fentanyl rately destroyed to prevent for 1 of 1 resident (R59)	F 75	DON and/or designee will in corrective action for R59 aff practice by: -RN-B was verbally educate on need to properly destroy	mplement fected by this ed on 4/25/18 Fentanyl		
	diagnoses that incl sclerosis, and scoli R59's significant ch (MDS) dated 3/14/ opiod medication, a indicated she had p was almost consta	dated 9/8/17, indicated uded muscle spasm, multiple osis.  nange Minimum Data Set 18, indicated R59 received and identified R59 had bain. R59 reported the pain nt, and rated the pain eight out pain and 10 rated as severe		patches by flushing to the seanother licensed nurse or T-EMAR was updated to requested to requested to document removal/destruction of Fent 4/25/18.  DON and/or designee will a residents having potential to affected:  -All residents that utilized patches.  DON and/or designee will in measures to ensure this practice.	MA. uire 2 staff  anyl patch on ssess being Fentanyl		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		E SURVEY IPLETED
			A. BOILDIN			c l
		245414	B. WING _			26/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 3111 CHURCH STREET	E	
VIEWCR	EST HEALTH CENTE	:K		DULUTH, MN 55811		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE	
F 755	R59 had an order pain medication particles Apply every 3 days. On 4/25/18, at 2:13 cart was complete During the tour and two unopened box belonging to R59. Used Fentanyl pate patch, and disposis Review of the narrot of 4/22/18, R59 has five times. During nurses documented patch.  On 4/25/18, at 3:23 (DON) verified documented two nurses witness patches. The DON where the Sharps removed from the pickup from an our 3:43 p.m. the DON were taken downsthey were picked units and the proper destruction.  The facility's Fental dated February 20 nurses or a trained licensed nurse woresident. Staff that	Orders dated 2/14/18, indicated for the Fentanyl patch (opiod atch) 75 microgram (mcg)/hour.	F 75	reoccur including: -All nursing staff will be educa 6/4/18 on the Fentanyl Patch Policy in regards to proper defentanyl patches including ne nursing staff or a nurse and T in EMAR on removal/destruction and need to properly dispose flushing patch down sewer. DON and/or designee will more corrective actions to ensure e of these actions including: -Random audits of nursing statestruction of Fentanyl patched done 3x/week x 2 weeks start 5/21/18, then 2x/week x 2 weekly there after by DON or designee to ensure proper patched destruction/documentationMonitoring will be reported to committee quarterly and as no QAPI committee will make recommendations for ongoing	Destruction struction of struction of ed to have 2 MA sign off on of patch of by nitor ffectiveness aff es will be ing week of eks, then facility tch  QAPI eeded. The	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245414	B. WING _		04/26/2018	
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHURCH STREET DULUTH, MN 55811	7 7729/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLÉTION	ı
F 755	destroying/wasting medication adminis	n staff removing and will sign off in the electronic stration record.	F 75		6/4/18	
SS=F	appropriate compe out the functions of taking into consider individual plans of cand diagnoses of the in accordance with required at §483.70 This includes:	nploy sufficient staff with the tencies and skills sets to carry the food and nutrition service, ration resident assessments, care and the number, acuity ne facility's resident population the facility assessment				
	clinically qualified n full-time, part-time, qualified dietitian or nutrition profession (i) Holds a bachelor a regionally accred United States (or a with completion of a program in nutritian appropriate native recognized for this (ii) Has completed supervised dietetics supervised dietetics supervision of a recognized for contrition professional. (iii) Is licensed or contrition profession services are perfort provide for licensur	utrition professional either or on a consultant basis. A other clinically qualified al is one who- 's or higher degree granted by ited college or university in the nequivalent foreign degree) the academic requirements of on or dietetics accredited by onal accreditation organization				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY IPLETED
		245414	B. WING				C <b>26/2018</b>
	PROVIDER OR SUPPLIER	R		3	TREET ADDRESS, CITY, STATE, ZIP CODE 1111 CHURCH STREET DULUTH, MN 55811	1 0-11	20,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 801	or she is recognized the Commission on successor organizarequirements of pathis section.  (iv) For dietitians his November 28, 2016 no later than 5 years as required by states \$483.60(a)(2) If a qualified nemployed full-time, person to serve as nutrition services with (i) For designations meets the following years after November 28, (A) A certified dieta (B) A certified dieta (B) A certified food (C) Has similar natisservice management certifying body; or D) Has an associated service management, from higher learning; and (ii) In States that he food service management, from higher learning; and (iii) Receives frequent from a qualified diequalified nutrition processors of the service management of the service man	d as a "registered dietitian" by Dietetic Registration or its ation, or meets the ragraphs (a)(1)(i) and (ii) of red or contracted with prior to 5, meets these requirements as after November 28, 2016 or elaw.  Inualified dietitian or other utrition professional is not the facility must designate a the director of food and hose prior to November 28, 2016, a requirements no later than 5 per 28, 2016, or no later than 1 per 28, 2016 for designations and certification for food and and safety from a national red so restaurant of the service of the service or restaurant of the service of the service or restaurant of the service of the	F8	301			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		245414	B. WING _		C <b>04/26/2018</b>
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE	04/20/2010
10 WIL 01 1	TO VIDER OR GOL LEER			3111 CHURCH STREET	
VIEWCR	EST HEALTH CENTE	R		DULUTH, MN 55811	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROFICIENCY)	O BE COMPLÉTION
F 801	801 Continued From page 37		F 80	1	
	Based on interview facility failed to ens certified and creder preparation and sel potential to affect a food from the kitched food from the food from the facility food fr	and document review, the ure the dietary manager was nitialed to oversee food vice in the kitchen. This had all 83 residents who consumed en.  12 p.m. dietary manager he is not a certified dietary ated he recently signed up to etary manager training, and he back from them.  5 p.m. the administrator as hired in December 2017. tated that DM-C had ServSafe dministrator said she had work regarding the certified aining that week. The diethat DM-C has access to the registered dietician, and the dietitian if he has questions. If director position description ded the requirement that is the a graduate of an lanager's course that meets		Administrator and/or designee will implement corrective action for this practice by: -Removing current Dietary Managorole. Administrator and/or designee will residents having potential to being affected by this practice including: -All residents have poter be impacted by this practice. Administrator and/or designee will implement measure to ensure this practice does not reoccur including: - A clinically qualified nutrition professional licensed by the state Minnesota will be recruited to fulfill responsibilities of Dietary Director time role. A registered dietitian revassessments and provides direction relates to resident nutrition and therapeutic diets. Administrator and Assistant Dietary Managers will ovbudget and purchasing of food and supplies, food preparation, service storage during recruitment and onboarding.  Administrator and/or designee will corrective actions to ensure effection these actions including: -Monitoring will be reported to QAF committee quarterly and as neede QAPI committee will make	er from assess ntial to  g: of the in a full views on as it ersee d e and  monitor iveness
F 880 SS=E	Infection Prevention CFR(s): 483.80(a)( §483.80 Infection C	1)(2)(4)(e)(f)	F 88	recommendations for ongoing mo	6/4/18
	3.00.00 ////				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245414	B. WING				C <b>26/2018</b>
	PROVIDER OR SUPPLIER	R		31 <sup>-</sup>	REET ADDRESS, CITY, STATE, ZIP CODE  11 CHURCH STREET  JLUTH, MN 55811	1 041	20/2010
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	The facility must es infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program.  The facility must es and control program a minimum, the foll §483.80(a)(1) A systemorting, investigation and communicable staff, volunteers, visproviding services arrangement based conducted accordinaccepted national staff. (i) A system of survivial procedures for the but are not limited to (i) A system of survivial procedures for the but are not limited to (ii) A system of survivial procedures for the but are not limited to (iii) When and to who communicable diserported; (iii) Standard and tr to be followed to provivial procedures for the persons in the facilial (iii) When and to who communicable diserported; (iii) Standard and tr to be followed to provivial procedures for the persons in the facilial (iii) When and to who communicable diserported; (iii) Standard and tr to be followed to provivial provided to provivial provided to provivial provided to provivial provided to provided to provivial provided to p	tablish and maintain an and control program a safe, sanitary and ament and to help prevent the ansmission of communicable ions.  In prevention and control tablish an infection prevention in (IPCP) that must include, at owing elements:  Item for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual lupon the facility assessmenting to §483.70(e) and following tandards;  en standards, policies, and program, which must include, or eillance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a	F8	80			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245414	B. WING			C <b>26/2018</b>	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP C 3111 CHURCH STREET DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 880	involved, and (B) A requirement least restrictive pocircumstances. (v) The circumstanust prohibit emp disease or infecte contact with resid contact will transr (vi)The hand hygi by staff involved i  §483.80(a)(4) A s identified under th corrective actions  §483.80(e) Linens Personnel must h transport linens s infection.  §483.80(f) Annua The facility will co IPCP and update This REQUIREM by: Based on observ review, the facility stored appropriate reviewed for infect facility failed to er incontinent produ transported for 1 for activities of da failed to ensure h	that the isolation should be the ossible for the resident under the nessible for the resident under the nessible for the resident under the nessible for the resident under the nessions with a communicable of skin lesions from direct ents or their food, if direct ents or their food, if direct nit the disease; and ene procedures to be followed in direct resident contact.  System for recording incidents are facility's IPCP and the taken by the facility.	F8	DON and/or designee will i corrective action for R40, R R49 affected by this practice. NA-A and NA-B were verba on 5/1/18 on need to disposincontinent products into a pimmediately after removal a plastic bag to wastebasket i room for disposal.  -NA-B was verbally educate not to wear soiled gloves ouresidents' rooms.  -NA-C, NA-D, NA-E, and NA-E.	46, R89, and e by: ally educated se of plastic bag and then bring in dirty utility ed on 5/1/18 utside		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		E SURVEY MPLETED
		245414	B. WING			C <b>26/2018</b>
NAME OF F	PROVIDER OR SUPPLIE	<u></u>	1	STREET ADDRESS, CITY, S	•	20/2010
				3111 CHURCH STREET	- · · · -, - · · · · · · · · · · · · · ·	
VIEWCR	EST HEALTH CENT	ER		DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	( (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From p	page 40	F 8	80		
r oou	On 4/24/18, at 1:0 put the bedpan av stated the bedpan av stated the bedpan av stated the bedpan bedside stand, an her over bed table R40's annual Mini 3/12/18, indicated hemiplegia (paraly hemiparesis (weathemiparesis (weathemiparesis (weathemiparesis (weathemiparesis (weathemiparesis (weathemiparesis (weathemipared extensive included using the adjustment.  On 4/24/18, at 1:5 was observed plastand. R40 stated used it that morniout the bedpan in bedside stand. R40 used it that morniout the bedpan in bedside stand. R40 used it that morniout the bedpan in bedside stand. R40 out most days eith over bed table, "Rher card table.  On 4/26/18, at 9:1 bothered her whe the over bed table cookies. R40 furth was next to her be and did not use the embarrassed her	25 p.m. R40 stated staff do not way after she has used it. R40 in was currently sitting on her and there are times staff put it on e.  Immum Data Set (MDS) dated a diagnoses that included yesis on one side of the body) or ikness on one side of the body). It is a comparison one side of the body in the set of the body in the set of the body in the set of the body. It is a comparison one side of the body in the set of the set of the body in the body in the body in the set of the body in the body in the set of the body in the	F8	verbally educated wash hands as so removed.  DON and/or desig residents having paffected by this properties of the pool of the pool of these actions of these actions of these actions of gloves and handward pool of the pool	gnee will assess potential to being actice including: have potential to be practice. Including will be educated on need attinent products into a diately after removal and bag to wastebasket in or disposal, not to wear ide residents' rooms, to son as gloves are in Policy and Hand and to place bedpans in abinet by bed or per ot to leave on bedside iton will be completed by gnee will monitor to ensure effectiveness including: f proper g of incontinent products beek x 2 weeks starting then 2x/week x 2 weeks, after by DON or facility to proper removal of vashing will be done	
	cookies. R40 furth was next to her be and did not use th embarrassed her not in the proper p	ner stated the over bed table ed, she only used the bedpan, ne toilet. R40 stated it		designee to ensur control techniques -Random audits of gloves and handw 3x/week x 2 week	re proper infection s. f proper removal of vashing will be done s starting week of veek x 2 weeks, then	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	PLE CONSTRUCTION  IG	`´сом	(X3) DATE SURVEY COMPLETED	
		245414	B. WING _			26/2018	
	PROVIDER OR SUPPLIER EST HEALTH CENTE	R		STREET ADDRESS, CITY, STATE, ZIP ( 3111 CHURCH STREET DULUTH, MN 55811	•	20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 880	(DON) stated bedp unless the resident The facility's Clean Equipment policy d should be rinsed w should be washed	ans should not be left out requested it be left out.  ing/Disinfecting Resident Care ated 6/5/17, directed bedpans th cool water. The surface with a disinfectant solution, er, set out to dry, and stored in	F 88	designee to ensure proper control techniquesRandom audits of proper spans will be done 3x/week starting week of 5/21/18, the weeks, then weekly there a appropriate storage per factomoritoring will be reported committee quarterly and as QAPI committee will make recommendations for ongo	storage of bed x 2 weeks len 2x/week x 2 lifter to ensure cility policy. I to QAPI s needed. The		
	R46 required extenstaff with activities use. In addition, the frequently incontined R46's Face Sheet of diagnoses that inclused weakness, and spirit R46's care plan darequired extensive toilet use, and personal hygiene.  On 4/24/18, at 9:56 was observed to was observed to was soiled incontinent phand. NA-B walked the soiled utility root	ted 4/20/18, indicated R46 assistance with bed mobility, onal hygiene. The care plan wide assist of one to two staff es including toilet use and a.m. nursing assistant (NA)-B alk out of R46's room holding a and and a towel in her gloved down the hallway and into to m.					
	normally she would pad in a plastic bag	was interviewed and stated have the soiled incontinent growing it not bagged this the thing." NA-B verified the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	TIPLE CONSTRUCTION  NG	) ´COM	(X3) DATE SURVEY COMPLETED	
		245414	B. WING_			C / <b>26/2018</b>	
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP C 3111 CHURCH STREET DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	stated she was not hallways wearing s  On 4/25/18, at 7:34 into R46's room an hallway, NA-A was and stated she was incontinent brief, as changed. NA-A unf with the door still of incontinent brief, ar provided pericare a brief. NA-A then low washed her hands 7:38 a.m. NA-A wa "Normally we don't change her right the was not close, and inside the plastic based on 4/25/18, at 1:03 stated she would e incontinent product soiled incontinent product soiled incontinent product.	s soiled with urine. NA-B also supposed to walk in the	F 84	30			
	would expect staff incontinent product soiled incontinent product the room before brithe DON  The facility Linen H	p.m. the DON stated she would not throw soiled s on the floor, and stated products were to be bagged in nging them out of the room.  andling policy revised 3/20/17, andle all soiled linen as though it					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		TE SURVEY MPLETED C
		245414	B. WING _		04	/26/2018
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP C 3111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EAC		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	Continued From pa	age 43	F 88	0		
	diagnoses that inclipulmonary disease R89's annual MDS had moderately impextensive assistant hygiene and toiletir R89 was always interequently incontine R89's care plan dabowel incontinence congestive heart far R89's care plan dir	ted 9/30/14, indicated R89 had related to immobility, illure, diabetes and diuretics. ected staff to toilet every three ay, and check/change every				
	R89's Care Card (rundated indicated I of bladder and bow every three hours,  On 4/25/18, at 7:43 observed to enter Facares. NA-C and N toilet with the assis machine. NA-C dolpaper, then a warm movement (BM) frovisible on the toilet NA-C used a towel doffed her gloves, a	nursing assistant care guide) R89 was frequently incontinent rel, and directed staff to toilet				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245414	B. WING _			C / <b>26/2018</b>	
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CO 3111 CHURCH STREET DULUTH, MN 55811		72072010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	attach it to the mach handles to position touched the sling a R89, and straighter On 4/25/18, at 12:5 know if she perform providing incontine On 4/25/18, at 1:13 hygiene should occremoval.  On 4/25/18, at 1:28 hand hygiene should glove removal.	chine, touched the wheelchair the wheelchair below R89, gain to remove it from around ned R89's dress.  66 p.m. NA-C stated she didn't ned hand hygiene or not after nce care for R89.  8 p.m. RN-F confirmed hand cur immediately after glove  8 p.m. the DON confirmed ld occur immediately after	F 88				
	directed hands shot gloves.  R49's Face Sheet pressure R49's diagnoses in unspecified osteoa.  R49's significant chindicated R49 had a radio to request a incontinent of bower of the most	nange MDS dated 3/8/18, severe cognitive impairment. cated R49 was frequently					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION ING			SURVEY PLETED
		245414	B. WING			04/2	: 26/2018
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, 2 3111 CHURCH STREET DULUTH, MN 55811	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD E THE APPROPRI		(X5) COMPLETION DATE
F 880	onto his left side, wincontinent brief an can. NA-E proceed brief on R49. NA-F and did not perform NA-E worked toget then used a lift to mit wheelchair. Once he the gown he wore a shirt over his head to get the shirt pull appropriately on Raher hands.  On 4/25/18, at 10:3 she had failed to wimmediately after a she usually washes gloves, and has a spocket.	while NA-F removed the wet ad placed it in a bag in a trash ded to put a clean incontinent and NA-E doffed their gloves, in hand hygiene. NA-F and ther to get a lift pad under R49, nove him from the bed to his ne was seated, NA-E removed as sleepwear, and NA-F put a . NA-E and NA-F both worked down and situated 49's body. NA-E then washed so her hands after removing her small bottle of sanitizer in her 38 a.m. the DON confirmed it in staff wash their hands after	F8	380			

5414027

PRINTED: 05/22/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 245414 B. WING 04/25/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3111 CHURCH STREET VIEWCREST HEALTH CENTER **DULUTH, MN 55811** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS Anderson, James A. FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. Fire Marshal Division. At the time of this survey, Viewcrest Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR. Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY (X6) DATE

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

TITLE

Electronically Signed

05/21/2018

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.

Facility ID: 00602

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		TIPLE CONSTRUCTION NG <b>01 - MAIN BUILDING 01</b>		COMPLETED	
		245414	B. WING			04/	25/2018
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHURCH STREET DULUTH, MN 55811				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETION DATE
K 000	STATE FIRE MAR 445 MINNESOTA ST. PAUL, MN 55 By e-mail to both: Marian.Whitney@and Angela.Kappenma  THE PLAN OF CODEFICIENCY MUST FOLLOWING INF  1. A description of to correct the defice 2. The actual, or possible for coprevent a reoccurrence in 196 apartial basement constructed in 196 in 1968, 2002 and building is type II(building is type II(building is type II(construction types 3 additions meet to the state of the	RE INSPECTIONS ISHAL DIVISION STREET, SUITE 145 101-5145, or  state.mn.us an@state.mn.us  DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION:  what has been, or will be, done ciency.  proposed, completion date.  or title of the person rrection and monitoring to rence of the deficiency		000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			X3) DATE SURVEY COMPLETED	
	245414	B. WING	-		04/2	5/2018
VIEWCREST HEALTH CENTER			311	1 CHURCH STREET		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Continued From pa	age 2	ΚC	00			
has a complete fire detection in the cocorridor and all restor automatic fire of and had a census. The requirement a NOT MET.  Sprinkler System - CFR(s): NFPA 101  Spinkler System - 2012 EXISTING  Nursing homes, ar construction type, approved automat accordance with N Installation of Sprin In Type I and II comeasures are perrisprinkler protection or local regulations. In hospitals, sprink closets of patients of the closet does sprinkler coverage required by NFPA Sprinkler Systems 19.3.5.1, 19.3.5.2, 19.4.2, 19.3.5.10, This REQUIREMED:	e alarm system with smoke rridors, spaces open to the ident rooms, that is monitored lepartment notification.  censed capacity of 92 beds of 83 at the time of the survey.  It 42 CFR Subpart 483.70(a) is Installation  Installation  Installation  Installation  Installation  Installation  Installation  Installation  Installation  In HPA 13, Standard for the object of		951	Maintenance Supervisor and/or de	esignee	6/4/18
Daseu on observa	ations, the automatic spiritier			Maintenance Supervisor and/or de	23191100	
	PROVIDER OR SUPPLIER  SUMMARY ST,  (EACH DEFICIENC REGULATORY OR I  Continued From pa  The building is fully has a complete fire detection in the co- corridor and all res for automatic fire of  The facility has a li and had a census  The requirement a NOT MET. Sprinkler System - CFR(s): NFPA 101  Spinkler System - 2012 EXISTING Nursing homes, ar construction type, approved automat accordance with N Installation of Sprin In Type I and II con measures are per sprinkler protection or local regulations In hospitals, sprink closets of patient s of the closet does sprinkler coverage required by NFPA Sprinkler Systems 19.3.5.1, 19.3.5.2, 19.4.2, 19.3.5.10, This REQUIREME by:	The building is fully fire sprinkler protected and has a complete fire alarm system with smoke detection in the corridors, spaces open to the corridor and all resident rooms, that is monitored for automatic fire department notification.  The facility has a licensed capacity of 92 beds and had a census of 83 at the time of the survey.  The requirement at 42 CFR Subpart 483.70(a) is NOT MET.  Sprinkler System - Installation  CFR(s): NFPA 101  Spinkler System - Installation  2012 EXISTING  Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler systems in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.  In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.  In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler Coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.  19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)  This REQUIREMENT is not met as evidenced	The building is fully fire sprinkler protected and has a complete fire alarm system with smoke detection in the corridors, spaces open to the corridor and all resident rooms, that is monitored for automatic fire department notification.  The facility has a licensed capacity of 92 beds and had a census of 83 at the time of the survey.  The requirement at 42 CFR Subpart 483.70(a) is NOT MET.  Sprinkler System - Installation  CFR(s): NFPA 101  Spinkler System - Installation  2012 EXISTING  Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.  In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where the area of the closet does not exceed 6 square feet and sprinkler Systems.  In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.  19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)  This REQUIREMENT is not met as evidenced by:	The building is fully fire sprinkler protected and has a complete fire alarm system with smoke detection in the corridors, spaces open to the corridor and all resident rooms, that is monitored for automatic fire department notification.  The requirement at 42 CFR Subpart 483.70(a) is NOT MET.  Sprinkler System - Installation CFR(s): NFPA 101  Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler systems.  In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.  In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler Coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.  19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by:	PROVIDER OR SUPPLIER  245414  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHURCH STREET DULUTH, MN 55811  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  K 000  Continued From page 2  K 000  The building is fully fire sprinkler protected and has a complete fire alarm system with smoke detection in the corridors, spaces open to the corridor and all resident rooms, that is monitored for automatic fire department notification.  The facility has a licensed capacity of 92 beds and had a census of 83 at the time of the survey.  The requirement at 42 CFR Subpart 483.70(a) is NOT MET. Sprinkler System - Installation CFR(s): NFPA 101  Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closet does not exceed 6 square feet and sprinkler Systems. In 3.5.5. 1, 9.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.3.5.1, 19.3.5.1, 19.3.5.1, 19.3.5.1, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)  This REQUIREMENT is not met as evidenced by:	TOURISHER SUPPLIER  245414  245414  245414  245414  245414  245414  245414  245414  245414  245414  25TRECTADDRESS, CITY, STATE, ZIP CODE 3111 CHURCH STREET 311 CHURCH STREET 31

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01			X3) DATE SURVEY COMPLETED	
		245414	B. WING_		04/2	25/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3111 CHURCH STREET DULUTH, MN 55811	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
K 355	accordance with N Installation of Sprir The failure to main compliance with N being place out of the fire protection of an emergency the well as an undeter visitors.  Findings include:  On facility tour betton 04/25/2018, obsprinkler head that in the kitchen were	lled and maintained in FPA 13 the Standard for the akler Systems 2010 edition. Itain the sprinkler system in FPA 13 (10) could allow system service causing a decrease in system capability in the event hat could affect patients, as mined number of staff, and  ween 10:30 a.m. to 2:30 p.m. servations reveled that the fire it is located in aisle by the stove e found to be corroded.  dition was verified by a ervisor. Iguishers	K 3	will implement corrective acti  Changing the corroded s in the kitchen.  Maintenance Supervisor and will assess the rest of the built by this practice by:  Conducting an additional all sprinkler heads in the built Maintenance Supervisor and will implement measures to expractice does not reoccur by:  Routine internal inspectic conducted in addition to the expression of the conducted in addition to the expression of the section of the conducted in addition to the expression of the section of the conducted quarterly and report committee on a quarterly bas needed. The QAPI committee recommendations as needed.	prinkler head /or designee Iding affected inspection of ding. /or designee ensure this ons will be contracted d annually. /or designee is to ensure is including: results will be orted to QAPI sis and as see will make	6/4/18	
	inspected, and ma NFPA 10, Standard Extinguishers. 18.3.5.12, 19.3.5.1 This REQUIREME by: Based on docume interview, it was de to maintain portab	guishers are selected, installed, intained in accordance with d for Portable Fire		K355 Maintenance Supervisor and will implement corrective act Visually inspecting the fi	ion by:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			COMPLETED		
		245414	B. WING			04/2	5/2018
	NAME OF PROVIDER OR SUPPLIER  VIEWCREST HEALTH CENTER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 355	undetermined number event of an emerger findings include:  On facility tour betwon 04/25/2018, obstacility had not condimonthly visual inspeal of the fire exting facility. The fire extinspected in Noveminspection was con	dents, as well as an ber of staff, and visitors in the ency  ween 10:30 a.m. to 2:30 p.m. ervations revealed that the ducted or annotated the ection for December 2017 for uishers located throughout the tinguisher were last annually aber 2017 and the first monthly ducted in January 2018.	K3	355	2017 documentation.  Maintenance Supervisor and/or de will assess the rest of the building by this practice by:  Conducting an additional inspeall fire extinguishers to ensure appinspections and related documents Maintenance Supervisor and/or de will implement measures to ensure practice does not reoccur by:  Routine internal inspections we conducted in addition to the month inspection to ensure inspection and documentation is completed mont Maintenance Supervisor and/or de will monitor corrective actions to e effectiveness of these actions included the inspection results conducted quarterly and reported committee on a quarterly basis and needed. The QAPI committee will recommendations as needed.	ection of ropriate ation. esignee ethis dill be ally dinly. esignee nsure uding: s will be to QAPI di as	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 10, 2018

Ms.. Katie Collins, Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

Re: State Nursing Home Licensing Orders - Project Number S5414029 and H5414055

Dear Ms.. Collins:

The above facility was surveyed on April 23, 2018 through April 26, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5414055 that was found to be unsubstantiated. 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 <u>only a suggestion</u> 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

Viewcrest Health Center May 10, 2018 Page 2

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 Teresa Ament, Unit Supervisor at (218) 302-6151 or teresa.ament@state.mn.us .

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

PRINTED: 05/30/2018 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		С	
		00602	B. WING			26/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	RCH STREE MN 55811	ΞT		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surve found that the deficiency found that the deficiency for the management of the Minnesota Deputermination of which is corrected requires a requirements of the number and MN Ru When a rule contains comply with any of lack of compliance. The result in the assess	hether a violation has been				
	that may result fron orders provided that the Department with notice of assessment in the Department with notice of assessment in the Department of the Department of State lice the Minnesota Department on the Department of State lice the Minnesota Department on the Department of State lice the Minnesota Department of State lice	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 05/30/18

STATE FORM 6899 If continuation sheet 1 of 44 O2WN11

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00602	B. WING			C <b>26/2018</b>
	PROVIDER OR SUPPLIER	3111 CHU	DRESS, CITY, S RCH STREE MN 55811	STATE, ZIP CODE T		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically, is necessary for Sta enter the word "context. You must then State licensure procompletion date, the corrected prior to elements and identify the following correction that you and identify the date.  H Complaint H5283 substantiated.  Minnesota Department the State Licensing federal software. To assigned to Minnesota Nursing Homes.  The assigned tag in column entitled "ID statute/rule out of constant the statement and replaces the "To correction order. The findings which are in after the statement, evidence by." Followare the Suggested Time period for Constant is necessary to the statement, evidence by." Followare the Suggested Time period for Constant is necessary to the statement, evidence by." Followare the Suggested Time period for Constant is necessary to the statement, evidence by." Followare the Suggested Time period for Constant is necessary to the statement of the st	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  1.4/26/18, surveyors of this visited the above provider and ction orders are issued. Four electronic plan of have reviewed these orders, e when they will be completed.  1.6019 was investigated and not correction Orders using ag numbers have been cota state statutes/rules for umber appears in the far left of Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column for Comply" portion of the nis column also includes the nis column also inclu	2 000			

6899

Minnesota Department of Health STATE FORM

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
			A. BUILDING.		С		
		00602	B. WING			26/2018	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
VIEWCR	EST HEALTH CENTE	R	RCH STREE MN 55811	T			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	"PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC	ge 2 IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.	2 000				
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			6/4/18	
	by: Based on observati review, the facility f develop care plann residents (R89) rev Findings include: R89's Face Sheet, diagnoses that include	ent is not met as evidenced ion, interview, and document ailed to assess for causes and ed interventions for 1 of 1 iewed with skin tears.  printed on 4/26/18, identified uded: chronic obstructive (COPD), and diabetes.		corrected.			

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 3 of 44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		С	
		00602	B. WING		<b>I</b>	26/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VIEWCE	EST HEALTH CENTE	R	RCH STREE MN 55811	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	R89's annual Minin 2/19/18, indicated R cognition, and requactivities of daily livindicated R89 had a R89's care plan data history of skin teatinsulin, and a historaccident. The goal skin tears. Interven preventions as need R89's care card (noundated, indicated staff for transfers where the company of the	num Data Set (MDS) dated R89 had moderately impaired ired extensive assistance with ing (ADLs). The MDS further skin tears.  Ited 7/1/15, indicated R89 had ars due to a history of falls, ry of bumping into objects by was for R89 to be free from tions included safety ded/ordered, and update the	2 830			

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 4 of 44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING			
	00602			04/2	26/2018
NAME OF PROVIDER OR SUPPLI		DRESS, CITY, S JRCH STREE	STATE, ZIP CODE		
VIEWCREST HEALTH CEN	rer -	MN 55811	-1		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
with R89's trans off the toilet a ski just above the let to see the skin to R89's dress had the skin tear. At (RN)-E entered glucose levels, a administered R8 approximately 6 tear. At 9:03 a.m and stated, "I had from; it had to had the blood on the NA-C stated she during the transfincurred a skin to source of the blood on the floor. RN-wipe it up, they so nurse.  On 4/26/18, at 1 (DON) stated should let the nurse if they saw stated her expect addressed.  The facility Accident and incident and i	a.m. NA-D returned to assist er off the toilet. Once R89 was in tear was visible on R89's arm, it elbow. NA-D was in a position ear, but did not say anything. short sleeves, and did not cover 3:46 a.m. registered nurse R89's room to check her blood and give her insulin. RN-E 9's insulin in her left arm, inches above the visible skin ., NA-C entered R89's bathroom we no idea where that came ve been there." (in reference to floor), and went to wipe it up. did not hear R89 call out "Ow", er, did not know R89 had ear, and did not look for the od.  2:35 a.m. RN-F stated the NAs rese know if they saw blood drops F stated they should not just hould investigate first and tell the ebod on the floor. The DON tation is that the blood would be ent/Incident policy dated 1/8/18, ent report is completed for skin or unknown origin.  Documentation policy dated d staff to observe resident's skin and notify a licensed nurse with	2 830			

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 5 of 44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED	
		00602	B. WING		04/2	) 16/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	IRCH STREE MN 55811	:T		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 5	2 830			
	The Director of Nur develop, review, an procedures to ensu skin tears, and resir receiving the prope promote healing, ar The Director of Nur educate all appropr procedures.  The Director of Nur develop monitoring compliance.	THOD OF CORRECTION: sing or designee could d/or revise policies and re residents do not develop dents who do incur skin tears r care and services needed to not prevent infection. sing or designee could iate staff on the policies and systems to ensure ongoing				
2 900	MN Rule 4658.0525 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			6/4/18
	comprehensive res of nursing services development of a n provides that:  A. a resident wh without pressure so pressure sores unle condition demonstrauthenticates, that  B. a resident w receives necessary	sores. Based on the ident assessment, the director must coordinate the ursing care plan which o enters the nursing home pres does not develop ess the individual's clinical ates, and a physician they were unavoidable; and ho has pressure sores y treatment and services to revent infection, and prevent yeloping.				
	of nursing services development of a n provides that:  A. a resident wh without pressure so pressure sores unle condition demonstrauthenticates, that a service sore services necessary promote healing, pressure services developed to the services of the services are services of the servi	must coordinate the ursing care plan which  o enters the nursing home pres does not develop pess the individual's clinical pates, and a physician they were unavoidable; and tho has pressure sores by treatment and services to revent infection, and prevent				

6899

Minnesota Department of Health STATE FORM

O2WN11 If continuation sheet 6 of 44

STATEMENT OF I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00602	B. WING		04/2	; 6/2018
NAME OF PROVID	DER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
VIEWCREST H	HEALTH CENTER	R 3111 CHUI DULUTH,	RCH STREE MN 55811	T .		
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
This by: Base review implement of the present of th	ded on observative, the facility fallement intervent elopment and ward of 3 residents ers. This resulted eloped a pressure dings include:  Sure Ulcer stages are Ulcer Advitude eloped a pressure Ulcer Advitude eloped elo	ent is not met as evidenced on, interview, and document ailed to thoroughly assess and tions to prevent the orsening of pressure ulcers (R33) reviewed for pressure d in actual harm for R33, who are ulcer that worsened.  ges defined by the National isory Panel (NPUAP):  njury: Partial-thickness skin lermis as of skin with exposed bed is viable, pink or red, or present as an intact or d blister. Adipose (fat) is not issues are not visible. slough and eschar are not ries commonly result from te and shear in the skin over or in the heel.  njury: Full-thickness skin loss of skin, in which adipose (fat) or and granulation tissue and and edges) are often present. ar may be visible. The depth aries by anatomical location; adiposity can develop deep ing and tunneling may occur. don, ligament, cartilage it exposed. If slough or eschar it of tissue loss this is an	2 900	Corrected.		

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00602	B. WING		04/2	6/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	RCH STREE MN 55811	ΙΤ		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Unstageable Press full-thickness skin a Full-thickness skin extent of tissue darbe confirmed becaueschar. If slough of 3 or Stage 4 press. Stable eschar (i.e. of erythema or fluctual limb should not be a R33's Face Sheet processes or brain injuragitation, and diabeted assessment periodentified R33 requitive staff for transfers. From R33 was frequently always incontinent pressure ulcers, had ulcers, and had modamage. The MDS reducing device in the treated with ointmes R33's Care Area Assignificant change I R33 was at low risk 12/4/17, Braden Scidentifying risk for prolerance Test (TT determining the abit assessment and the significant change I R33 was at low risk 12/4/17, Braden Scidentifying risk for prolerance Test (TT determining the abit assessment and the significant change I R33 was at low risk 12/4/17, Braden Scidentifying risk for prolerance Test (TT determining the abit assessment periode I R33 was at low risk 12/4/17, Braden Scidentifying risk for prolerance Test (TT determining the abit assessment periode I R33 was at low risk 12/4/17, Braden Scidentifying risk for prolerance Test (TT determining the abit assessment periode I R33 was at low risk 12/4/17, Braden Scidentifying risk for prolerance Test (TT determining the abit assessment periode I R33 was at low risk 12/4/17, Braden Scidentifying risk for prolerance Test (TT determining the abit assessment periode I R33 was at low risk 12/4/17, Braden Scidentifying risk for prolerance Test (TT determining the abit assessment periode I R33 was at low risk 12/4/17, Braden Scidentifying risk for prolerance Test (TT determining the abit assessment periode I R33 was at low risk 12/4/17, Braden Scidentifying risk for prolerance Test (TT determining the abit assessment periode I R33 was at low risk 12/4/17, Braden Scidentifying risk for prolerance Test (TT determining the abit assessment periode I R33 was at low risk 12/4/17, Braden Scidentifying risk for prolerance Test (TT determining the abit at large Prolerance Test (TT determining the abit at large Prolera	ure Injury: Obscured and tissue loss and tissue loss and tissue loss in which the mage within the ulcer cannot use it is obscured by slough or reschar is removed, a Stage ure injury will be revealed. dry, adherent, intact without ince) on the heel or ischemic softened or removed.  Orinted 4/26/18, indicated cluded dementia with inces, encephalopathy (brain ury), restlessness and etes mellitus type 2.  Immum Data Set (MDS) dated 33 had severe cognitive ind no rejection of cares during riod. The MDS further irred extensive assistance of obbility, and total assist of two incontinent of bladder and of bowel, was at risk for d no unhealed pressure isture associated skin indicated R33 had a pressure the chair and in bed, and was	2 900			

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 8 of 44

winnesc	<u>ita Department of He</u>	aith				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					_	
			D WING			
		00602	B. WING	<del></del>	04/2	6/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDESS CITY S	STATE, ZIP CODE		
NAME OF I	-KOVIDER OR SUFFLIER					
VIEWCR	EST HEALTH CENTE	₹	RCH STREE	Т		
VIEVVOIX	LOT TILALITY GENTL	DULUTH,	MN 55811			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	.D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
2 900	Continued From pa	go 9	2 900			
2 900	Continued From pa	ge o	2 900			
	effects) indicated R	33 tolerated repositioning				
		wheelchair, and every 3				
		R33's most current TTT was				
		ough 11/30/17. R33's CAA				
		mpaired mobility and				
	,	he CAA noted R33 had a				
		ne gluteus when in the hospital				
		on admission to the facility on				
	9/7/17. The CAA in	dicated R33 required staff				
	assist with toileting	and repositioning, had a				
	problem for friction	and shearing, but used a				
		lift for transfers, and a pad				
		with boosting to avoid				
		further indicated R33 was				
		ence of bowel and bladder,				
	-	nent brief to wick excess				
		the skin, and was checked				
		eted every two hours, and as				
		ndicated R33 was at risk for				
		medications, and R33 was				
		es at times. The CAA also				
	indicated R33 had a	a pressure reduction cushion				
	on the chair, and pr	essure redistributing/relieving				
	mattress on the bed	d, was repositioned per the				
	TTT results, and wa	as toileted every two hours to				
		R33 was to have a barrier				
		any noted redness after				
		s, an adult incontinent brief to				
		re away from the skin, Prafo				
		elief boot for patients with				
	` •	•				
		lity and at risk of developing				
	pressure sores at the	пе пеег) то теет.				
		iated 9/15/17, indicated R33				
		breakdown related to impaired				
	mobility and refusal	s of turning and repositioning,				
		The goal was for R33 to				
		sure ulcers. R33's care plan				
		pect skin weekly and observe				
		ovide Prafo boots on feet when				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 9 of 44 O2WN11

Minnesota Department of Health

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		SURVEY PLETED
			B. WING		<b>I</b>	С
		00602	B. WING		04/2	26/2018
NAME OF PROVIDER OR S	UPPLIER			STATE, ZIP CODE		
VIEWCREST HEALTH	CENTE	R	IRCH STREE MN 55811	T		
PREFIX (EACH DE	EFICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
the chair. Oupdated to it refused or was reposition in turn and represults to he addition, R3 3/13/18, ide directed the mattress, tuposition with bed was not eating or draws as a sistant care position R33 was to every two here. R33's curre assistant careposition R side with pill were to be a Care Card for change eventhe bed was eating or draws eating eventhe bed was eating eventhe eventhe bed was eating eventhe bed was eating eventhe eve	and a pon 4/4/1 include: was resigned so sition elp previous entified se use of irrn side in a pillo televation in the toile ours an interpretation in the toile ours and irre guid so irry two has no high inking.  I during the toile ely 30 do irre	ressure reducing cushion on 8, R33's care plan was reapproach when R33 istive to turning and 's care plan directed staff to per the tissue tolerance ent skin breakdown. In e plan was updated on shearing to the coccyx, and an alternating pressure to side with repositioning, and w, and ensure the head of the ed beyond 45 degrees unless and treat per physician orders. Ited or checked and changed das needed.  Ited Care Card (nursing e) directed staff to turn and ry two hours, position side to hen in bed, and Prafo boots in up in the wheelchair. The directed staff to check and hours and ensure the head of her than 45 degrees unless continuous observations a.m. when staff exited R33's en lying quietly in bed, tilted with the head of the bed at egrees. At 8:31 a.m. and raised the head of the he	2 900			

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 10 of 44

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00602			C <b>04/26/2018</b>	
		00602	I.		04/2	6/2018
NAME OF I	PROVIDER OR SUPPLIER		RCH STREE	STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	MN 55811	.1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 900	nursing assistant to time. Nursing assistant to time. Nursing assist thought R33 had be a.m. when NA-E had her up. When infor repositioned at 7:40 reposition her, and the room.  On 4/25/18, at 10:3 entered R33's room incontinent brief wa NA-E. NA-E cleans cleansing wipe. R3 R33 was turned to the dressing from Fhad a small amoun odor. RN-B cleans cleanser, and measom x 0.3 cm. The vexcept from 6 o'clowound bed was circ slough covering it. ulcer would be a St wound with lodofor with an Allevyn dres R33 and got her up alternating pressure.  On 4/25/18, at 11:0 of her room in her hor (brand name) whee approximately 45 d changed and reposmorning, and states	g) when surveyor stopped a ask about R33's repositioning stant (NA)-G stated she een repositioned about 8:30 and changed her and washed med R33 was last a.m. NA-G stated she would called a nurse to meet her in a to reposition her. R33's as wet, and was opened by ed R33's perineal area with a sis's right hip had no redness. The right, and RN-B removed R33's coccyx. The dressing to f clear pink drainage without ed R33's ulcer with wound sured the ulcer at 0.5 cm x 0.5 wound edges were regular, ck to 10 o'clock, and the cular with yellow/white stringy RN-B stated the pressure age 3. RN-B packed the m packing strip, and covered sing. NA-E finished dressing in the wheelchair. R33 had an emattress on her bed.  7 a.m. NA-E brought R33 out high back reclining Broda elchair, reclined at egrees. NA-E stated she had itioned R33 at 7:40 a.m. that d R33 should be repositioned A-E verified she had not	2 900	DETIGIENCT)		
	On 4/25/18, at 10:5	1 a.m. RN-B stated her				

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 11 of 44

STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ,	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<del></del>	COMPLETED	
		00602	B. WING		04/2	; 6/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
VIEWCREST HEALTH CENTER			RCH STREE MN 55811	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	previous statement pressure ulcer was be Unstageable precovering the wound should be reposition stated she had not had given her medi she thought R33 repressure mattress,  On 12/28/17, at 2:3 indicated R33 had be the beginning of the R33 was agitated a Resident yelled out asked where she here Resident was laid dipreference, and one ended and she rest indication if R33's stime.  On 1/10/18, a physical R33's skin had no here she	regarding the staging of R33's incorrect, and stated it would essure ulcer with the slough bed. RN-B verified R33 ned every two hours, and repositioned R33 when she cations earlier. RN-B stated ceived the alternating but was not sure.  O a.m. a progress note been up in the wheelchair at enurse's shift at 6:00 p.m. and yelling at other people. "Ow, ow, ow," and when curt, replied, "My butt!" lown in bed per her been bed, R33's behaviors ed. The progress note lacked kin had been observed at that the incident of the progress note indicated that lacked pigmentation (darkened that lacked any other skin borogress notes and Skin progression note indicated R33 of blanchable redness on the eal area, and a small open and area, and a small open. R33's open area was assion. The progress note incontinent of bowel and tently refused cares and te was left in the rounding	2 900	DETICIENCY)		

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 12 of 44

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
						С	
		00602	B. WING		04/2	6/2018	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
VIEWCR	EST HEALTH CENTE	R	RCH STREE MN 55811	Т			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 900	area was changed cleft. R33's wound (cm) x 0.3 cm and wound base was st connective tissue thealing) with white noted to be frequer bladder, had loose cares at times, which an increase of mois skin breakdown." A initiated with incont be checked and changed checked and checked and changed checked and checked an	age 12 Indicated R33's coccyx open to a moisture lesion in the anal measured 0.5 centimeters was very superficial, and niny granulation tissue (new nat forms when the wound is surrounding skin. R33 was ntly incontinent of bowel and stools at times, and refused ch "Could have contributed to sture on the skin and lead to An emollient barrier cream was inent cares, and R33 was to anged every 2 hours and as  Skin Condition/Wound ndicated R33's moisture lesion by shaped, and measured 0.5 very superficial, and had shiny. The wound edges had no ere normal skin colored.  Incomparison of the coccyx wound ped, very superficial, and a co.7 cm. The coccyx wound ped, very superficial, and co.7 cm. The coccyx wound ped ped pe	2 900				
		d and very superficial					

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 13 of 44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00602	B. WING		l l	C <b>26/2018</b>
	PROVIDER OR SUPPLIER	3111 CHU	DRESS, CITY, S RCH STREE MN 55811	TATE, ZIP CODE <b>T</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	measuring 0.6 cm of tissue (yellow devita stringy or thick, and in the wound base, skin color and bland continued to be the On 2/16/18, R33's of Progression note in was circular shaped was very superficial tissue on the wound normal skin color, and on 2/16/18, R33's of the R33's progress not purple linear areas were not open. The through the rounding to provide side to sillay her down after mote, indicated and evaluation of the whole with the color, indicated and evaluation of the whole with the color of the whole of the color of the color of the whole of the color of the whole of the color of the whole of the color of the c	x 0.6 cm with yellow slough alized tissue, that can be I adherent on the tissue bed) Wound edges were normal chable. R33's treatment same.  Skin Condition/Wound edicated 33's coccyx wound d, measured 0.8 cm x 1.0 cm, I, though it had white slough d bed. The wound edges were	2 900			

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 14 of 44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00602	B. WING		04/2	26/2018	
	PROVIDER OR SUPPLIER	3111 CHU	DRESS, CITY, S	STATE, ZIP CODE			
VIEWCK	ESI NEALIN CENTE	DULUTH,	MN 55811				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 900	Continued From pa	ge 14	2 900				
	speaking with the R [manager] she had importance of follow every 2 hrs [hours] improved with staff again after the re-ea	RN [registered nurse] MGR re-educated staff on the ving the care card/care plan of toileting and lesion had then compliance (when looking ducation completed)." No e to R33's care plan at that					
	Progression note in had some depth, ar 0.2 cm, and appear had a pink/red and wound edges were blanchable. R33's areas of very dry ar pin-point macerated nurse assessed R3 suggested applicati treat and prevent di skin) and Vaseline dincontinent cares. nurse practitioner was practitioner was progression note in lesion" appeared as measured 1 cm x 1 base was pink and macerated looking macerated areas was treatment was continuicated R33 had reas was pink and macerated R33 had reas was pink and macerated areas was pink and pink and pink	Skin Condition/Wound dicated R33's coccyx wound and measured 1 cm x 1.2 cm x red as "Kissing ulcers." These moist wound base, and the normal skin colored and buttocks were noted to have and peeling skin along with diareas. The wound care 3's skin on that date, and on of 50/50 Calazime (helps aper rash, wet and cracked cream to the buttocks with The note further indicated the ras to be updated with diers the following day.  kin Condition/Wound dicated R33's, "Moisture is one open area and incertain 2 cm x 0.1 cm. R33's wound red and moist, with white and irregular edges. R33's other ere healed. The same inued.  In spicial progress notes no hyperpigmentation, vitiligo, as. The note lacked any other					

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 20.25 10.			
		00602	B. WING		04/2	6/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	RCH STREE MN 55811	:1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 15	2 900			
	Progression note in measured 1.1 cm x appeared less mois R33's wound edges macerated and irre	9				
	Progression note in measured 1.1 cm x o'clock to 6 o'clock remainder measure was pink and dry, a irregular, and slight	Skin Condition/Wound idicated R33's coccyx wound 0.8 cm and the depth from 12 measured 0.1 cm, and the ed 0.3 cm. R33's wound base and wound edges were pink, ly firm to touch. R33's care to turn and reposition R33 from				
	discharge summary treated from 3/1/18 positioning equipme R33 would be proving wheelchair cushion weight distribution, upright posture, and chance of further strong that R33 had coccyx that had wo lay on side for pression-ambulatory, and on the wheelchair, appropriate cushion and improve skin in On 4/6/18, R33's S Progression note in lesion" measured 1	upational therapy (OT) y indicated R33 had been , through 3/28/18, for ent. R33's goals included: ded with a specialized that would provide optimal off loading ability, encourage d pressure relief to reduce the kin integrity issues. It was a moisture lesion on the rsened, and R33 refused to sure relief. R33 was d sat on a gel/foam cushion R33 was provided with an a to provide pressure relief, attegrity and weight distribution. kin Condition/Wound adicated R33's "Moisture cm x 0.7 cm x 0.2 cm with a and irregular, firm, pink edges. mained the same.				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7 501251110.		С		
		00602	B. WING		04/2	26/2018	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
VIEWCR	EST HEALTH CENTE	R	IRCH STREE MN 55811	T .			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
2 900	On 4/10/18, R33's is notes indicated R33 nutritional assessm R33's progress not dining room waiting indicated R33 had a on her coccyx that possible cause is a shearing." It was noteen used over the attempting to keep with incontinence, a maceration. R33's supplement had be R33's progress not coccyx ulcer (press staging," and direct initiate follow up if some sured 0.8 cm x dry wound base, are that appeared as some sured on 4/16/18, R33's is Progression note in "Moisture lesion" macerate appeared to be scaled on 4/20/18, R33's is Progression note in "macerate appeared to be scaled on 4/20/18, R33's is Progression note in lesion" measured 0 pink wound base the white, macerated a edges. R33's note	nurse practitioner progress 3 was seen for follow up of tent to support wound healing, e indicated she was up in the g for brunch. The note a "Moisture associated wound has been slowly healing, brasion secondary to oted that barrier cream had a last two weeks, nursing was resident as dry as possible and the wound had areas of progress note indicated a ren initiated to support healing, e documented a "Decubitus sure ulcer), unspecified ted the nurse manager to skin breakdown worsened.  Skin Condition/Wound adicated R33's coccyx wound to 0.7 cm x 0.2 cm, with a pink, and pink, irregular, firm edges, car tissue. R33's treatment e.  Skin Condition/Wound adicated R33's coccyx wound adicated R33's coccyx wound adicated R33's coccyx weasured 0.8 cm x 0.7 cm x 0.5 base, with white, firm, d appearing edges, that					

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 17 of 44

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  VIEWCREST HEALTH CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  3111 CHURCH STREET DULUTH, MN 55811   (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  DEFICIENCY  B. WING DEFICION (EACH CORRECTION (EACH CORRECTION SHOULD BE COMPL DATE DEFICIENCY)  DEFICIENCY)  DEFICIENCY  COMPL DATE  COMPL DATE  COMPL DATE  COMPL DATE DEFICIENCY		NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3111 CHURCH STREET  DULUTH, MN 55811   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  STREET ADDRESS, CITY, STATE, ZIP CODE  3111 CHURCH STREET  DULUTH, MN 55811  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE DEFICIENCY)  ONLY OF THE ADDRESS, CITY, STATE, ZIP CODE  3111 CHURCH STREET  DULUTH, MN 55811						С	
VIEWCREST HEALTH CENTER  3111 CHURCH STREET DULUTH, MN 55811  (X4) ID PREFIX FAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  3111 CHURCH STREET DULUTH, MN 55811  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			00602	B. WING		04/2	6/2018
VIEWCREST HEALTH CENTER  DULUTH, MN 55811   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  DULUTH, MN 55811  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)  OUT OF THE APPROPRIATE DEFICIENCY)	NAME OF	PROVIDER OR SUPPLIER					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE OF THE APPROPRIATE D	VIEWCR	REST HEALTH CENTE	R		Т		
2 900 Continued From page 17 2 900	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
orders. The physician was noted to have ordered, "Cleanse wound with wound cleanser and pat dry. Pack wound with lodoform packing strips [used to absorb drainage in draining open and/or infected wounds]. Cover with Allevyn boardered [sic] [foam] dressing. Change BID [twice daily] & prn [as necessary] if soiled or falls off."  On 4/23/18, R33's Skin Condition/Wound Progression note indicated the moisture lesion was changed to a shearing injury. R33's coccyx wound measured 1.2 cm x 1.2 cm x 0.6 cm with undermining present to the wound of 0.2 cm around the entire circumference. R33's wound base was pink with scant amount of serosanguinous drainage noted on the dressing and wound base. Wound edges were white, macerated, and irregular from 6 o'clock to 11 o'clock, and were less firm. The note indicated R33 had been compliant with repositioning and changing of incontinent brief every 2 hours. It was noted at that time, R33's head of the bed had been elevated beyond 45 degrees, and R33 was not eating or drinking at that time, so the change in the wound appeared to be related to shearing. R33 had been observed to be scooling herself down in bed, and attempting to swing her legs over to the right side. R33's Care Card and care plan were updated to direct staff to not elevate the head of the bed beyond 45 degrees unless she was eating or drinking. All other interventions remained the same.  R33's progress notes lacked documentation of R33's resistance to cares and repositioning.  On 4/25/18, at 12.47 p.m. RN-B stated R33's ulcer was moisture related, and developed into a	2 900	orders. The physic ordered, "Cleanse and pat dry. Pack strips [used to absorded and/or infected work boardered [sic] [foot [twice daily] & prn [off."  On 4/23/18, R33's Progression note in was changed to as wound measured 1 undermining prese around the entire cobase was pink with serosanguinous drand wound base. In macerated, and irreso'clock, and were le R33 had been comounded at that time, been elevated beyone eating or drinking in the wound appears and wound appears and wound presence at the wound appears and word the right side plan were updated the head of the bed she was eating or or remained the same R33's progress not R33's resistance to On 4/25/18, at 12:4	cian was noted to have wound with wound cleanser wound with lodoform packing orb drainage in draining open unds]. Cover with Allevyn am] dressing. Change BID as necessary] if soiled or falls  Skin Condition/Wound ndicated the moisture lesion shearing injury. R33's coccyx 1.2 cm x 1.2 cm x 0.6 cm with nt to the wound of 0.2 cm ircumference. R33's wound scant amount of ainage noted on the dressing Wound edges were white, egular from 6 o'clock to 11 ess firm. The note indicated apliant with repositioning and nent brief every 2 hours. It was R33's head of the bed had and 45 degrees, and R33 was ng at that time, so the change ared to be related to shearing. Erved to be scooting herself attempting to swing her legs are to direct staff to not elevate to direct staff to not elevate to direct staff to not elevate to beyond 45 degrees unless drinking. All other interventions expenses and repositioning.	2 900			

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 18 of 44

Minnesota Department of Health

Millineso	ita Department of He	aitii				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<del></del>	COMP	LETED
					0	
		00602	B. WING			<i>,</i> 6/2018
		00002			04/2	0/2010
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VIEWOD	COT LICALTII OCNICI	3111 CHU	RCH STREE	Т		
VIEWCREST HEALTH CENTER DULUTH.			MN 55811			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN .	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				DEI ICIENCI)		
2 900	Continued From pa	ge 18	2 900			
	•					
	injury was a pressu	re related injury.				
	On 1/25/19 at 2:1/	In m. DN C confirmed abo				
		p.m. RN-G confirmed she pressure ulcer because it				
		so she recommended a				
		t. RN-G stated it was now				
		G stated she questioned				
		een rubbing the barrier cream				
		d undermining of the wound.				
	•	ad of R33's bed had been				
	elevated too high, a	and the pressure ulcer had				
	developed more de	pth. RN-G stated R33 initially				
	had moisture assoc	ciated skin damage (MASD),				
	rather then shearing	g. RN-G stated that				
		essure ulcer was classic				
		ated R33 had an alternating				
	pressure mattress,					
		am, and it had been				
		3 did not have unsustained				
		rified R33 should be turned				
		very 2 hours, and stated the				
		ing audits on repositioning				
		weeks ago, and all the audits ne back showing no concerns.				
		cility did assessments with a				
		, and the doctor signed off on				
		D had signed off on hers.				
		cility does measurements,				
		ance, drainage, treatment, and				
		on to the physician. The				
		es pictures of the wounds.				
		-				
		2 a.m. the nurse practitioner				
	,	wed and verified she had not				
		ssure ulcer, and stated she				
		ed of the worsening and the				
		re ulcer. NP-E stated she was				
		a, "Hole" and an ulcer, and				
		the information provided by				
	the nurses. NP-E ve	erified shearing can cause a				

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 19 of 44

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		SURVEY PLETED	
		00602	B. WING			C <b>26/2018</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	3111 CHU	JRCH STREE	Г		
VILVOIN	EOT HEALIN OLIVIE	DULUTH.	MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 900	the pressure ulcer unstageable. NP-E informed of the worpressure ulcer, and look at it, and the p be identified correct appropriately. NP-E a physician had ordwound, and did not looked at the wound. On 4/26/18, at 11:3 moisture, was incorat 45 degrees, so F determined to be from On 4/26/18, at 11:4 ointments would not of the pressure ulcenteded to heal from On 4/26/18, at 2:00 (DON) was intervied manager does a rotimpairments, and dould be caused from coccyx wound was 4/23/18, it had gotte had changed, and the tat 90 degrees, cause undermining. Whe depth and slough in February, the DON related, but was fro DON said at that tir score had changed	P-E stated if there is slough, would be considered is stated she expected to be sening and condition of the verified she would need to ressure ulcer would need to tly, so it can be treated is stated she was unaware that lered the packing of the know if the physician had d.  4 a.m. RN-G stated R33 had nationent, and her bed had been a33's pressure ulcer was som moisture and shearing.  5 p.m. NP-E verified barrier at treat the inside or the base er. NP-E stated the wound in the inside out.  p.m. the director of nursing wed and stated the nurse of cause analysis of skin etermines what the injury om. It was determined R33's from moisture, and then on en worse. R33's Braden score he head of her bed was noted sing shearing and in asked about the increased of oted in R33's wound in stated it was not pressure m sliding down in bed. The me it was noted R33's Braden, and an alternating pressure	2 900	DEFICIENCY		
	audits were done o	mented. The DON stated n R33's repositioning, and ing had been done on time.				

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 20 of 44

winnesc	<u>ita Department of He</u>	ealth				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						,
		00602	B. WING		1	
		00602			04/2	6/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		3111 CHU	RCH STREE	т		
VIEWCR	EST HEALTH CENTE	R	MN 55811	•		
	0				~	
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
		,		DEFICIENCY)		
	<del>-</del>					
2 900	Continued From pa	ge 20	2 900			
	That was how the fa	acility determined R33's				
		ring injury. The DON stated				
		33's bed was elevated at 90				
		as sliding down. The DON				
		d not feel R33's pressure ulcer				
		ed. The DON was asked about				
		e pressure ulcer and if barrier				
		iate to treat the pressure				
		olied the nurse manager noted				
		ed to be changed, and new				
		ed. Their wound nurse looked				
		ommendations. When asked				
		nd if the barrier cream was				
		that, the DON replied the				
		e practitioner addressed it and				
		nent, and the NP stated it had				
		he DON stated they have				
		und certified and are trained				
		stated the staff are to follow				
		that is what they have access				
		skin assessments should be				
	done when there is	a new open area. The DON				
		en resistive to reposition and				
	cares in the past, b	ut was less resistive now. The				
	DON stated resistiv	e behaviors should be				
	documented, and fo	ollowed up on.				
	The Resident Asses	ssment Instrument (RAI) 3.0				
		d 10/17, indicated pressure				
		tissue is compressed between				
		and an external surface. In				
		e, shear force, and friction are				
		ors to pressure ulcer				
		underlying health of a				
		e affects how much pressure,				
		ion is needed to damage				
		ft tissue changes associated				
		small blood vessel disease,				
		rease vulnerability to pressure				
		xternal factors, such as				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. DOILDING.	<del></del>		_
		00602	B. WING		04/2	: :6/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEMOREST HEALTH SENTER 3111 CHU			RCH STREE	Т		
VIEWCR	EST HEALTH CENTE	DULUTH,	MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 21	2 900			
	feces, can increase ulcer development trochanters, ischial areas, such as bon braces, and skin su	nd tissue exposure to urine or e risk. Key areas for pressure include the sacrum, coccyx, tuberosities, and heels. Other y deformities, skin under ubjected to excess pressure, e also at risk for pressure				
	Documentation dat who enters the faci not develop a press condition demonstr and a resident who receive necessary promote healing. To directed nursing to Tissue Tolerance To admission, quarterl significant changes be done for the first. The nurse manage impaired skin integring and would of factors, and implement to prevent skin alter healing. The nurse update all necessary factors associated primary care physic hours of any new street the physician requerounds only. The Arand discussed with weekly and as necessary and weekly, and if no impossible to the property of the physician requerounds only. The Arand discussed with weekly and as necessary and weekly, and if no impossible to the physician requerounds only.	and procedure for Skin ed 6/30/17, directed a resident lity without a pressure sore will sure sore unless their clinical ates that it was unavoidable had a pressure sore would treatment and services to the policy and procedure complete a Braden Scale and est lying and sitting upon y, and annually and with any , and the Braden would also the four weeks after admission. It would assess risk factors for rity and/or delayed wound document the identified risk nent appropriate interventions rations and/or promote wound a manager was to would repropriate interventions rations and/or promote wound a manager was to would repropriate interventions rations and/or promote wound a manager was to would repropriate interventions rations and/or promote wound a manager was to would repropriate interventions rations and/or promote wound repropriate interventions rations and/or promote would repropriate interventions rations and/or promote would repropriate interventions rations and repropriate interventions repropriate interventions rations and repropriate interventions repropriate interventio				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
			A. BUILDING.	<del></del>		,
		00602	B. WING		1	6/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	RCH STREE MN 55811	T .		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ige 22	2 900			
	necessary. Nursing non-compliance by	g staff to document any the resident with the rventions and education				
	Planning revised 10	nd procedure for Care 0/17, directed that it is the aff would follow the resident's re plan.				
	The Director of Nur develop, review, an procedures to ensu and services to pre worsening of press The Director of Nur educate all appropr procedures. The Director of Nur develop monitoring compliance.	THOD OF CORRECTION: rsing or designee could ad/or revise policies and are residents are provided care vent the development and ure ulcers. rsing or designee could riate staff on the policies and rsing or designee could systems to ensure ongoing				
	(21) days.					
2 910	MN Rule 4658.0529 Incontinence	5 Subp. 5 A.B Rehab -	2 910			6/4/18
	have a continuous management to recunnecessary use of comprehensive reshome must ensure  A. a resident w without an indwellinunless the resident	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: 'ho enters a nursing home ag catheter is not catheterized 's clinical condition indicates was necessary; and				

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 23 of 44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE S  COMPL				
		00602	B. WING		04/2	6/2018
	NAME OF PROVIDER OR SUPPLIER  VIEWCREST HEALTH CENTER  3111 CH DULUTH			STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	B. a resident wh receives appropriat prevent urinary trac	ge 23 no is incontinent of bladder e treatment and services to t infections and to restore as er function as possible.	2 910			
	by: Based on observati review, the facility facares were provided (R33) reviewed for	ent is not met as evidenced on, interview, and document ailed to ensure incontinent d timely for 1 of 3 residents pressure ulcers.		Corrected.		
	beginning at 7:41 a room, R33 had bee slightly to the right of approximately 30 deregistered nurse (R give oral medication bed up to approximadministered medic of the bed to approximately 30 definition of the right of the righ	continuous observations .m. when staff exited R33's In lying quietly in bed, tilted with the head of the bed at egrees. At 8:31 a.m. N)-B entered R33's room to us, and raised the head of the ately 90 degrees. RN-B eations, then returned the head kimately 30 degrees. RN-B did d toileting needs, or if she was intinued to lay in her bed tilted with the head of her bed at egrees until 10:30 a.m. (2 es without being checked and ed, nursing assistant (NA)-G NA-E had changed R33 and bout 8:30 a.m. When informed itioned at 7:40 a.m. and had or changed since that time, buld call a nurse to meet her in				

6899

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	
		C <b>04/26/2018</b>
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	E OF PROVIDER OR SUPPLIER	
VIEWCREST HEALTH CENTER  3111 CHURCH STREET  DULUTH, MN 55811	WCREST HEALTH CENTER	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	FIX (EACH DEFICIENCY MU	D BE COMPLETE
2 910  Continued From page 24  On 4/25/18, at 10:36 a.m. RN-B and NA-E entered R33's room to reposition her. R33's incontinent brief was wet, and was opened by NA-E. NA-E cleansed R33's perineal area with a cleansing wipe. NA-E finished dressing R33 and got her up in the wheelchair.  R33's Face Sheet printed 4/26/18, indicated R33's diagnoses included dementia with behavioral disturbances, encephalopathy (brain disease or brain injury), restlessness and agitation, and diabetes mellitus type 2.  R33's quarterly Minimum Data Set (MDS) dated 3/2/18, indicated R33 had severe cognitive impairment, and had no rejection of cares during the assessment period. The MDS further identified R33 was frequently incontinent of bladder and always incontinent of bowel, was at risk for pressure ulcers, and had moisture associated skin damage.  R33's Care Area Assessment (CAAs) dated 12/4/17, indicated R33 had an impaired mobility and functional ability, and required staff assist with toileting. The CAA further indicated R33 was exposed to incontinent brief to wick excess moisture away for the skin, and was checked and changed or toileted every two hours and as needed. R33's CAA also indicated R33 was at risk for diarrhea related to medications. R33 was to have a barrier cream applied with any noted redness after incontinent brief to wick excess moisture away from the skin.  R33's care plan initiated 9/15/17, indicated R33 was at risk for skin breakdown related to impaired	On 4/25/18, at 10:36 a entered R33's room to incontinent brief was w NA-E. NA-E cleansed cleansing wipe. NA-E got her up in the wheel R33's Face Sheet print R33's diagnoses inclubehavioral disturbance disease or brain injury agitation, and diabetes R33's quarterly Minima 3/2/18, indicated R33 impairment, and had refer the assessment periodidentified R33 was free bladder and always in risk for pressure ulcert associated skin dama. R33's Care Area Asse 12/4/17, indicated R33 and functional ability, a with toileting. The CAA exposed to incontinen but wore an incontinen but wore an incontinen but wore an incontinen but wore an incontinen but wore a barrier crear redness after incontine incontinent brief to with from the skin.	

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 25 of 44

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED	
		00602	B. WING		<b> </b>	C <b>26/2018</b>
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	K	MN 55811	.1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 910	incontinence. The cor check and change needed. R33's care to include R33 had staff to check and conclude R33's Care Card (nundated, directed severy two hours.  On 2/19/18, R33's R33's risk for press to a moderate risk was a moderate risk was resistance to On 4/25/18, at 10:5 should be checked and stated she had had given her medical conclusion. On 4/25/18, at 11:0 of her room in her respositioned R33 at should be changed verified she was late. On 4/25/18, at 2:14 initially had moisture (MASD).  On 4/26/18, at 2:00 (DON) stated staff was that is what they	care plan directed staff to toilet ge R33 every two hours and as a plan was updated on 4/18/18, a history of refusing to allow change resident when soiled.  ursing assistant care guide) taff to check and change R33  Braden Scale score indicated ure injuries had increased due with increased moisture.  es lacked documentation of cares and repositioning.  1 a.m. RN-B verified R33 and changed every two hours not checked R33 when she cations earlier.  7 a.m. NA-E brought R33 out high back reclining Broda chair, at approximately 45 ed she had changed and 17:40 a.m. and stated R33 every two hours. NA-E e.  4 p.m. RN-G stated R33 e associated skin damage  p.m. the director of nursing were to follow the Care Cards, have access to.	2 910			
		are Planning revised 10/17, the expectation that staff				

6899

Minnesota Department of Health STATE FORM

O2WN11 If continuation sheet 26 of 44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  (X3) DATE COMP			SURVEY PLETED	
			7. BOILDING.			
		00602	B. WING			26/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTER	₹	RCH STREE MN 55811	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 26	2 910			
	would follow the resplan.	sident's comprehensive care				
	The Director of Nurdevelop, review, an procedures to ensu incontinent receive directed by the care. The Director of Nurdeducate all appropriocedures. The Director of Nurdevelop monitoring compliance.	HOD OF CORRECTION: sing or designee could d/or revise policies and re residents who are cares and services as a plan. sing or designee could iate staff on the policies and sing or designee could systems to ensure ongoing				
2 920		5 Subp. 6 B Rehab - ADLs	2 920			6/4/18
	comprehensive resi home must ensure B. a resident who activities of daily livi	is unable to carry out ing receives the necessary in good nutrition, grooming,				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview, and document ailed to offer oral cares for 1 of eviewed for personal cares.		Corrected.		
	Findings include:					
	R89's Face Sheet p	printed 4/26/18, identified				

6899

Minnesota Department of Health STATE FORM

O2WN11 If continuation sheet 27 of 44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7. BOILDING.			:
		00602	B. WING		1	6/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	RCH STREE	Т		
(VA) ID	SLIMMADV STA	ATEMENT OF DEFICIENCIES	MN 55811	PROVIDER'S PLAN OF CORRECTI	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ige 27	2 920			
	diagnoses that incl	uded dementia.				
	2/19/18, indicated F cognition, and requipersonal hygiene. Thad obvious or like	num Data Set (MDS) dated R89 had moderately impaired ired extensive assistance with The MDS further indicated R89 ly cavities or broken natural pleeding gums, or loose natural				
	lower dentures, and teeth and gums, and The care plan direct with a soft brush in bedtime cares. The staff to set up a too	ted 9/30/14, indicated R89 had d the potential for changes in and had her own upper teeth. Sted staff to brush R89's teeth the morning and during a care plan further directed outhbrush, and paste for the er own remaining teeth.				
	R89's care card (nursing assistant care guide) undated, indicated R89 required assistance with activities of daily living (ADLs), and she had her own teeth.					
	continuously observations room to assist R89 Continuous observations cocurred until 9:20 breakfast to R89 in or provide oral care continued until 11:3 to the dining room to observations resum wheeled R89 from fair, where R89 brothe hair dresser cal	o a.m. until 7:15 a.m. R89 was ved. R89 was in bed, asleep. g assistant (NA)-C entered the with getting up for the day. ations of R89's morning cares a.m. when NA-C brought her room. NA-C did not offer as to R89. Observations by p.m. when NA-C took R89 for lunch. Continuous ned at 12:13 p.m. when NA-D the dining room to the book towsed until 12:35 p.m. when me and got R89. Neither NA-C r provided R89 with oral cares.				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			,
		00602	B. WING		04/2	6/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	RCH STREE MN 55811	T		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 28	2 920			
		6 p.m. NA-C confirmed she to R89, but stated R89 didn't it didn't matter.				
	stated she would ex	p.m. registered nurse (RN)-F xpect NAs to offer residents nwash or a toothette for oral				
	(DON) stated she e brush around in a r	p.m. the director of nursing expected staff to rinse and esident's mouth in the and after meals if needed.				
	The facility's Oral Hygiene policy dated 6/30/13, directed to cleanse the mouth, teeth and dentures to prevent infection and irritation, to moisten the mucous membranes, and to promote personal hygiene. The policy directed staff to offer oral hygiene before breakfast, and at bedtime.					
	The Director of Nur develop, review, an procedures to ensu- cares. The Director of Nur educate all appropr procedures. The Director of Nur	THOD OF CORRECTION: rsing or designee could ad/or revise policies and are residents are offered oral rsing or designee could riate staff on the policies and asing or designee could rsing or designee could systems to ensure ongoing				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 980	MN Rule 4658.0609 service; Director	5 Subp. 2 Director of dietary	2 980			6/4/18

6899

Minnesota Department of Health STATE FORM

O2WN11 If continuation sheet 29 of 44

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE : COMPI	
			A. BOILDING.		C	
		00602	B. WING			, 6/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	RCH STREE MN 55811	ET .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 980	dietitian is not empladministrator must service who is enrominimum, a dietary receives frequently qualified dietitian. consultation must be the nursing home. hired before May 28 complete a dietary.  This MN Requirements by: Based on interview facility failed to ensicertified and creder preparation and serpotential to affect a food from the kitched. Findings include:  On 04/26/18, at 12: (DM)-C stated that manager. DM-C stated that manager. DM-C stated that manager. On 04/26/18, at 3:3 stated that DM-C when the signed off on paper dietary manager transministrator stated facility's contracted.	of dietary service. If a qualified loyed full time, the designate a director of dietary elled in or has completed, at a manager course, and who scheduled consultation from a The number of hours of the based upon the needs of Directors of dietary service ellegations, are not required to manager course.  The number of hours of the based upon the needs of Directors of dietary service ellegations, and the dietary manager was entialed to oversee food envice in the kitchen. This had ellegations who consumed entire is not a certified dietary ellegation and the ellegation between the dietary manager training, and her back from them.  The pure the administrator as hired in December 2017, that ellegation is the total certified ellegation in the treatment of the total pure the dietary and the registered dietician, and the registered dietician, and the registered dietician, and the	2 980	Administrator and/or designee will implement corrective action for thi practice by: -Removing current Dietary Managrole. Administrator and/or designee will residents having potential to being affected by this practice including: -All residents have poter be impacted by this practice. Administrator and/or designee will implement measure to ensure this practice does not reoccur including: - A clinically qualified nutrition professional licensed by the state Minnesota will be recruited to fulfil responsibilities of Dietary Director time role. A registered dietitian regassessments and provides direction relates to resident nutrition and therapeutic diets. Administrator and Assistant Dietary Managers will over budget and purchasing of food and	er from assess ntial to g: of I the in a full views on as it od versee d	
		d dietitian if he has questions.		supplies, food preparation, service storage during recruitment and		

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 30 of 44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00000	B. WING	R WING		C <b>04/26/2018</b>	
		00602			04/2	6/2018	
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
VIEWCR	EST HEALTH CENTE	<b>-</b>	RCH STREE MN 55811	:T			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
2 980	Continued From page 30		2 980				
	dated 2/19/13 including dietary director must approved Dietary M State and Federal r SUGGESTED MET The Administrator or review, and/or revisensure the Dietary I qualifications for the Administrator of appropriate staff on	HOD OF CORRECTION: or designee could develop, e policies and procedures to Manager has the proper e position. or designee could educate all the policies and procedures. or designee could develop		onboarding.  Administrator and/or designee will corrective actions to ensure effecti of these actions including: -Monitoring will be reported to QAF committee quarterly and as neede QAPI committee will make recommendations for ongoing mon	veness Pl d. The		
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21375	Program  Subpart 1. Infection home must establish	on Subp. 1 Infection Control; on control program. A nursing the and maintain an infection signed to provide a safe and ant.	21375			6/4/18	
	by: Based on observati review, the facility fa stored appropriately reviewed for infectio facility failed to ensi incontinent product transported for 1 of	ent is not met as evidenced on, interview, and document ailed to ensure a bedpan was y for 1 of 1 residents (R40) on control. In addition, the ure soiled linen and s were properly handled and 1 residents (R46) reviewed y living. In addition, the facility		Corrected.			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00602	B. WING		l l	C <b>26/2018</b>
	PROVIDER OR SUPPLIER	3111 CHU	DRESS, CITY, S RCH STREE <sup>-</sup> MN 55811	TATE, ZIP CODE <b>T</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21375	failed to ensure har 2 of 4 residents (R8 personal cares.  Findings include:  On 4/24/18, at 1:05 put the bedpan awastated the bedpan bedside stand, and her over bed table.  R40's annual Minim 3/12/18, indicated the hemiplegia (paralyshemiparesis (weak The MDS indicated The MDS also indicated the miplegia (paralyshemiparesis (weak The MDS also indicated the MDS als	and hygiene was maintained for 39, R49) observed during  appearance of p.m. R40 stated staff do not any after she has used it. R40 was currently sitting on her there are times staff put it on the sis on one side of the body) or ness on one side of the body). R40 was cognitively intact. Cated R40 had occasional ce, and was always continent of further indicated R40 assistance with toilet use that bedpan, and clothing  appearance on the top of R40's bedside that been there since she had good R40 stated staff had rinsed the bathroom, and set it on the obstated the bedpan was left er on her bedside stand, her ght next to my ice tea" or on the stated the over bed table down to her ice tea and the stated the over bed table down toilet. R40 stated it	21375			

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 32 of 44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00000	B. WING			C <b>04/26/2018</b>	
		00602	l .		04/2	26/2018	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
VIEWCR	EST HEALTH CENTE	R	IRCH STREE MN 55811	:1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
21375	Continued From pa	nge 32	21375				
	embarrassed her when she had company. "It's not in the proper place where it should be."						
	On 4/26/18, at 2:16 p.m. the director of nursing (DON) stated bedpans should not be left out unless the resident requested it be left out.						
	Equipment policy d should be rinsed wi should be washed	ing/Disinfecting Resident Care ated 6/5/17, directed bedpans ith cool water. The surface with a disinfectant solution, er, set out to dry, and stored in					
	R46's quarterly MDS dated 2/23/18, indicated R46 required extensive assistance of one to two staff with activities of daily living including toilet use. In addition, the MDS indicated R46 was frequently incontinent of both bowel and bladder.						
		dated 4/26/18, identified uded generalized muscle nal stenosis.					
	required extensive toilet use, and pers directed staff to pro	ted 4/20/18, indicated R46 assistance with bed mobility, onal hygiene. The care plan ovide assist of one to two staff es including toilet use and					
	was observed to was soiled incontinent phand. NA-B walked the soiled utility roo At 9:58 a.m. NA-B normally she would pad in a plastic bag	is a.m. nursing assistant (NA)-B alk out of R46's room holding a bad and a towel in her gloved I down the hallway and into to om. was interviewed and stated I have the soiled incontinent g, carrying it not bagged this the thing." NA-B verified the					

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 33 of 44

Minnesc	<u>ita Department of He</u>	ealth	_			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						:
		00602	B. WING		1	6/2018
						0.2010
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VIEWCR	VIEWCREST HEALTH CENTER 3111 CH			T		
		DULUTH,	MN 55811			
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
		,		DEFICIENCY)		
21375	Continued From pa	go 22	21375			
21373	Continued From pa	ge 33	21373			
		s soiled with urine. NA-B also				
	stated she was not supposed to walk in the					
	hallways wearing so	oiled gloves.				
	0 4/05/40 17.04					
		a.m. NA-A was observed go				
		d left the door open. From the				
		observed to approach R46 going to change R46's				
		R46 had requested to be				
		astened the incontinent brief				
		pen, removed the soiled				
		nd threw it on the floor. NA-A				
		nd applied a clean incontinent				
		vered the bed, covered R46,				
		hands and left the room. At				
	7:38 a.m. NA-A was	s interviewed. NA-A stated,				
		do that. [R46] insisted I had to				
		ere and then. The trash can				
		at times I would set the pad				
	inside the plastic ba	ag at the bottom of the bed."				
	On 4/05/40 at 4:00	n no registered name (DNI) A				
		p.m. registered nurse (RN)-A				
		kpect staff to bag soiled s in the room, not to throw				
		roducts on the floor. RN-A				
		ould not be walking in the				
	hallways with glove	•				
	On 4/25/18, at 1:37	p.m. the DON stated she				
		would not throw soiled				
	incontinent product	s on the floor, and stated				
		roducts were to be bagged in				
		nging them out of the room.				
	The DON					
	<b>-</b>	III II I I I I I I I I I I I I I I I I				
		andling policy revised 3/20/17,				
		ndle all soiled linen as though it				
	was potentially infe	cuous.				
	R89's Face Sheet p	printed on 4/26/18, identified				

STATE FORM 6899 If continuation sheet 34 of 44 O2WN11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					С	
		00602	B. WING		04/2	6/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	MN 55811	T .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	diagnoses that inclupulmonary disease R89's annual MDS had moderately impextensive assistant hygiene and toiletin R89 was always incompleted incontinence congestive heart fa R89's care plan dire hours during the dat two hours during the R89's Care Card (rundated indicated for bladder and bow every three hours, and observed to enter for cares. NA-C and N toilet with the assis machine. NA-C dor paper, then a warm movement (BM) fro visible on the toilet NA-C used a towel doffed her gloves, an hygiene, NA-C touc attach it to the mach handles to position touched the sling a R89, and straighter	uded chronic obstructive (COPD), and dementia.  dated 2/19/18, indicated R89 paired cognition, and required be for transferring, personal ag. The MDS further indicated continent of bladder, and directed staff to toilet every three ay, and check/change every the night.  The second s	21375			
		ned hand hygiene or not after				

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 35 of 44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		С	
		00602	B. WING			26/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	JRCH STREE MN 55811	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21375	Continued From pa	nge 35	21375			
	•					
	on 4/25/18, at 1:13 p.m. RN-F confirmed hand hygiene should occur immediately after glove removal.					
		p.m. the DON confirmed ld occur immediately after				
		Hygiene policy revised 5/8/17, uld be washed after removing				
		orinted 4/26/17, indicated cluded vascular dementia, and rthritis.				
	indicated R49 had	nange MDS dated 3/8/18, severe cognitive impairment. cated R49 was frequently el and bladder.				
	preparing for mornia radio to request a incontinence brief of using a mechanica to a wheelchair. At flattened R49's bed incontinent brief wit cloth to wipe R49's onto his left side, wincontinent brief an can. NA-E proceed brief on R49. NA-F	4 a.m. NA-F was observed ing cares for R49. NA-F used assistance to get R49's changed, and to assist with I lift to transfer R49 from bed 10:21 a.m. NA-F lowered and I, and loosened R49's soiled th gloved hands. NA-F used a periarea. NA-E rolled R49 while NA-F removed the wet d placed it in a bag in a trash ded to put a clean incontinent and NA-E doffed their gloves,				
	NA-E worked toget then used a lift to m	n hand hygiene. NA-F and her to get a lift pad under R49, hove him from the bed to his				

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 36 of 44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
		00602	B. WING		C <b>04/26/2018</b>	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	₹	IRCH STREE MN 55811	ΞT		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	the gown he wore a shirt over his head. to get the shirt pulle appropriately on R4 her hands.  On 4/25/18, at 10:3 she had failed to waimmediately after dishe usually washes gloves, and has a spocket.  On 4/25/18, at 10:3 was her expectation doffing soiled glove  SUGGESTED MET The Director of Nur develop, review, an procedures to ensur procedures. The Director of Nur educate all appropriate procedures. The Director of Nur develop monitoring compliance.	as sleepwear, and NA-F put a NA-E and NA-F both worked ad down and situated 9's body. NA-E then washed 6 a.m. NA-E confirmed that ash or sanitize her hands offing her gloves. NA-E stated her hands after removing her mall bottle of sanitizer in her 8 a.m. the DON confirmed it a staff wash their hands after	21375			
21630	Medications; Destru		21630			6/4/18
	remaining in the nu	on of medications. ions of controlled substances rsing home after death or dent for whom they were				

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 37 of 44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00602	B. WING		C <b>04/26/2018</b>	
NAME OF			l	27ATE 7/D 00DE	04/2	10/2010
NAME OF	PROVIDER OR SUPPLIER		RCH STREE	STATE, ZIP CODE : <b>T</b>		
VIEWCR	REST HEALTH CENTE	R	MN 55811	••		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21630	prescribed, or any discontinued perma manner recommen or the consultant pl pharmacist must fur instructions and for kept on file in the n B. Unused por drugs remaining in death or discharge were prescribed or discontinued perma according to part 6 be returned to the p6800.2700, subpart destruction listing the medication, prescriperson destroying the witness to the destruction listing the clinical record.  This MN Requirem by: Based on observative review, the facility final patches were accurpotential diversion reviewed for medication.  Findings include:  R59's Face Sheet of diagnoses that inclusive sclerosis, and scolic R59's significant check (MDS) dated 3/14/10 opiod medication, as	controlled substance anently must be destroyed in a ded by the Board of Pharmacy narmacist. The board or the trinish the necessary ms, a copy of which must be ursing home for two years. Itions of other prescription the nursing home after the of the resident for whom they any prescriptions anently, must be destroyed 8800.6500, subpart 3, or must bharmacy according to part to 2. A notation of the he date, quantity, name of ption number, signature of the ruction must be recorded on the ruction must be recorded on the ruction must be recorded on the diled to ensure Fentanyl rately destroyed to prevent for 1 of 1 resident (R59) ation storage	21630	Corrected.		

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 38 of 44

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00602	B. WING			C <b>26/2018</b>
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	₹	RCH STREE MN 55811	T		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21630	Continued From pa	ge 38	21630			
	was almost constant, and rated the pain eight out of ten (with 0 as no pain and 10 rated as severe pain).					
	R59 had an order fo	Orders dated 2/14/18, indicated or the Fentanyl patch (opiod tch) 75 microgram (mcg)/hour.				
	On 4/25/18, at 2:13 p.m. a tour of the medication cart was completed with registered nurse (RN)-B. During the tour a narcotic box was observed with two unopened boxes of Fentanyl patches belonging to R59. RN-B stated she destroyed used Fentanyl patches by removing the used patch, and disposing of it in the Sharps container. Review of the narcotic log revealed from 4/1/18, to 4/22/18, R59 had received the Fentanyl patch five times. During this time, only twice had two nurses documented witnessing destruction of the patch.					
	(DON) verified docutwo nurses witness patches. The DON where the Sharps or removed from the rigidal pickup from an outs 3:43 p.m. the DON were taken downstathey were picked up RN-B was not follow.	p.m. the director of nursing umentation lacked evidence of ing the destruction of used stated she was not sure containers were stored once nedication cart while waiting side service for disposal. At stated Sharps containers airs to a unsecured room until of for disposal. The DON stated wing the facility policy for of Fentanyl patches.				
	dated February 201 nurses or a trained licensed nurse wou	nyl Patch Destruction policy 4, directed two licensed medication aide (TMA) and ld remove the patch from the				

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 39 of 44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP			SURVEY PLETED	
		00602 B. WING			1	C 26/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	₹	RCH STREE MN 55811	T		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21630	immediately destroy sewer system. Both destroying/wasting medication adminis SUGGESTED MET The Director of Nur develop, review, an procedures to ensu disposed of safely i The Director of Nur educate all appropr procedures. The Director of Nur develop monitoring compliance.	y (waste) by flushing down the staff removing and will sign off in the electronic	21630			
21805	MN St. Statute 144 Residents of HC Fa Subd. 5. Courteouresidents have the courtesy and respe employees of or pehealth care facility.  This MN Requirements: Based on observation review, the facility faprovided during car reviewed for activition the facility failed to by ensuring a urina	651 Subd. 5 Patients & ac.Bill of Rights  us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a ent is not met as evidenced on, interview, and document ailed to ensure privacy was es for 1 of 1 residents (R46) es of daily living. In addition, ensure dignity was maintained ry drainage bag was covered (R296) reviewed for urinary	21805	Corrected.		6/4/18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
					С	
		00602	B. WING		04/2	26/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	IRCH STREE MN 55811	:I		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21805	Continued From pa	nge 40	21805			
	catheter.					
	Findings include:					
		dated 4/26/18, identified uded generalized muscle al stenosis.				
	2/23/18, indicated F required extensive	nimum Data Set (MDS) dated R46 had intact cognition, and assistance of one to two staff ily living (ADLs) including toilet				
	R46's care plan dated 4/20/18, indicated resident required extensive assistance with bed mobility, toilet use and personal hygiene. The care plan directed staff to provide assist of one to two staff as needed with cares including toilet use and personal hygiene.					
	was observed go in door open. From the to approach R46 and change R46's incorrequested to be change incontinent brief with the soiled incontine applied a clean incollowered the bed, con hands and left the rinterviewed. NA-As the door to provide as the E-Z stand lift acknowledged the to provide for private					
		60 a.m. when R46 stated it sing if someone was able to				

Minnesota Department of Health

STATE FORM 6899 O2WN11 If continuation sheet 41 of 44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7. BOILDING.		С	
		00602	B. WING			6/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VIEWCR	VIEWCREST HEALTH CENTER 3111 CHU DULUTH,			T .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	5 Continued From page 41		21805			
	see her from outsid	le the room.				
	On 4/25/18, at 1:37 p.m. the director of nursing (DON) was interviewed and stated she would expect the staff to provide privacy by shutting the door during cares.					
	directed staff to pro resident privacy, inc assistance with per procedures. In addi help avoid things th	y policy revised 10/23/17, amote, maintain, and protect cluding bodily privacy during sonal cares and treatment ition, the policy directed staff to lat could be demeaning to the helping the resident to keep gs covered.				
		printed 4/26/18, indicated uded chronic kidney disease				
	R296's care plan dated 4/24/18, indicated R296 was at risk for complications such as urinary tract infections due to indwelling catheter use for urinary retention. R296's further directed staff to empty the catheter bas using aseptic technique, and keep the catheter bag below the level of the bladder. The care plan lacked direction on keeping the catheter bag covered.					
	from outside of the uncovered urinary	a.m. R296 was observed room, in bed, with the drainage bag hanging on the The drainage bag contained				
	from outside of the uncovered urinary of	p.m. R296 was observed room, in bed, with the drainage bag hanging on the The drainage bag contained				

6899

Minnesota Department of Health STATE FORM

O2WN11 If continuation sheet 42 of 44

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
						0				
		00602	B. WING		04/2	26/2018				
NAME OF	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 (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETE DATE						
21805	Continued From page 42		21805							
	On 4/25/18, at 6:56 a.m. R296 was observed from outside of the room, in bed, with the uncovered urinary drainage bag hanging on the outside of the bed. The drainage bag contained urine.									
	from outside of the uncovered urinary	a.m. R296 was observed room, in bed, with the drainage bag hanging on the The drainage bag contained								
	from outside of the uncovered urinary	a.m. R296 was observed room, in bed, with the drainage bag hanging on the The drainage bag contained								
	On 4/25/18, at 10:10 a.m. family member (FM)-A stated they asked staff about covering the catheter bag, and were told they were left uncovered.									
		4 p.m. registered nurse eter bags were not covered as in their room.								
	(DON) stated she was be covered whethe	a.m. the director of nursing would expect catheter bags to r a resident was in their room esident stated they did not								
		ter Care Policy undated, sure drainage bags were not lway.								
		THOD OF CORRECTION:								

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED					
		00602	B. WING			C <b>26/2018</b>					
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3111 CHURCH STREET  DULUTH, MN 55811											
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETE DATE							
21805	develop, review, an procedures to ensu privacy and are trea. The Director of Nur educate all appropr procedures. The Director of Nur develop monitoring compliance.	d/or revise policies and re residents are provided with	21805								

6899