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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: O2WN
Facility ID: 00602

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

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

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/06/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date:
Susan Frericks, HPR - SWS 06/14/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 06/14/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/01/2018
(L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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

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)

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, 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: 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
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

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

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(L3) **VIEWCREST HEALTH CENTER**
(L4) **3111 CHURCH STREET**
(L5) **DULUTH, MN** (L6) **55811**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/26/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Susan Frericks, HPR Social Work Specialist 05/30/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 05/31/2018 (L20)

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

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

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3. Both of the Above :

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01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by 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; <u>OR</u>
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; <u>OR</u>
- 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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 4/23/18, through 4/26/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 4/23/18, through 4/26/18, and complaint investigation(s) were also completed at the time of the standard survey. At the time of the survey, an investigation of complaint #H5414055 was completed and was found to be unsubstantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and	F 550		6/4/18

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

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	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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

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F 550	Continued From page 1 outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure privacy was	F 550	DON and/or designee will implement correction action for R46 and R296	

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F 550	Continued From page 2 provided during cares for 1 of 1 residents (R46) reviewed for activities of daily living. In addition, the facility failed to ensure dignity was maintained by ensuring a urinary drainage bag was covered for 1 of 1 residents (R296) reviewed for urinary catheter. Findings include: R46's Face Sheet dated 4/26/18, identified diagnoses that included generalized muscle weakness,and spinal stenosis. R46's quarterly Minimum Data Set (MDS) dated 2/23/18, indicated R46 had intact cognition, and required extensive assistance of one to two staff with activities of daily living (ADLs) including toilet use. 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. On 4/25/18, at 7:34 a.m. nursing assistant (NA)-A was observed go into R46's room and left the door open. From the hallway, NA-A was observed to approach R46 and stated she was going to change R46's incontinent brief, as R46 had requested to be changed. NA-A unfastened the incontinent brief with the door still open, removed the soiled incontinent brief, provided pericare and applied a clean incontinent brief. NA-A then lowered the bed, covered R46, washed her hands hands and left the room. At 7:38 a.m. NA-A was interviewed. NA-A stated she was not able to shut the door to provide privacy while providing cares,	F 550	affected by this practice by: -NA-A was verbally educated on 4/26/18 regarding need to ensure doors/curtains are closed prior to performing cares/toileting with resident in order to provide for privacy. -DON met with R46 on 5/1/18 to ensure that resident did not have any distress related to NA-A not closing door completely during toileting. -R296's catheter was permanently removed per MD order. -DON met with R296 on 5/1/18 to ensure that resident did not have any distress related to incidents of her not having her catheter bag covered. DON and/or designee will assess residents having potential to being affected by this practice including: -All residents have potential to be impacted by this practice. - All residents with catheters have potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: -Education will be provided to all Nursing Staff by DON or designee by 6/4/18 on our Dignity Policy and Catheter Care Policy, including addressing the need to provide bodily privacy during assistance with personal cares and treatment procedures and on ensuring catheter bags are not visible from the hallway. - Nurse Managers to review all residing residents with catheters to ensure they have proper coverage of catheter bag for dignity by 6/4/18. All resident's with	

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F 550	Continued From page 3 as the E-Z stand lift was in the way. NA-A acknowledged the door should have been closed to provide for privacy. On 4/25/18, at 10:50 a.m. when R46 stated it would be embarrassing if someone was able to see her from outside 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. The facility's Dignity policy revised 10/23/17, directed staff to promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal cares and treatment procedures. In addition, the policy directed staff to help avoid things that could be demeaning to the residents such as helping the resident to keep urinary catheter bags covered. R296's Face Sheet printed 4/26/18, indicated diagnoses that included 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. On 4/24/18, at 8:44 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.	F 550	catheters will have their care plans and care cards reviewed for accuracy by the Nurse Managers and updated to reflect ensuring catheter bag is not visible from the hallway by 6/4/18. DON and/or designee will monitor corrective actions to ensure effectiveness of these actions including: -Random audits of staff providing personal cares and treatment procedures to watch that they provide bodily privacy and to ensure catheter bags are not visible from doors of rooms will be done 3x/week x 4 weeks beginning the week of 5/21/18, then 2x a week x2 weeks, and monthly thereafter. -Monitoring will be reported to QAPI committee quarterly and as needed. The QAPI Committee will make recommendations as needed.	

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F 550	Continued From page 4	F 550		

On 4/24/18, at 2:21 p.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.

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.

On 4/25/18, at 9:24 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.

On 4/26/18, at 8:52 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.

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.

On 4/25/18, at 12:44 p.m. registered nurse (RN)-E stated catheter bags were not covered when a resident was in their room.

On 4/26/18, at 9:31 a.m. the director of nursing (DON) stated she would expect catheter bags to be covered whether a resident was in their room or not, unless the resident stated they did not want it covered.

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F 550	Continued From page 5 The facility's Catheter Care Policy undated, directed staff to ensure drainage bags were not visible from the hallway.	F 550		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accurately code the Minimum Data Set for 1 of 3 residents (R40) reviewed for dental concerns. Findings include: On 4/23/18, at 12:20 p.m. a chipped front denture tooth was visible when R40's spoke. R40 stated, "I have a chipped denture tooth in the upper jaw. They dropped it in the bathroom." R40's annual Minimum Data Set (MDS) dated 3/2/18, identified diagnoses that included hemiplegia or hemiparesis (weakness or paralysis on one side of the body) and dysphagia (difficulty swallowing). In addition, the MDS indicated on Section L that R40 had no natural teeth or tooth fragments, however the MDS lacked indication R40 had "Broken of loose fitting full or partial denture (chipped, cracked, uncleanable or loose)." R40's care plan dated 3/31/17, indicated R40 had both upper and lower dentures. The care plan indicated R40 had been offered and declined a	F 641	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 to 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 not reoccur including: -MDS coordinators will receive education by 6/4/18 on need to properly code all sections of the MDS. -All sections of current residents' most recent MDS will be reassessed by the MDS Coordinators to ensure accuracy of coding by 6/4/18. DON and/or designee will monitor corrective actions to ensure effectiveness	6/4/18

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F 641	Continued From page 6 dentist examination March 2018. R40's Oral Assessment dated 3/1/18, indicated R40 had both upper and lower dentures however, did not indicate the denture had a chipped tooth. On 4/25/18, at 8:45 a.m. R40 stated she had told the staff about the chipped tooth, and the staff assisted her twice daily with the dentures and saw they were chipped. R40 stated the dentures had been chipped for, "Awhile" and thought was in the last year when one of the nursing assistants was brushing/cleaning them at the sink when they dropped them. On 4/25/18, at 9:44 a.m. registered nurse (RN)-C (the MDS coordinator) stated RN-D had completed R40's MDS assessment, and based on that assessment, RN-C had signed off on the MDS indicating it was accurate. RN-C verified the MDS should have been coded to included the chipped denture tooth. RN-D acknowledged the MDS should have been coded accurately to reflect the actual oral status of R40. On 12/7/17, R40's Resident Summary with Comprehensive Progress Notes indicated R40 had full upper and lower dentures, the front tooth was broken, and social services was looking into getting fixed. On 4/25/18, at 1:35 p.m. the director of nursing (DON) stated she would expect all resident MDS assessments to be coded accurately to reflect the current resident status and care needs.	F 641	of these actions including: -Random audits of sections of the MDS's will be completed 3x/week x 2 weeks starting the week of 5/21/18, then 2x weekly x 2 weeks, then weekly thereafter by DON or facility designee to ensure accuracy of coding. -Monitoring will be reported to QAPI committee quarterly and as needed. The QAPI committee will make recommendations for ongoing monitoring.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		6/4/18

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F 677	Continued From page 7 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to offer oral cares for 1 of 3 residents (R89) reviewed for personal cares. Findings include: R89's Face Sheet printed 4/26/18, identified diagnoses that included dementia. R89's annual Minimum Data Set (MDS) dated 2/19/18, indicated R89 had moderately impaired cognition, and required extensive assistance with personal hygiene. The MDS further indicated R89 had obvious or likely cavities or broken natural teeth, inflamed or bleeding gums, or loose natural teeth. R89's care plan dated 9/30/14, indicated R89 had lower dentures, and the potential for changes in teeth and gums, and had her own upper teeth. The care plan directed staff to brush R89's teeth with a soft brush in the morning and during bedtime cares. The care plan further directed staff to set up a toothbrush, and paste for the resident to brush her 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. On 4/25/18, at 6:59 a.m. until 7:15 a.m. R89 was continuously observed. R89 was in bed, asleep.	F 677	DON and/or designee will implement corrective action for R89 affected by this practice by: -NA-C and NA-D were verbally educated on 4/26/18 on the need to offer oral care to all residents during AM and HS cares and after meals if needed. DON and/or designee will assess residents having potential to being affected by this practice including: -All residents have potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur: -All nursing staff will be educated by 6/4/18 on the Oral Hygiene Policy and need to provide oral care to all residents including those with dentures during AM and HS cares and after meals if needed. DON and/or designee will monitor corrective actions to ensure effectiveness of these actions including: -Random audits of oral hygiene being completed will be done 3x/week x 4 weeks beginning the week of 5/21/18, then 2x a week x2 weeks, then weekly thereafter by DON or facility designee to ensure oral cares being offered/completed. -Monitoring will be reported to QAPI Committee quarterly and as needed. QAPI will make recommendations for	

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F 677	Continued From page 8 At 7:15 a.m. nursing assistant (NA)-C entered the room to assist R89 with getting up for the day. Continuous observations of R89's morning cares occurred until 9:20 a.m. when NA-C brought breakfast to R89 in her room. NA-C did not offer or provide oral cares to R89. Observations continued until 11:39 p.m. when NA-C took R89 to the dining room for lunch. Continuous observations resumed at 12:13 p.m. when NA-D wheeled R89 from the dining room to the book fair, where R89 browsed until 12:35 p.m. when the hair dresser came and got R89. Neither NA-C nor NA-D offered or provided R89 with oral cares. On 4/25/18, at 12:56 p.m. NA-C confirmed she hadn't offer oral care to R89, but stated R89 didn't have any teeth, so it didn't matter. On 4/25/18, at 1:13 p.m. registered nurse (RN)-F stated she would expect NAs to offer residents with no teeth mouthwash or a toothette for oral cares. On 4/25/18, at 1:29 p.m. the director of nursing (DON) stated she expected staff to rinse and brush around in a resident's mouth in the morning, at night, 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.	F 677	ongoing monitoring.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		6/4/18

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F 684	Continued From page 9 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess for causes and develop care planned interventions for 1 of 1 residents (R89) reviewed with skin tears. Findings include: R89's Face Sheet, printed on 4/26/18, identified diagnoses that included: chronic obstructive pulmonary disease (COPD), and diabetes. R89's annual Minimum Data Set (MDS) dated 2/19/18, indicated R89 had moderately impaired cognition, and required extensive assistance with activities of daily living (ADLs). The MDS further indicated R89 had skin tears. R89's care plan dated 7/1/15, indicated R89 had a history of skin tears due to a history of falls, insulin, and a history of bumping into objects by accident. The goal was for R89 to be free from skin tears. Interventions included safety preventions as needed/ordered, and update the physician as needed. R89's care card (nursing assistant care guide) undated, indicated R89 required an assist of 2 staff for transfers with a sit-to-stand lift.	F 684	DON and/or designee will implement corrective action for R89 affective by this practice by: -NA-C, NA-D, and RN-E were educated on 5/1/18 on need to be observant of skin during ADLs and treatments. NA-C and NA-D were educated on 5/1/18 on need to notify nurse immediately of any skin issue or blood noted during cares. - R89 left elbow skin tear was assessed on 4/25/18 and a skin incident report was completed. Currently almost healed. DON and/or designee will assess residents having potential to being affected by this practice including: -All residents have potential to being impacted by this practice. DON and/or designee will implement measure to ensure this practice does not reoccur including: -All nursing staff will be re-educated on the Accident/Incident Policy and Skin Documentation Policy by 6/4/18, including the need to be observant during cares and treatments and to notify nurse immediately of any incident regarding skin or any blood noted during cares. DON and/or designee will monitor corrective actions to ensure effectiveness	

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F 684	Continued From page 10 On 4/25/18 at 6:59 a.m. R89 was continuously observed. At 7:43 a.m. nursing assistant (NA)-C and NA-D were observed to enter R89's room to 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 was seated on the toilet, NA-D left to go to another room and NA-C left to get supplies. R89 stated her arm got bumped when she came in the bathroom, it had hurt at the time, but didn't any more. At 7:50 a.m. bright red drops of blood were noted on the floor to the left of R89. At 7:52 a.m. NA-C noticed the blood and commented, "Oh, what is that? I don't know what that is from." NA-C did not check R89's skin, but continued to perform morning cares which included taking off R89's hospital gown and putting a dress over both of R89's arms, including the one that was bumped. At 7:59 a.m. NA-D returned to assist with R89's transfer off the toilet. Once R89 was off the toilet a skin tear was visible on R89's arm, just above the left elbow. NA-D was in a position to see the skin tear, but did not say anything. R89's dress had short sleeves, and did not cover the skin tear. At 8:46 a.m. registered nurse (RN)-E entered R89's room to check her blood glucose levels, and give her insulin. RN-E administered R89's insulin in her left arm, approximately 6 inches above the visible skin tear. At 9:03 a.m., NA-C entered R89's bathroom and stated, "I have no idea where that came from; it had to have been there." (in reference to the blood on the floor), and went to wipe it up. NA-C stated she did not hear R89 call out "Ow", during the transfer, did not know R89 had	F 684	of these actions including: -Random audits of NAR cares/nurse treatments will be done 3x/week x 4 weeks starting week of 5/21/18, then 2x weekly x 2 weeks, then weekly there after by DON or facility designee to ensure skin incidents/issues are assessed/reported. -Monitoring will be reported to QAPI committee quarterly and as needed. The QAPI committee will make recommendations for ongoing monitoring.	

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F 684	Continued From page 11 incurred a skin tear, and did not look for the source of the blood. On 4/26/18, at 10:35 a.m. RN-F stated the NAs should let the nurse know if they saw blood drops on the floor. RN-F stated they should not just wipe it up, they should investigate first and tell the nurse. On 4/26/18, at 12:00 p.m. the director of nursing (DON) stated she would expect NAs to tell a nurse if they saw blood on the floor. The DON stated her expectation is that the blood would be addressed. The facility Accident/Incident policy dated 1/8/18, directed an incident report is completed for skin tears with known or unknown origin. The facility Skin Documentation policy dated 12/19/13, directed staff to observe resident's skin daily with cares, and notify a licensed nurse with any skin alterations noted.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686		6/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 686 Continued From page 12 — F 686

promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to thoroughly assess and implement interventions to prevent the development and worsening of pressure ulcers for 1 of 3 residents (R33) reviewed for pressure ulcers. This resulted in actual harm for R33, who developed a pressure ulcer that worsened.

Findings include:

Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP):

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel.

Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar

Provider's plan of correction:

DON and/or designee will implement corrective action for R33 affected by this practice by:
-A new RCA was completed by the Nurse Manager for the skin alteration to Coccyx on 5/15/18.
- Based off of the new RCA and NP Assessment, skin Alteration to coccyx was changed to a pressure ulcer on 5/15/18.
-An updated tissue tolerance test in bed and w/c was completed on 5/2/18 and 5/3/18, indicating every 3 hour repositioning when in bed and every 2 hours positioning while sitting Care Sheets and Care Plan were updated to reflect these times.
-NP assessed/reviewed wound on 5/4/18 for the pressure ulcer to coccyx and continued treatment as ordered by MD.
- R33 Care Plan was reviewed on 5/2/18 for appropriate skin interventions to promote wound healing and prevent further skin breakdown with no changes made except for change in repositioning times.
- NA-G and NA-E were re-educated on 5/1/18 to ensure following R33 repositioning schedule per her care plan.
DON and/or designee will assess residents having potential to being affected by this practice including:
-All residents with shearing injuries or pressure ulcers.
DON and/or designee will implement measures to ensure that this practice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 686 Continued From page 13

obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

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 required extensive assistance of two staff for bed mobility, and total assist of two staff for transfers. R33's MDS further indicated R33 was frequently incontinent of bladder and always incontinent of bowel, was at risk for pressure ulcers, had no unhealed pressure ulcers, and had moisture associated skin damage. The MDS indicated R33 had a pressure reducing device in the chair and in bed, and was treated with ointments.

R33's Care Area Assessment (CAA) for a significant change MDS dated 12/4/17, indicated R33 was at low risk for skin breakdown per a 12/4/17, Braden Score (tool used to assist in

F 686

does not reoccur including:
-All current residents with shearing injuries or pressure ulcers will be reassessed for correct identification of skin alteration and to ensure appropriate treatments and interventions are in place to promote wound healing by 6/4/18.
-Education of all management nurses regarding corporate skin protocol and identification of pressure ulcers will be completed by 6/4/18.
-All Nursing Staff will be educated on the Care Plan Policy, in regards to ensuring the care plan interventions are being followed in regards to for skin by 6/4/18.
DON and/or designee will monitor corrective actions to ensure effectiveness of these actions including:
-Random audits of nursing skin assessments will be done 3x/week x 4 weeks starting week of 5/21/18, then 2x a week x 2 weeks, then weekly there after by DON or facility designee to ensure skin assessments/treatments are appropriate/effective.
-Random audits of ensuring residents care plan is being followed for skin interventions will be completed 5x/week x 2 weeks, starting the week of 5/21/18, then 4x/week x 2 weeks, then 3x/week x2 weeks, then 2x/week x 2 weeks, then weekly there after.
-Monitoring will be reported to QAPI committee quarterly and as needed. The QAPI committee will make recommendations for ongoing monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 686 Continued From page 14 F 686

identifying risk for pressure ulcers). R33's Tissue Tolerance Test (TTT, a tool used to assist in determining the ability of the skin and tissues to endure the effects of pressure without adverse effects) indicated R33 tolerated repositioning every 4 hours in the wheelchair, and every 3 hours when lying. R33's most current TTT was dated 11/29/17, through 11/30/17. R33's CAA indicated R33 had impaired mobility and functional ability. The CAA noted R33 had a pressure injury to the gluteus when in the hospital that was healed upon admission to the facility on 9/7/17. The CAA indicated R33 required staff assist with toileting and repositioning, had a problem for friction and shearing, but used a Hoyer (mechanical) lift for transfers, and a pad was used to assist with boosting to avoid shearing. The CAA further indicated R33 was exposed to incontinence of bowel and bladder, but wore an incontinent brief to wick excess moisture away from the skin, and was checked and changed or toileted every two hours, and as needed. The CAA indicated R33 was at risk for diarrhea related to medications, and R33 was noted to refuse cares at times. The CAA also indicated R33 had a pressure reduction cushion on the chair, and pressure redistributing/relieving mattress on the bed, was repositioned per the TTT results, and was toileted every two hours to help keep her dry. R33 was to have a barrier cream applied with any noted redness after incontinent episodes, an adult incontinent brief to wick excess moisture away from the skin, Prafo boots (a pressure-relief boot for patients with compromised mobility and at risk of developing pressure sores at the heel) to feet.

R33's care plan initiated 9/15/17, indicated R33 was at risk for skin breakdown related to impaired

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 15	F 686		

Continued From page 15

mobility and refusals of turning and repositioning, and incontinence. The goal was for R33 to remain free of pressure ulcers. R33's care plan directed staff to inspect skin weekly and observe daily with cares, provide Prafo boots on feet when up in chair, and a pressure reducing cushion on the chair. On 4/4/18, R33's care plan was updated to include: reapproach when R33 refused or was resistive to turning and repositioning. R33's care plan directed staff to turn and reposition per the tissue tolerance results to help prevent skin breakdown. In addition, R33's care plan was updated on 3/13/18, identified shearing to the coccyx, and directed the use of an alternating pressure mattress, turn side to side with repositioning, and position with a pillow, and ensure the head of the bed was not elevated beyond 45 degrees unless eating or drinking, and treat per physician orders. R33 was to be toileted or checked and changed every two hours and as needed.

R33's current undated Care Card (nursing assistant care guide) directed staff to turn and reposition R33 every two hours, position side to side with pillows when in bed, and Prafo boots were to be on when up in the wheelchair. The Care Card further directed staff to check and change every two hours and ensure the head of the bed was no higher than 45 degrees unless eating or drinking.

On 4/25/18, during continuous observations beginning at 7:41 a.m. when staff exited R33's room, R33 had been lying quietly in bed, tilted slightly to the right with the head of the bed at approximately 30 degrees. At 8:31 a.m. registered nurse (RN)-B entered R33's room to give oral medications, and raised the head of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 16	F 686		

bed up to approximately 90 degrees. RN-B administered medications, then returned the head of the bed to approximately 30 degrees. R33 continued to lay in her bed tilted slightly to the right with the head of her bed at approximately 30 degrees until 10:30 a.m. (2 hours and 49 minutes without repositioning) when surveyor stopped a nursing assistant to ask about R33's repositioning time. Nursing assistant (NA)-G stated she thought R33 had been repositioned about 8:30 a.m. when NA-E had changed her and washed her up. When informed R33 was last repositioned at 7:40 a.m. NA-G stated she would reposition her, and called a nurse to meet her in the room.

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. R33's right hip had no redness. R33 was turned to the right, and RN-B removed the dressing from R33's coccyx. The dressing had a small amount of clear pink drainage without odor. RN-B cleansed R33's ulcer with wound cleanser, and measured the ulcer at 0.5 cm x 0.5 cm x 0.3 cm. The wound edges were regular, except from 6 o'clock to 10 o'clock, and the wound bed was circular with yellow/white stringy slough covering it. RN-B stated the pressure ulcer would be a Stage 3. RN-B packed the wound with Iodoform packing strip, and covered with an Allevyn dressing. NA-E finished dressing R33 and got her up in the wheelchair. R33 had an alternating pressure mattress on her bed.

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, reclined at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 17	F 686		

approximately 45 degrees. NA-E stated she had changed and repositioned R33 at 7:40 a.m. that morning, and stated R33 should be repositioned every two hours. NA-E verified she had not repositioned R33 timely.

On 4/25/18, at 10:51 a.m. RN-B stated her previous statement regarding the staging of R33's pressure ulcer was incorrect, and stated it would be Unstageable pressure ulcer with the slough covering the wound bed. RN-B verified R33 should be repositioned every two hours, and stated she had not repositioned R33 when she had given her medications earlier. RN-B stated she thought R33 received the alternating pressure mattress, but was not sure.

On 12/28/17, at 2:30 a.m. a progress note indicated R33 had been up in the wheelchair at the beginning of the nurse's shift at 6:00 p.m. R33 was agitated and yelling at other people. Resident yelled out, "Ow, ow, ow," and when asked where she hurt, replied, "My butt!" Resident was laid down in bed per her preference, and once in bed, R33's behaviors ended and she rested. The progress note lacked indication if R33's skin had been observed at that time.

On 1/10/18, a physician progress note indicated R33's skin had no hyperpigmentation (darkened skin), vitiligo (skin that lacked pigmentation), or suspicious lesions; but lacked any other skin concerns.

On 1/18/18, R33's progress notes and Skin Condition/Wound Progression note indicated R33 had multiple areas of blanchable redness on the buttocks and perineal area, and a small open

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 initiated 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 was 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 was irregularly shaped, very superficial, and	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 19	F 686		

measured 0.8 cm x 0.7 cm. The coccyx wound base continued to be shiny granulation tissue, with white tissue surrounding the wound, though wound edges were normal skin color and blanchable.

On 2/5/18, R33's Skin Condition/Wound Progression note indicated R33's coccyx wound was circular shaped and very superficial measuring 0.6 cm x 0.6 cm with yellow slough tissue (yellow devitalized tissue, that can be stringy or thick, and adherent on the tissue bed) in the wound base. Wound edges were normal skin color and blanchable. R33's treatment continued to be the same.

On 2/16/18, R33's Skin Condition/Wound Progression note indicated 33's coccyx wound was circular shaped, measured 0.8 cm x 1.0 cm, was very superficial, though it had white slough tissue on the wound bed. The wound edges were normal skin color, and blanchable.

On 2/16/18, R33's progress notes indicated R33's coccyx wound was larger in size with some depth noted to 75% of the wound bed, and had slough. R33's progress note indicated there were two purple linear areas noted to the right buttock, but were not open. The provider was updated through the rounding book. Staff were instructed to provide side to side positioning for R33, and to lay her down after meals. An addendum to the note, indicated an occupational therapy evaluation of the wheelchair cushion was requested.

On 2/19/18, R33's Braden Scale score indicated R33's risk for pressure injuries had increased to a moderate risk with increased moisture.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 20	F 686		

On 2/19/18, R33's progress note referencing the quarterly MDS assessment, indicated R33 required extensive to total assist of two staff for toileting, and was frequently incontinent of bowel and bladder. The note indicated R33 had a moisture associated lesion to her coccyx, and she was checked and changed every two hours and as necessary, which was determined to remain appropriate. R33's documentation noted, "After speaking with the RN [registered nurse] MGR [manager] she had re-educated staff on the importance of following the care card/care plan of every 2 hrs [hours] toileting and lesion had then improved with staff compliance (when looking again after the re-education completed)." No changes were made to R33's care plan at that time.

On 2/22/18, R33's Skin Condition/Wound Progression note indicated R33's coccyx wound had some depth, and measured 1 cm x 1.2 cm x 0.2 cm, and appeared as "Kissing ulcers." These had a pink/red and moist wound base, and the wound edges were normal skin colored and blanchable. R33's buttocks were noted to have areas of very dry and peeling skin along with pin-point macerated areas. The wound care nurse assessed R33's skin on that date, and suggested application of 50/50 Calazime (helps treat and prevent diaper rash, wet and cracked skin) and Vaseline cream to the buttocks with incontinent cares. The note further indicated the nurse practitioner was to be updated with requests of new orders the following day.

On 3/1/18, R33's Skin Condition/Wound Progression note indicated R33's, "Moisture lesion" appeared as one open area and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 21 measured 1 cm x 1.2 cm x 0.1 cm. R33's wound base was pink and red and moist, with white and macerated looking irregular edges. R33's other macerated areas were healed. The same treatment was continued. On 3/7/18, R33's physician progress notes indicated R33 had no hyperpigmentation, vitiligo, or suspicious lesions. The note lacked any other skin concerns. On 3/15/18, R33's Skin Condition/Wound Progression note indicated R33's coccyx wound measured 1.1 cm x 0.8 cm x 0.1 cm, and appeared less moist with a pink-red sound base. R33's wound edges were white or pink, macerated and irregular. On 3/20/18, R33's Skin Condition/Wound Progression note indicated R33's coccyx wound measured 1.1 cm x 0.8 cm and the depth from 12 o'clock to 6 o'clock measured 0.1 cm, and the remainder measured 0.3 cm. R33's wound base was pink and dry, and wound edges were pink, irregular, and slightly firm to touch. R33's care plan was updated to turn and reposition R33 from side to side only. On 3/28/18, an occupational therapy (OT) discharge summary indicated R33 had been treated from 3/1/18, through 3/28/18, for positioning equipment. R33's goals included: R33 would be provided with a specialized wheelchair cushion that would provide optimal weight distribution, off loading ability, encourage upright posture, and pressure relief to reduce the chance of further skin integrity issues. It was noted that R33 had a moisture lesion on the coccyx that had worsened, and R33 refused to	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 22	F 686		

lay on side for pressure relief. R33 was non-ambulatory, and sat on a gel/foam cushion on the wheelchair. R33 was provided with an appropriate cushion to provide pressure relief, and improve skin integrity and weight distribution.

On 4/6/18, R33's Skin Condition/Wound Progression note indicated R33's "Moisture lesion" measured 1 cm x 0.7 cm x 0.2 cm with a pink wound base and irregular, firm, pink edges. R33's treatment remained the same.

On 4/10/18, R33's nurse practitioner progress notes indicated R33 was seen for follow up of nutritional assessment to support wound healing. R33's progress note indicated she was up in the dining room waiting for brunch. The note indicated R33 had a "Moisture associated wound on her coccyx that has been slowly healing, possible cause is abrasion secondary to shearing." It was noted that barrier cream had been used over the last two weeks, nursing was attempting to keep resident as dry as possible with incontinence, and the wound had areas of maceration. R33's progress note indicated a supplement had been initiated to support healing. R33's progress note documented a "Decubitus coccyx ulcer (pressure ulcer), unspecified staging," and directed the nurse manager to initiate follow up if skin breakdown worsened.

On 4/11/18, R33's Skin Condition/Wound Progression note indicated R33's coccyx wound measured 0.8 cm x 0.7 cm x 0.2 cm, with a pink, dry wound base, and pink, irregular, firm edges, that appeared as scar tissue. R33's treatment remained the same.

On 4/16/18, R33's Skin Condition/Wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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

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F 686	Continued From page 23 Progression note indicated R33's coccyx "Moisture lesion" measured 0.8 cm x 0.7 cm x 0.5 cm with a pink, dry base, with white, firm, irregular, macerated appearing edges, that appeared to be scar tissue. On 4/20/18, R33's Skin Condition/Wound Progression note indicated R33's "Moisture lesion" measured 0.8 cm x 0.7 cm x 0.5 cm with a pink wound base that was not moist, and had white, macerated and irregular, slightly firm edges. R33's note indicated the physician was updated with a request to change the wound care orders. The physician was noted to have ordered, "Cleanse wound with wound cleanser and pat dry. Pack wound with Iodoform 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.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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

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F 686	Continued From page 24	F 686		

R33 had been observed to be scooting 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 shearing injury. RN-B agreed that a shearing injury was a pressure related injury.

On 4/25/18, at 2:14 p.m. RN-G confirmed she had looked at R33's pressure ulcer because it had gotten worse, so she recommended a change in treatment. RN-G stated it was now getting better. RN-G stated she questioned whether staff had been rubbing the barrier cream off, and then noticed undermining of the wound. RN-G stated the head of R33's bed had been elevated too high, and the pressure ulcer had developed more depth. RN-G stated R33 initially had moisture associated skin damage (MASD), rather then shearing. RN-G stated that undermining of a pressure ulcer was classic shearing. RN-G stated R33 had an alternating pressure mattress, and a turning and repositioning program, and it had been determined that R33 did not have unsustained pressure. RN-G verified R33 should be turned and repositioned every 2 hours, and stated the facility had been doing audits on repositioning about three to four weeks ago, and all the audits on that unit had come back showing no concerns. RN-G stated the facility did assessments with a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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

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F 686	Continued From page 25	F 686		

root cause analysis, and the doctor signed off on them, and R33's MD had signed off on hers. RN-G stated the facility does measurements, documents appearance, drainage, treatment, and faxes the information to the physician. The physician group takes pictures of the wounds.

On 4/26/18, at 11:32 a.m. the nurse practitioner (NP)-E was interviewed and verified she had not looked at R33's pressure ulcer, and stated she had not been notified of the worsening and the depth of the pressure ulcer. NP-E stated she was unaware that it was a, "Hole" and an ulcer, and stated she went by the information provided by the nurses. NP-E verified shearing can cause a pressure injury. NP-E stated if there is slough, the pressure ulcer would be considered unstageable. NP-E stated she expected to be informed of the worsening and condition of the pressure ulcer, and verified she would need to look at it, and the pressure ulcer would need to be identified correctly, so it can be treated appropriately. NP-E stated she was unaware that a physician had ordered the packing of the wound, and did not know if the physician had looked at the wound.

On 4/26/18, at 11:34 a.m. RN-G stated R33 had moisture, was incontinent, and her bed had been at 45 degrees, so R33's pressure ulcer was determined to be from moisture and shearing.

On 4/26/18, at 11:45 p.m. NP-E verified barrier ointments would not treat the inside or the base of the pressure ulcer. NP-E stated the wound needed to heal from the inside out.

On 4/26/18, at 2:00 p.m. the director of nursing (DON) was interviewed and stated the nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 26 manager does a root cause analysis of skin impairments, and determines what the injury could be caused from. It was determined R33's coccyx wound was from moisture, and then on 4/23/18, it had gotten worse. R33's Braden score had changed, and the head of her bed was noted at 90 degrees, causing shearing and undermining. When asked about the increased depth and slough noted in R33's wound in February, the DON stated it was not pressure related, but was from sliding down in bed. The DON said at that time it was noted R33's Braden score had changed, and an alternating pressure mattress was implemented. The DON stated audits were done on R33's repositioning, and indicated repositioning had been done on time. That was how the facility determined R33's wound was a shearing injury. The DON stated also, the head of R33's bed was elevated at 90 degrees and she was sliding down. The DON stated the facility did not feel R33's pressure ulcer was pressure related. The DON was asked about the treatment of the pressure ulcer and if barrier cream was appropriate to treat the pressure injury. The DON replied the nurse manager noted the treatment needed to be changed, and new orders were obtained. Their wound nurse looked at it, and made recommendations. When asked about the slough, and if the barrier cream was appropriate to treat that, the DON replied the physician and nurse practitioner addressed it and agreed to the treatment, and the NP stated it had been addressed. The DON stated they have nurses who are wound certified and are trained annually. The DON stated the staff are to follow the Care Cards, as that is what they have access to. The DON stated skin assessments should be done when there is a new open area. The DON stated R33 had been resistive to reposition and	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 27 cares in the past, but was less resistive now. The DON stated resistive behaviors should be documented, and followed up on. The Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/17, indicated pressure ulcers occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force, and friction are important contributors to pressure ulcer development. The underlying health of a resident's soft tissue affects how much pressure, shear force, or friction is needed to damage tissue. Skin and soft tissue changes associated with aging, illness, small blood vessel disease, and malnutrition increase vulnerability to pressure ulcers. Additional external factors, such as excess moisture, and tissue exposure to urine or feces, can increase risk. Key areas for pressure ulcer development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear or friction, are also at risk for pressure ulcers. The facility policy and procedure for Skin Documentation dated 6/30/17, directed a resident who enters the facility without a pressure sore will not develop a pressure sore unless their clinical condition demonstrates that it was unavoidable and a resident who had a pressure sore would receive necessary treatment and services to promote healing. The policy and procedure directed nursing to complete a Braden Scale and Tissue Tolerance Test lying and sitting upon admission, quarterly, and annually and with any significant changes, and the Braden would also be done for the first four weeks after admission.	F 686		

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	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 28 The nurse manager would assess risk factors for impaired skin integrity and/or delayed wound healing and would document the identified risk factors, and implement appropriate interventions to prevent skin alterations and/or promote wound healing. The nurse manager was to would update all necessary departments of any risk factors associated with that department. The primary care physician would be notified within 24 hours of any new skin alterations, except when the physician requests to be notified on routine rounds only. The All wound would be reviewed and discussed with the interdisciplinary team weekly and as necessary, wound nurse or nurse manager would assess all pressure ulcers, venous ulcers, and other wounds of concern weekly, and if no improvement with wounds within 2 to 4 weeks, a new treatment would be tried if necessary. Nursing staff to document any non-compliance by the resident with the recommended interventions and education provided to the resident. The facility policy and procedure for Care Planning revised 10/17, directed that it is the expectation that staff would follow the resident's comprehensive care plan.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		6/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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F 690	Continued From page 29 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure incontinent cares were provided timely for 1 of 3 residents (R33) reviewed for pressure ulcers. Findings include: On 4/25/18, during continuous observations beginning at 7:41 a.m. when staff exited R33's room, R33 had been lying quietly in bed, tilted slightly to the right with the head of the bed at	F 690	DON and/or designee will implement corrective action for R33 affected by this practice by: -NA-E and NA-G were verbally educated on 5/1/18 on need to follow resident's individualized schedule for toileting residents. -R33's toileting plan was reviewed with resident appropriate for check and change every 2 hours and prn. Care Plan and NAR Care Sheets were reviewed for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

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F 690

Continued From page 30

approximately 30 degrees. At 8:31 a.m. registered nurse (RN)-B entered R33's room to give oral medications, and raised the head of the bed up to approximately 90 degrees. RN-B administered medications, then returned the head of the bed to approximately 30 degrees. RN-B did not check if R33 had toileting needs, or if she was incontinent. R33 continued to lay in her bed tilted slightly to the right with the head of her bed at approximately 30 degrees until 10:30 a.m. (2 hours and 49 minutes without being checked and changed) when asked, nursing assistant (NA)-G stated she thought NA-E had changed R33 and washed her up at about 8:30 a.m. When informed R33 was last repositioned at 7:40 a.m. and had not been checked or changed since that time, NA-G stated she would call a nurse to meet her in the room.

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

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 assistance with toileting have the potential to be impacted by this practice.
DON and/or designee will implement measure to ensure this practice does not occur by:
-All nursing staff will be educated on the Care Planning Policy and need to follow residents' care plan for toileting resident by 6/4/18.
DON and/or designee will monitor corrective actions to ensure effectiveness of these actions including:
-Random audits of ensuring resident toileting plans are being followed will be done 5x/week x 2 weeks starting week of 5/21/18, then 4x/week x 2 weeks, then 3x/week x 2 weeks, then 2x/week x2 weeks, then weekly there after by DON or facility designee.
-Monitoring will be reported to QAPI committee quarterly and as needed. The QAPI committee will make recommendations for ongoing monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 31	F 690		

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 incontinence of bowel and bladder, but wore an 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 episodes, and an adult 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 mobility refusals of turning and repositioning, and incontinence. The care plan directed staff to toilet or check and change R33 every two hours and as needed. R33's care plan was updated on 4/18/18, to include R33 had a history of refusing to allow staff to check and change resident when soiled.

R33's Care Card (nursing assistant care guide) undated, directed staff to check and change R33 every two hours.

On 2/19/18, R33's Braden Scale score indicated R33's risk for pressure injuries had increased due to a moderate risk with increased moisture.

R33's progress notes lacked documentation of R33's resistance to cares and repositioning.

On 4/25/18, at 10:51 a.m. RN-B verified R33 should be checked and changed every two hours

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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 690		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		6/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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F 755	Continued From page 33 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure Fentanyl patches were accurately destroyed to prevent potential diversion for 1 of 1 resident (R59) reviewed for medication storage Findings include: R59's Face Sheet dated 9/8/17, indicated diagnoses that included muscle spasm, multiple sclerosis, and scoliosis. R59's significant change Minimum Data Set (MDS) dated 3/14/18, indicated R59 received opiod medication, and identified R59 had indicated she had pain. R59 reported the pain was almost constant, and rated the pain eight out of ten (with 0 as no pain and 10 rated as severe	F 755	DON and/or designee will implement corrective action for R59 affected by this practice by: -RN-B was verbally educated on 4/25/18 on need to properly destroy Fentanyl patches by flushing to the sewer with another licensed nurse or TMA. -EMAR was updated to require 2 staff members to document removal/destruction of Fentanyl patch on 4/25/18. DON and/or designee will assess residents having potential to being affected: -All residents that utilize Fentanyl patches. DON and/or designee will implement measures to ensure this practice does not	

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	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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F 755	Continued From page 34 pain). R59's Physician's Orders dated 2/14/18, indicated R59 had an order for the Fentanyl patch (opiod pain medication patch) 75 microgram (mcg)/hour. Apply every 3 days. 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. On 4/25/18, at 3:22 p.m. the director of nursing (DON) verified documentation lacked evidence of two nurses witnessing the destruction of used patches. The DON stated she was not sure where the Sharps containers were stored once removed from the medication cart while waiting pickup from an outside service for disposal. At 3:43 p.m. the DON stated Sharps containers were taken downstairs to a unsecured room until they were picked up for disposal. The DON stated RN-B was not following the facility policy for proper destruction of Fentanyl patches. The facility's Fentanyl Patch Destruction policy dated February 2014, directed two licensed nurses or a trained medication aide (TMA) and licensed nurse would remove the patch from the resident. Staff that remove the patch will immediately destroy (waste) by flushing down the	F 755	reoccur including: -All nursing staff will be educated by 6/4/18 on the Fentanyl Patch Destruction Policy in regards to proper destruction of Fentanyl patches including need to have 2 nursing staff or a nurse and TMA sign off in EMAR on removal/destruction of patch and need to properly dispose of by flushing patch down sewer. DON and/or designee will monitor corrective actions to ensure effectiveness of these actions including: -Random audits of nursing staff destruction of Fentanyl patches will be done 3x/week x 2 weeks starting week of 5/21/18, then 2x/week x 2 weeks, then weekly there after by DON or facility designee to ensure proper patch destruction/documentation. -Monitoring will be reported to QAPI committee quarterly and as needed. The QAPI committee will make recommendations for ongoing monitoring.	

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F 755	Continued From page 35 sewer system. Both staff removing and destroying/wasting will sign off in the electronic medication administration record.	F 755		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he	F 801		6/4/18

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F 801	Continued From page 36 or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by:	F 801		

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F 801	Continued From page 37 Based on interview and document review, the facility failed to ensure the dietary manager was certified and credentialed to oversee food preparation and service in the kitchen. This had potential to affect all 83 residents who consumed food from the kitchen. Findings include: On 04/26/18, at 12:12 p.m. dietary manager (DM)-C stated that he is not a certified dietary manager. DM-C stated he recently signed up to take the certified dietary manager training, and he was waiting to hear back from them. On 04/26/18, at 3:35 p.m. the administrator stated that DM-C was hired in December 2017. The administrator stated that DM-C had ServSafe certification. The administrator said she had signed off on paperwork regarding the certified dietary manager training that week. The administrator stated that DM-C has access to the facility's contracted registered dietician, and the corporate registered dietitian if he has questions. The facility's dietary director position description dated 2/19/13 included the requirement that dietary director must be a graduate of an approved Dietary Manager's course that meets State and Federal requirements.	F 801	Administrator and/or designee will implement corrective action for this practice by: -Removing current Dietary Manager from role. Administrator and/or designee will assess residents having potential to being affected by this practice including: -All residents have potential to 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 of Minnesota will be recruited to fulfill the responsibilities of Dietary Director in a full time role. A registered dietitian reviews assessments and provides direction as it relates to resident nutrition and therapeutic diets. Administrator and Assistant Dietary Managers will oversee budget and purchasing of food and supplies, food preparation, service and storage during recruitment and onboarding. Administrator and/or designee will monitor corrective actions to ensure effectiveness of these actions including: -Monitoring will be reported to QAPI committee quarterly and as needed. The QAPI committee will make recommendations for ongoing monitoring.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		6/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 38 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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F 880	Continued From page 39 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a bedpan was stored appropriately for 1 of 1 residents (R40) reviewed for infection control. In addition, the facility failed to ensure soiled linen and incontinent products were properly handled and transported for 1 of 1 residents (R46) reviewed for activities of daily living. In addition, the facility failed to ensure hand hygiene was maintained for 2 of 4 residents (R89, R49) observed during personal cares. Findings include:	F 880	DON and/or designee will implement corrective action for R40, R46, R89, and R49 affected by this practice by: -NA-A and NA-B were verbally educated on 5/1/18 on need to dispose of incontinent products into a plastic bag immediately after removal and then bring plastic bag to wastebasket in dirty utility room for disposal. -NA-B was verbally educated on 5/1/18 not to wear soiled gloves outside residents' rooms. -NA-C, NA-D, NA-E, and NA-F were	

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F 880	Continued From page 40 On 4/24/18, at 1:05 p.m. R40 stated staff do not put the bedpan away after she has used it. R40 stated the bedpan was currently sitting on her bedside stand, and there are times staff put it on her over bed table. R40's annual Minimum Data Set (MDS) dated 3/12/18, indicated diagnoses that included hemiplegia (paralysis on one side of the body) or hemiparesis (weakness on one side of the body). The MDS indicated R40 was cognitively intact. The MDS also indicated R40 had occasional bladder incontinence, and was always continent of bowel. The MDS further indicated R40 required extensive assistance with toilet use that included using the bedpan, and clothing adjustment. On 4/24/18, at 1:58 p.m. an uncovered bedpan was observed placed on the top of R40's bedside stand. R40 stated it had been there since she had used it that morning. R40 stated staff had rinsed out the bedpan in the bathroom, and set it on the bedside stand. R40 stated the bedpan was left out most days either on her bedside stand, her over bed table, "Right next to my ice tea" or on her card table. On 4/26/18, at 9:17 a.m. R40 stated it really bothered her when they put the used bedpan on the over bed table next to her ice tea and cookies. R40 further stated the over bed table was next to her bed, she only used the bedpan, and did not use the toilet. R40 stated it 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	F 880	verbally educated on 5/1/18 on need to wash hands as soon as gloves are removed. DON and/or designee will assess residents having potential to being affected by this practice including: -All residents have potential to be impacted by this practice. DON and/or designee will implement measure to ensure this practice does not reoccur including: -All nursing staff will be educated on need to dispose of incontinent products into a plastic bag immediately after removal and then bring plastic bag to wastebasket in dirty utility room for disposal, not to wear soiled gloves outside residents' rooms, to wash hands as soon as gloves are removed per Linen Policy and Hand Washing policy, and to place bedpans in resident's room cabinet by bed or per resident choice (not to leave on bedside tables). All education will be completed by 6/4/18. DON and/or designee will monitor corrective actions to ensure effectiveness of these actions including: -Random audits of proper handling/disposing of incontinent products will be done 3x/week x 2 weeks starting week of 5/21/18, then 2x/week x 2 weeks, then weekly there after by DON or facility designee to ensure proper infection control techniques. -Random audits of proper removal of gloves and handwashing will be done 3x/week x 2 weeks starting week of 5/21/18, then 2x/week x 2 weeks, then weekly there after by DON or facility	

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F 880	Continued From page 41 (DON) stated bedpans should not be left out unless the resident requested it be left out. The facility's Cleaning/Disinfecting Resident Care Equipment policy dated 6/5/17, directed bedpans should be rinsed with cool water. The surface should be washed with a disinfectant solution, rinsed with hot water, set out to dry, and stored in a cupboard. 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. R46's Face Sheet dated 4/26/18, identified diagnoses that included generalized muscle weakness, and spinal stenosis. R46's care plan dated 4/20/18, indicated R46 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. On 4/24/18, at 9:56 a.m. nursing assistant (NA)-B was observed to walk out of R46's room holding a soiled incontinent pad and a towel in her gloved hand. NA-B walked down the hallway and into to the soiled utility room. At 9:58 a.m. NA-B was interviewed and stated normally she would have the soiled incontinent pad in a plastic bag, carrying it not bagged this time was a "one time thing." NA-B verified the	F 880	designee to ensure proper infection control techniques. -Random audits of proper storage of bed pans will be done 3x/week x 2 weeks starting week of 5/21/18, then 2x/week x 2 weeks, then weekly there after to ensure appropriate storage per facility policy. -Monitoring will be reported to QAPI committee quarterly and as needed. The QAPI committee will make recommendations for ongoing monitoring.	

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F 880	Continued From page 42	F 880		

incontinent pad was soiled with urine. NA-B also stated she was not supposed to walk in the hallways wearing soiled gloves.

On 4/25/18, at 7:34 a.m. NA-A was observed go into R46's room and left the door open. From the hallway, NA-A was observed to approach R46 and stated she was going to change R46's incontinent brief, as R46 had requested to be changed. NA-A unfastened the incontinent brief with the door still open, removed the soiled incontinent brief, and threw it on the floor. NA-A provided pericare and applied a clean incontinent brief. NA-A then lowered the bed, covered R46, washed her hands hands and left the room. At 7:38 a.m. NA-A was interviewed. NA-A stated, "Normally we don't do that. [R46] insisted I had to change her right there and then. The trash can was not close, and at times I would set the pad inside the plastic bag at the bottom of the bed."

On 4/25/18, at 1:03 p.m. registered nurse (RN)-A stated she would expect staff to bag soiled incontinent products in the room, not to throw soiled incontinent products on the floor. RN-A also stated staff should not be walking in the hallways with gloves on.

On 4/25/18, at 1:37 p.m. the DON stated she would expect staff would not throw soiled incontinent products on the floor, and stated soiled incontinent products were to be bagged in the room before bringing them out of the room. The DON

The facility Linen Handling policy revised 3/20/17, directed staff to handle all soiled linen as though it was potentially infectious.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 43	F 880		

R89's Face Sheet printed on 4/26/18, identified diagnoses that included chronic obstructive pulmonary disease (COPD), and dementia.

R89's annual MDS dated 2/19/18, indicated R89 had moderately impaired cognition, and required extensive assistance for transferring, personal hygiene and toileting. The MDS further indicated R89 was always incontinent of bladder, and frequently incontinent of bowel.

R89's care plan dated 9/30/14, indicated R89 had bowel incontinence related to immobility, congestive heart failure, diabetes and diuretics. R89's care plan directed staff to toilet every three hours during the day, and check/change every two hours during the night.

R89's Care Card (nursing assistant care guide) undated indicated R89 was frequently incontinent of bladder and bowel, and directed staff to toilet every three hours, and upon request.

On 4/25/18, at 7:43 a.m. NA-C and NA-D were observed to enter R89's room to perform morning cares. NA-C and NA-D lowered R89 onto the toilet with the assistance of a sit-to-stand machine. NA-C donned gloves and used toilet paper, then a warm wash cloth, to wipe bowel movement (BM) from R89's bottom. BM was visible on the toilet paper and the washcloth. NA-C used a towel to dry R89's bottom. NA-C doffed her gloves, and without performing hand hygiene, NA-C touched the sit-to-stand sling to

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F 880	Continued From page 44	F 880		

attach it to the machine, touched the wheelchair handles to position the wheelchair below R89, touched the sling again to remove it from around R89, and straightened R89's dress.

On 4/25/18, at 12:56 p.m. NA-C stated she didn't know if she performed hand hygiene or not after providing incontinence care for R89.

On 4/25/18, at 1:13 p.m. RN-F confirmed hand hygiene should occur immediately after glove removal.

On 4/25/18, at 1:28 p.m. the DON confirmed hand hygiene should occur immediately after glove removal.

The facility's Hand Hygiene policy revised 5/8/17, directed hands should be washed after removing gloves.

R49's Face Sheet printed 4/26/17, indicated R49's diagnoses included vascular dementia, and unspecified osteoarthritis.

R49's significant change MDS dated 3/8/18, indicated R49 had severe cognitive impairment. The MDS also indicated R49 was frequently incontinent of bowel and bladder.

On 4/25/18, at 10:14 a.m. NA-F was observed preparing for morning cares for R49. NA-F used a radio to request assistance to get R49's incontinence brief changed, and to assist with using a mechanical lift to transfer R49 from bed to a wheelchair. At 10:21 a.m. NA-F lowered and flattened R49's bed, and loosened R49's soiled incontinent brief with gloved hands. NA-F used a cloth to wipe R49's periarea. NA-E rolled R49

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 45	F 880		

onto his left side, while NA-F removed the wet incontinent brief and placed it in a bag in a trash can. NA-E proceeded to put a clean incontinent brief on R49. NA-F and NA-E doffed their gloves, and did not perform hand hygiene. NA-F and NA-E worked together to get a lift pad under R49, then used a lift to move him from the bed to his wheelchair. Once he was seated, NA-E removed the gown he wore as sleepwear, and NA-F put a shirt over his head. NA-E and NA-F both worked to get the shirt pulled down and situated appropriately on R49's body. NA-E then washed her hands.

On 4/25/18, at 10:36 a.m. NA-E confirmed that she had failed to wash or sanitize her hands immediately after doffing her gloves. NA-E stated she usually washes her hands after removing her gloves, and has a small bottle of sanitizer in her pocket.

On 4/25/18, at 10:38 a.m. the DON confirmed it was her expectation staff wash their hands after doffing soiled gloves.

F5414027

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**04/25/2018**

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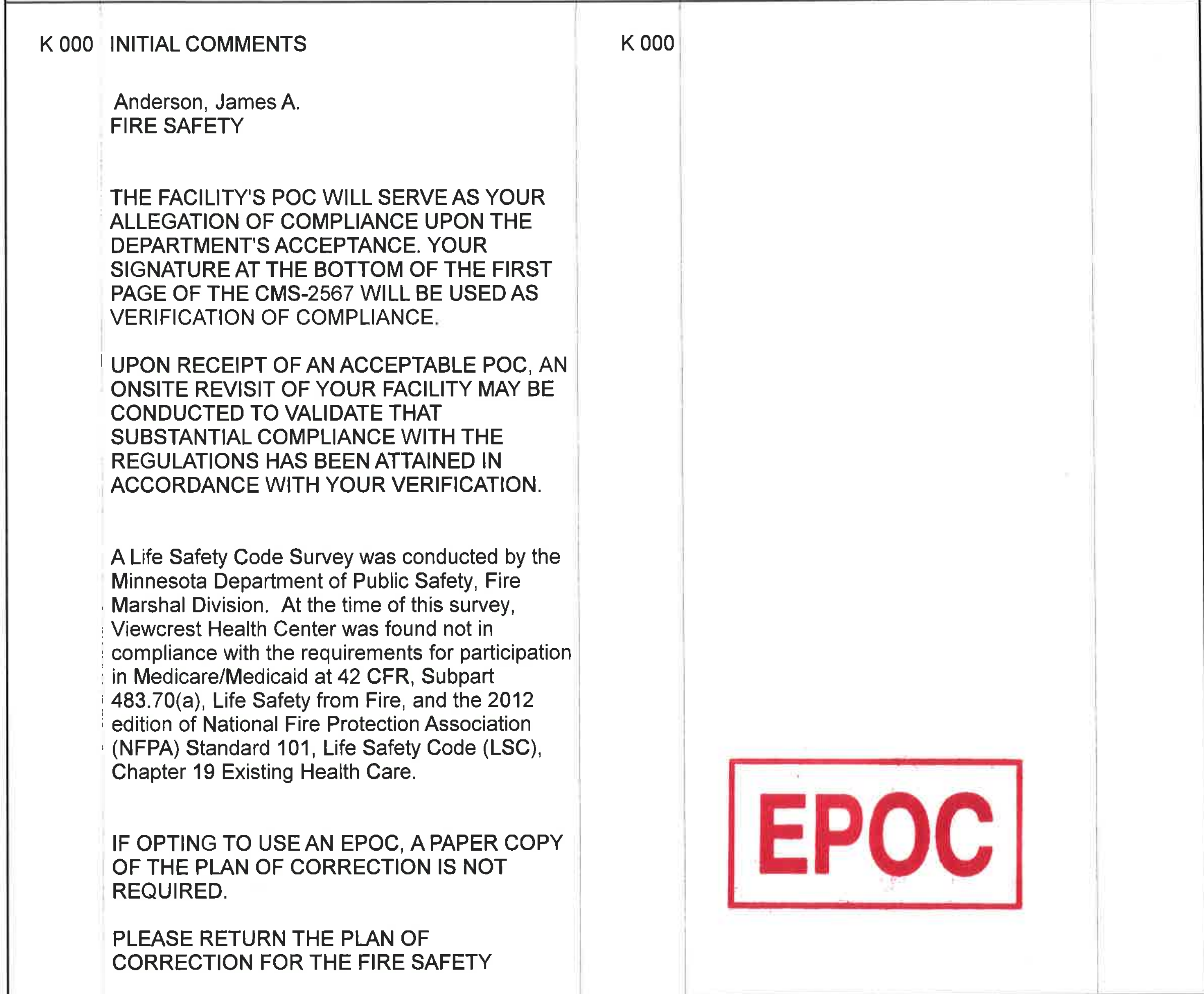

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K 000	INITIAL COMMENTS Anderson, James A. FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. 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	K 000	EPOC	

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

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K 000	Continued From page 1	K 000		

DEFICIENCIES (K TAGS) TO:

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
445 MINNESOTA STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

By e-mail to both:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

Inspected as one building:
Viewcrest Health Center, is a 2-story building with a partial basement. The original building was constructed in 1960 with 3 additions constructed in 1968, 2002 and 2008. The 1960 and the 1968 building is type II(111) construction. The 2002 building is two (2) story Type II(000), and the 2008 building is Type II(111) 2-story. Since the construction types of the original building and the 3 additions meet the minimum requirements for existing healthcare facilities it was inspected as one building.

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K 000	Continued From page 2 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.	K 000		
K 351 SS=D	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 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: Based on observations, the automatic sprinkler	K 351	Maintenance Supervisor and/or designee	6/4/18

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K 351	Continued From page 3 system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 2010 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (10) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect patients, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:30 a.m. to 2:30 p.m. on 04/25/2018, observations reveled that the fire sprinkler head that is located in aisle by the stove in the kitchen were found to be corroded. This deficient condition was verified by a Maintenance Supervisor.	K 351	will implement corrective action by: • Changing the corroded sprinkler head in the kitchen. Maintenance Supervisor and/or designee will assess the rest of the building affected by this practice by: • Conducting an additional inspection of all sprinkler heads in the building. Maintenance Supervisor and/or designee will implement measures to ensure this practice does not reoccur by: • Routine internal inspections will be conducted in addition to the contracted vendor inspections conducted annually. Maintenance Supervisor and/or designee will monitor corrective actions to ensure effectiveness of these actions including: • Audits of the inspection results will be conducted quarterly and reported to QAPI committee on a quarterly basis and as needed. The QAPI committee will make recommendations as needed.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This **REQUIREMENT** is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed to maintain portable fire extinguishers in accordance with NFPA 101 Life Safety Code (12) Section 19.3.5.5. This deficient practice could	K 355	K355 Maintenance Supervisor and/or designee will implement corrective action by: • Visually inspecting the fire extinguishers that missed the December	6/4/18

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

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K 355	Continued From page 4 affect 92 of 92 residents, as well as an undetermined number of staff, and visitors in the event of an emergency Findings include: On facility tour between 10:30 a.m. to 2:30 p.m. on 04/25/2018, observations revealed that the facility had not conducted or annotated the monthly visual inspection for December 2017 for all of the fire extinguishers located throughout the facility. The fire extinguisher were last annually inspected in November 2017 and the first monthly inspection was conducted in January 2018. This deficient condition was verified by a the Maintenance Supervisor.	K 355	2017 documentation. Maintenance Supervisor and/or designee will assess the rest of the building affected by this practice by: • Conducting an additional inspection of all fire extinguishers to ensure appropriate inspections and related documentation. Maintenance Supervisor and/or designee will implement measures to ensure this practice does not reoccur by: • Routine internal inspections will be conducted in addition to the monthly inspection to ensure inspection and documentation is completed monthly. Maintenance Supervisor and/or designee will monitor corrective actions to ensure effectiveness of these actions including: • Audits of the inspection results will be conducted quarterly and reported to QAPI committee on a quarterly basis and as needed. The QAPI committee will make recommendations as needed.	

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ____ B. WING ____	C 04/26/2018

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2 000	Initial Comments	2 000		

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota

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2 000	Continued From page 1	2 000		

Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On 4/23/18 through 4/26/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

H Complaint H5283019 was investigated and not substantiated.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,

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2 000	Continued From page 2 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess for causes and develop care planned interventions for 1 of 1 residents (R89) reviewed with skin tears. Findings include: R89's Face Sheet, printed on 4/26/18, identified diagnoses that included: chronic obstructive pulmonary disease (COPD), and diabetes.	2 830	corrected.	6/4/18

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2 830	Continued From page 3	2 830		

R89's annual Minimum Data Set (MDS) dated 2/19/18, indicated R89 had moderately impaired cognition, and required extensive assistance with activities of daily living (ADLs). The MDS further indicated R89 had skin tears.

R89's care plan dated 7/1/15, indicated R89 had a history of skin tears due to a history of falls, insulin, and a history of bumping into objects by accident. The goal was for R89 to be free from skin tears. Interventions included safety preventions as needed/ordered, and update the physician as needed.

R89's care card (nursing assistant care guide) undated, indicated R89 required an assist of 2 staff for transfers with a sit-to-stand lift.

On 4/25/18 at 6:59 a.m. R89 was continuously observed. At 7:43 a.m. nursing assistant (NA)-C and NA-D were observed to enter R89's room to 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 was seated on the toilet, NA-D left to go to another room and NA-C left to get supplies. R89 stated her arm got bumped when she came in the bathroom, it had hurt at the time, but didn't any more. At 7:50 a.m. bright red drops of blood were noted on the floor to the left of R89. At 7:52 a.m. NA-C noticed the blood and commented, "Oh, what is that? I don't know what that is from." NA-C did not check R89's skin, but continued to perform morning cares which included taking off R89's hospital gown and putting a dress over both of R89's arms, including the one that was

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2 830	Continued From page 4	2 830		

bumped. At 7:59 a.m. NA-D returned to assist with R89's transfer off the toilet. Once R89 was off the toilet a skin tear was visible on R89's arm, just above the left elbow. NA-D was in a position to see the skin tear, but did not say anything. R89's dress had short sleeves, and did not cover the skin tear. At 8:46 a.m. registered nurse (RN)-E entered R89's room to check her blood glucose levels, and give her insulin. RN-E administered R89's insulin in her left arm, approximately 6 inches above the visible skin tear. At 9:03 a.m., NA-C entered R89's bathroom and stated, "I have no idea where that came from; it had to have been there." (in reference to the blood on the floor), and went to wipe it up. NA-C stated she did not hear R89 call out "Ow", during the transfer, did not know R89 had incurred a skin tear, and did not look for the source of the blood.

On 4/26/18, at 10:35 a.m. RN-F stated the NAs should let the nurse know if they saw blood drops on the floor. RN-F stated they should not just wipe it up, they should investigate first and tell the nurse.

On 4/26/18, at 12:00 p.m. the director of nursing (DON) stated she would expect NAs to tell a nurse if they saw blood on the floor. The DON stated her expectation is that the blood would be addressed.

The facility Accident/Incident policy dated 1/8/18, directed an incident report is completed for skin tears with known or unknown origin.

The facility Skin Documentation policy dated 12/19/13, directed staff to observe resident's skin daily with cares, and notify a licensed nurse with any skin alterations noted.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents do not develop skin tears, and residents who do incur skin tears receiving the proper care and services needed to promote healing, and prevent infection. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.	2 900		6/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to thoroughly assess and implement interventions to prevent the development and worsening of pressure ulcers for 1 of 3 residents (R33) reviewed for pressure ulcers. This resulted in actual harm for R33, who developed a pressure ulcer that worsened. Findings include: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.	2 900	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 900	Continued From page 7	2 900		

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

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 required extensive assistance of two staff for bed mobility, and total assist of two staff for transfers. R33's MDS further indicated R33 was frequently incontinent of bladder and always incontinent of bowel, was at risk for pressure ulcers, had no unhealed pressure ulcers, and had moisture associated skin damage. The MDS indicated R33 had a pressure reducing device in the chair and in bed, and was treated with ointments.

R33's Care Area Assessment (CAA) for a significant change MDS dated 12/4/17, indicated R33 was at low risk for skin breakdown per a 12/4/17, Braden Score (tool used to assist in identifying risk for pressure ulcers). R33's Tissue Tolerance Test (TTT, a tool used to assist in determining the ability of the skin and tissues to endure the effects of pressure without adverse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 900	Continued From page 8	2 900		

Continued From page 8

effects) indicated R33 tolerated repositioning every 4 hours in the wheelchair, and every 3 hours when lying. R33's most current TTT was dated 11/29/17, through 11/30/17. R33's CAA indicated R33 had impaired mobility and functional ability. The CAA noted R33 had a pressure injury to the gluteus when in the hospital that was healed upon admission to the facility on 9/7/17. The CAA indicated R33 required staff assist with toileting and repositioning, had a problem for friction and shearing, but used a Hoyer (mechanical) lift for transfers, and a pad was used to assist with boosting to avoid shearing. The CAA further indicated R33 was exposed to incontinence of bowel and bladder, but wore an incontinent brief to wick excess moisture away from the skin, and was checked and changed or toileted every two hours, and as needed. The CAA indicated R33 was at risk for diarrhea related to medications, and R33 was noted to refuse cares at times. The CAA also indicated R33 had a pressure reduction cushion on the chair, and pressure redistributing/relieving mattress on the bed, was repositioned per the TTT results, and was toileted every two hours to help keep her dry. R33 was to have a barrier cream applied with any noted redness after incontinent episodes, an adult incontinent brief to wick excess moisture away from the skin, Prafo boots (a pressure-relief boot for patients with compromised mobility and at risk of developing pressure sores at the heel) to feet.

R33's care plan initiated 9/15/17, indicated R33 was at risk for skin breakdown related to impaired mobility and refusals of turning and repositioning, and incontinence. The goal was for R33 to remain free of pressure ulcers. R33's care plan directed staff to inspect skin weekly and observe daily with cares, provide Prafo boots on feet when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 9	2 900		

up in chair, and a pressure reducing cushion on the chair. On 4/4/18, R33's care plan was updated to include: reapproach when R33 refused or was resistive to turning and repositioning. R33's care plan directed staff to turn and reposition per the tissue tolerance results to help prevent skin breakdown. In addition, R33's care plan was updated on 3/13/18, identified shearing to the coccyx, and directed the use of an alternating pressure mattress, turn side to side with repositioning, and position with a pillow, and ensure the head of the bed was not elevated beyond 45 degrees unless eating or drinking, and treat per physician orders. R33 was to be toileted or checked and changed every two hours and as needed.

R33's current undated Care Card (nursing assistant care guide) directed staff to turn and reposition R33 every two hours, position side to side with pillows when in bed, and Prafo boots were to be on when up in the wheelchair. The Care Card further directed staff to check and change every two hours and ensure the head of the bed was no higher than 45 degrees unless eating or drinking.

On 4/25/18, during continuous observations beginning at 7:41 a.m. when staff exited R33's room, R33 had been lying quietly in bed, tilted slightly to the right with the head of the bed at approximately 30 degrees. At 8:31 a.m. registered nurse (RN)-B entered R33's room to give oral medications, and raised the head of the bed up to approximately 90 degrees. RN-B administered medications, then returned the head of the bed to approximately 30 degrees. R33 continued to lay in her bed tilted slightly to the right with the head of her bed at approximately 30 degrees until 10:30 a.m. (2 hours and 49 minutes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ____ B. WING ____	C 04/26/2018

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

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2 900	Continued From page 10	2 900		

Continued From page 10

without repositioning) when surveyor stopped a nursing assistant to ask about R33's repositioning time. Nursing assistant (NA)-G stated she thought R33 had been repositioned about 8:30 a.m. when NA-E had changed her and washed her up. When informed R33 was last repositioned at 7:40 a.m. NA-G stated she would reposition her, and called a nurse to meet her in the room.

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. R33's right hip had no redness. R33 was turned to the right, and RN-B removed the dressing from R33's coccyx. The dressing had a small amount of clear pink drainage without odor. RN-B cleansed R33's ulcer with wound cleanser, and measured the ulcer at 0.5 cm x 0.5 cm x 0.3 cm. The wound edges were regular, except from 6 o'clock to 10 o'clock, and the wound bed was circular with yellow/white stringy slough covering it. RN-B stated the pressure ulcer would be a Stage 3. RN-B packed the wound with Iodoform packing strip, and covered with an Allevyn dressing. NA-E finished dressing R33 and got her up in the wheelchair. R33 had an alternating pressure mattress on her bed.

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, reclined at approximately 45 degrees. NA-E stated she had changed and repositioned R33 at 7:40 a.m. that morning, and stated R33 should be repositioned every two hours. NA-E verified she had not repositioned R33 timely.

On 4/25/18, at 10:51 a.m. RN-B stated her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 11	2 900		

previous statement regarding the staging of R33's pressure ulcer was incorrect, and stated it would be Unstageable pressure ulcer with the slough covering the wound bed. RN-B verified R33 should be repositioned every two hours, and stated she had not repositioned R33 when she had given her medications earlier. RN-B stated she thought R33 received the alternating pressure mattress, but was not sure.

On 12/28/17, at 2:30 a.m. a progress note indicated R33 had been up in the wheelchair at the beginning of the nurse's shift at 6:00 p.m. R33 was agitated and yelling at other people. Resident yelled out, "Ow, ow, ow," and when asked where she hurt, replied, "My butt!" Resident was laid down in bed per her preference, and once in bed, R33's behaviors ended and she rested. The progress note lacked indication if R33's skin had been observed at that time.

On 1/10/18, a physician progress note indicated R33's skin had no hyperpigmentation (darkened skin), vitiligo (skin that lacked pigmentation), or suspicious lesions; but lacked any other skin concerns.

On 1/18/18, R33's progress notes and Skin Condition/Wound Progression note indicated R33 had multiple areas of blanchable redness on the buttocks and perineal area, and a small open 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 12	2 900		

Continued From page 12

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 initiated 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 was 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 was irregularly shaped, very superficial, and measured 0.8 cm x 0.7 cm. The coccyx wound base continued to be shiny granulation tissue, with white tissue surrounding the wound, though wound edges were normal skin color and blanchable.

On 2/5/18, R33's Skin Condition/Wound Progression note indicated R33's coccyx wound was circular shaped and very superficial

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 04/26/2018

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

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2 900	Continued From page 13	2 900		

measuring 0.6 cm x 0.6 cm with yellow slough tissue (yellow devitalized tissue, that can be stringy or thick, and adherent on the tissue bed) in the wound base. Wound edges were normal skin color and blanchable. R33's treatment continued to be the same.

On 2/16/18, R33's Skin Condition/Wound Progression note indicated 33's coccyx wound was circular shaped, measured 0.8 cm x 1.0 cm, was very superficial, though it had white slough tissue on the wound bed. The wound edges were normal skin color, and blanchable.

On 2/16/18, R33's progress notes indicated R33's coccyx wound was larger in size with some depth noted to 75% of the wound bed, and had slough. R33's progress note indicated there were two purple linear areas noted to the right buttock, but were not open. The provider was updated through the rounding book. Staff were instructed to provide side to side positioning for R33, and to lay her down after meals. An addendum to the note, indicated an occupational therapy evaluation of the wheelchair cushion was requested.

On 2/19/18, R33's Braden Scale score indicated R33's risk for pressure injuries had increased to a moderate risk with increased moisture.

On 2/19/18, R33's progress note referencing the quarterly MDS assessment, indicated R33 required extensive to total assist of two staff for toileting, and was frequently incontinent of bowel and bladder. The note indicated R33 had a moisture associated lesion to her coccyx, and she was checked and changed every two hours and as necessary, which was determined to remain appropriate. R33's documentation noted, "After

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 14	2 900		

speaking with the RN [registered nurse] MGR [manager] she had re-educated staff on the importance of following the care card/care plan of every 2 hrs [hours] toileting and lesion had then improved with staff compliance (when looking again after the re-education completed)." No changes were made to R33's care plan at that time.

On 2/22/18, R33's Skin Condition/Wound Progression note indicated R33's coccyx wound had some depth, and measured 1 cm x 1.2 cm x 0.2 cm, and appeared as "Kissing ulcers." These had a pink/red and moist wound base, and the wound edges were normal skin colored and blanchable. R33's buttocks were noted to have areas of very dry and peeling skin along with pin-point macerated areas. The wound care nurse assessed R33's skin on that date, and suggested application of 50/50 Calazime (helps treat and prevent diaper rash, wet and cracked skin) and Vaseline cream to the buttocks with incontinent cares. The note further indicated the nurse practitioner was to be updated with requests of new orders the following day.

On 3/1/18, R33's Skin Condition/Wound Progression note indicated R33's, "Moisture lesion" appeared as one open area and measured 1 cm x 1.2 cm x 0.1 cm. R33's wound base was pink and red and moist, with white and macerated looking irregular edges. R33's other macerated areas were healed. The same treatment was continued.

On 3/7/18, R33's physician progress notes indicated R33 had no hyperpigmentation, vitiligo, or suspicious lesions. The note lacked any other skin concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 15	2 900		

On 3/15/18, R33's Skin Condition/Wound Progression note indicated R33's coccyx wound measured 1.1 cm x 0.8 cm x 0.1 cm, and appeared less moist with a pink-red sound base. R33's wound edges were white or pink, macerated and irregular.

On 3/20/18, R33's Skin Condition/Wound Progression note indicated R33's coccyx wound measured 1.1 cm x 0.8 cm and the depth from 12 o'clock to 6 o'clock measured 0.1 cm, and the remainder measured 0.3 cm. R33's wound base was pink and dry, and wound edges were pink, irregular, and slightly firm to touch. R33's care plan was updated to turn and reposition R33 from side to side only.

On 3/28/18, an occupational therapy (OT) discharge summary indicated R33 had been treated from 3/1/18, through 3/28/18, for positioning equipment. R33's goals included: R33 would be provided with a specialized wheelchair cushion that would provide optimal weight distribution, off loading ability, encourage upright posture, and pressure relief to reduce the chance of further skin integrity issues. It was noted that R33 had a moisture lesion on the coccyx that had worsened, and R33 refused to lay on side for pressure relief. R33 was non-ambulatory, and sat on a gel/foam cushion on the wheelchair. R33 was provided with an appropriate cushion to provide pressure relief, and improve skin integrity and weight distribution.

On 4/6/18, R33's Skin Condition/Wound Progression note indicated R33's "Moisture lesion" measured 1 cm x 0.7 cm x 0.2 cm with a pink wound base and irregular, firm, pink edges. R33's treatment remained the same.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ____ B. WING ____	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 16 On 4/10/18, R33's nurse practitioner progress notes indicated R33 was seen for follow up of nutritional assessment to support wound healing. R33's progress note indicated she was up in the dining room waiting for brunch. The note indicated R33 had a "Moisture associated wound on her coccyx that has been slowly healing, possible cause is abrasion secondary to shearing." It was noted that barrier cream had been used over the last two weeks, nursing was attempting to keep resident as dry as possible with incontinence, and the wound had areas of maceration. R33's progress note indicated a supplement had been initiated to support healing. R33's progress note documented a "Decubitus coccyx ulcer (pressure ulcer), unspecified staging," and directed the nurse manager to initiate follow up if skin breakdown worsened. On 4/11/18, R33's Skin Condition/Wound Progression note indicated R33's coccyx wound measured 0.8 cm x 0.7 cm x 0.2 cm, with a pink, dry wound base, and pink, irregular, firm edges, that appeared as scar tissue. R33's treatment remained the same. On 4/16/18, R33's Skin Condition/Wound Progression note indicated R33's coccyx "Moisture lesion" measured 0.8 cm x 0.7 cm x 0.5 cm with a pink, dry base, with white, firm, irregular, macerated appearing edges, that appeared to be scar tissue. On 4/20/18, R33's Skin Condition/Wound Progression note indicated R33's "Moisture lesion" measured 0.8 cm x 0.7 cm x 0.5 cm with a pink wound base that was not moist, and had white, macerated and irregular, slightly firm edges. R33's note indicated the physician was updated with a request to change the wound care	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 17	2 900		

Continued From page 17

orders. The physician was noted to have ordered, "Cleanse wound with wound cleanser and pat dry. Pack wound with Iodoform 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 scooting 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 shearing injury. RN-B agreed that a shearing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 18	2 900		

injury was a pressure related injury.

On 4/25/18, at 2:14 p.m. RN-G confirmed she had looked at R33's pressure ulcer because it had gotten worse, so she recommended a change in treatment. RN-G stated it was now getting better. RN-G stated she questioned whether staff had been rubbing the barrier cream off, and then noticed undermining of the wound. RN-G stated the head of R33's bed had been elevated too high, and the pressure ulcer had developed more depth. RN-G stated R33 initially had moisture associated skin damage (MASD), rather then shearing. RN-G stated that undermining of a pressure ulcer was classic shearing. RN-G stated R33 had an alternating pressure mattress, and a turning and repositioning program, and it had been determined that R33 did not have unsustained pressure. RN-G verified R33 should be turned and repositioned every 2 hours, and stated the facility had been doing audits on repositioning about three to four weeks ago, and all the audits on that unit had come back showing no concerns. RN-G stated the facility did assessments with a root cause analysis, and the doctor signed off on them, and R33's MD had signed off on hers. RN-G stated the facility does measurements, documents appearance, drainage, treatment, and faxes the information to the physician. The physician group takes pictures of the wounds.

On 4/26/18, at 11:32 a.m. the nurse practitioner (NP)-E was interviewed and verified she had not looked at R33's pressure ulcer, and stated she had not been notified of the worsening and the depth of the pressure ulcer. NP-E stated she was unaware that it was a, "Hole" and an ulcer, and stated she went by the information provided by the nurses. NP-E verified shearing can cause a

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	00602	A. BUILDING: ____ B. WING ____	C 04/26/2018

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2 900	Continued From page 19	2 900		

pressure injury. NP-E stated if there is slough, the pressure ulcer would be considered unstageable. NP-E stated she expected to be informed of the worsening and condition of the pressure ulcer, and verified she would need to look at it, and the pressure ulcer would need to be identified correctly, so it can be treated appropriately. NP-E stated she was unaware that a physician had ordered the packing of the wound, and did not know if the physician had looked at the wound.

On 4/26/18, at 11:34 a.m. RN-G stated R33 had moisture, was incontinent, and her bed had been at 45 degrees, so R33's pressure ulcer was determined to be from moisture and shearing.

On 4/26/18, at 11:45 p.m. NP-E verified barrier ointments would not treat the inside or the base of the pressure ulcer. NP-E stated the wound needed to heal from the inside out.

On 4/26/18, at 2:00 p.m. the director of nursing (DON) was interviewed and stated the nurse manager does a root cause analysis of skin impairments, and determines what the injury could be caused from. It was determined R33's coccyx wound was from moisture, and then on 4/23/18, it had gotten worse. R33's Braden score had changed, and the head of her bed was noted at 90 degrees, causing shearing and undermining. When asked about the increased depth and slough noted in R33's wound in February, the DON stated it was not pressure related, but was from sliding down in bed. The DON said at that time it was noted R33's Braden score had changed, and an alternating pressure mattress was implemented. The DON stated audits were done on R33's repositioning, and indicated repositioning had been done on time.

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	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

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2 900	Continued From page 20 That was how the facility determined R33's wound was a shearing injury. The DON stated also, the head of R33's bed was elevated at 90 degrees and she was sliding down. The DON stated the facility did not feel R33's pressure ulcer was pressure related. The DON was asked about the treatment of the pressure ulcer and if barrier cream was appropriate to treat the pressure injury. The DON replied the nurse manager noted the treatment needed to be changed, and new orders were obtained. Their wound nurse looked at it, and made recommendations. When asked about the slough, and if the barrier cream was appropriate to treat that, the DON replied the physician and nurse practitioner addressed it and agreed to the treatment, and the NP stated it had been addressed. The DON stated they have nurses who are wound certified and are trained annually. The DON stated the staff are to follow the Care Cards, as that is what they have access to. The DON stated skin assessments should be done when there is a new open area. The DON stated R33 had been resistive to reposition and cares in the past, but was less resistive now. The DON stated resistive behaviors should be documented, and followed up on. The Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/17, indicated pressure ulcers occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force, and friction are important contributors to pressure ulcer development. The underlying health of a resident's soft tissue affects how much pressure, shear force, or friction is needed to damage tissue. Skin and soft tissue changes associated with aging, illness, small blood vessel disease, and malnutrition increase vulnerability to pressure ulcers. Additional external factors, such as	2 900		

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	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

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

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2 900	Continued From page 21	2 900		

excess moisture, and tissue exposure to urine or feces, can increase risk. Key areas for pressure ulcer development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear or friction, are also at risk for pressure ulcers.

The facility policy and procedure for Skin Documentation dated 6/30/17, directed a resident who enters the facility without a pressure sore will not develop a pressure sore unless their clinical condition demonstrates that it was unavoidable and a resident who had a pressure sore would receive necessary treatment and services to promote healing. The policy and procedure directed nursing to complete a Braden Scale and Tissue Tolerance Test lying and sitting upon admission, quarterly, and annually and with any significant changes, and the Braden would also be done for the first four weeks after admission. The nurse manager would assess risk factors for impaired skin integrity and/or delayed wound healing and would document the identified risk factors, and implement appropriate interventions to prevent skin alterations and/or promote wound healing. The nurse manager was to would update all necessary departments of any risk factors associated with that department. The primary care physician would be notified within 24 hours of any new skin alterations, except when the physician requests to be notified on routine rounds only. The All wound would be reviewed and discussed with the interdisciplinary team weekly and as necessary, wound nurse or nurse manager would assess all pressure ulcers, venous ulcers, and other wounds of concern weekly, and if no improvement with wounds within 2 to 4 weeks, a new treatment would be tried if

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2 900	Continued From page 22 necessary. Nursing staff to document any non-compliance by the resident with the recommended interventions and education provided to the resident. The facility policy and procedure for Care Planning revised 10/17, directed that it is the expectation that staff would follow the resident's comprehensive care plan. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents are provided care and services to prevent the development and worsening of pressure ulcers. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and	2 910		6/4/18

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2 910	Continued From page 23 B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure incontinent cares were provided timely for 1 of 3 residents (R33) reviewed for pressure ulcers. Findings include: On 4/25/18, during continuous observations beginning at 7:41 a.m. when staff exited R33's room, R33 had been lying quietly in bed, tilted slightly to the right with the head of the bed at approximately 30 degrees. At 8:31 a.m. registered nurse (RN)-B entered R33's room to give oral medications, and raised the head of the bed up to approximately 90 degrees. RN-B administered medications, then returned the head of the bed to approximately 30 degrees. RN-B did not check if R33 had toileting needs, or if she was incontinent. R33 continued to lay in her bed tilted slightly to the right with the head of her bed at approximately 30 degrees until 10:30 a.m. (2 hours and 49 minutes without being checked and changed) when asked, nursing assistant (NA)-G stated she thought NA-E had changed R33 and washed her up at about 8:30 a.m. When informed R33 was last repositioned at 7:40 a.m. and had not been checked or changed since that time, NA-G stated she would call a nurse to meet her in the room.	2 910	Corrected.	

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2 910	Continued From page 24	2 910		

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 incontinence of bowel and bladder, but wore an 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 episodes, and an adult 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 mobility refusals of turning and repositioning, and

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

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2 910	Continued From page 25	2 910		

Continued From page 25

incontinence. The care plan directed staff to toilet or check and change R33 every two hours and as needed. R33's care plan was updated on 4/18/18, to include R33 had a history of refusing to allow staff to check and change resident when soiled.

R33's Care Card (nursing assistant care guide) undated, directed staff to check and change R33 every two hours.

On 2/19/18, R33's Braden Scale score indicated R33's risk for pressure injuries had increased due to a moderate risk with increased moisture.

R33's progress notes lacked documentation of R33's resistance to cares and repositioning.

On 4/25/18, at 10:51 a.m. RN-B verified R33 should be checked and changed every two hours 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 910	Continued From page 26 would follow the resident's comprehensive care plan. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents who are incontinent receive cares and services as directed by the care plan. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to offer oral cares for 1 of 3 residents (R89) reviewed for personal cares. Findings include: R89's Face Sheet printed 4/26/18, identified	2 920	Corrected.	6/4/18

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2 920	Continued From page 27	2 920		

diagnoses that included dementia.

R89's annual Minimum Data Set (MDS) dated 2/19/18, indicated R89 had moderately impaired cognition, and required extensive assistance with personal hygiene. The MDS further indicated R89 had obvious or likely cavities or broken natural teeth, inflamed or bleeding gums, or loose natural teeth.

R89's care plan dated 9/30/14, indicated R89 had lower dentures, and the potential for changes in teeth and gums, and had her own upper teeth. The care plan directed staff to brush R89's teeth with a soft brush in the morning and during bedtime cares. The care plan further directed staff to set up a toothbrush, and paste for the resident to brush her 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.

On 4/25/18, at 6:59 a.m. until 7:15 a.m. R89 was continuously observed. R89 was in bed, asleep. At 7:15 a.m. nursing assistant (NA)-C entered the room to assist R89 with getting up for the day. Continuous observations of R89's morning cares occurred until 9:20 a.m. when NA-C brought breakfast to R89 in her room. NA-C did not offer or provide oral cares to R89. Observations continued until 11:39 p.m. when NA-C took R89 to the dining room for lunch. Continuous observations resumed at 12:13 p.m. when NA-D wheeled R89 from the dining room to the book fair, where R89 browsed until 12:35 p.m. when the hair dresser came and got R89. Neither NA-C nor NA-D offered or provided R89 with oral cares.

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	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

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

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2 920	Continued From page 28 On 4/25/18, at 12:56 p.m. NA-C confirmed she hadn't offer oral care to R89, but stated R89 didn't have any teeth, so it didn't matter. On 4/25/18, at 1:13 p.m. registered nurse (RN)-F stated she would expect NAs to offer residents with no teeth mouthwash or a toothette for oral cares. On 4/25/18, at 1:29 p.m. the director of nursing (DON) stated she expected staff to rinse and brush around in a resident's mouth in the morning, at night, 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. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents are offered oral cares. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
2 980	MN Rule 4658.0605 Subp. 2 Director of dietary service; Director	2 980		6/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 980	Continued From page 29 Subp. 2. Director of dietary service. If a qualified dietitian is not employed full time, the administrator must designate a director of dietary service who is enrolled in or has completed, at a minimum, a dietary manager course, and who receives frequently scheduled consultation from a qualified dietitian. The number of hours of consultation must be based upon the needs of the nursing home. Directors of dietary service hired before May 28, 1995, are not required to complete a dietary manager course. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the dietary manager was certified and credentialed to oversee food preparation and service in the kitchen. This had potential to affect all 83 residents who consumed food from the kitchen. Findings include: On 04/26/18, at 12:12 p.m. dietary manager (DM)-C stated that he is not a certified dietary manager. DM-C stated he recently signed up to take the certified dietary manager training, and he was waiting to hear back from them. On 04/26/18, at 3:35 p.m. the administrator stated that DM-C was hired in December 2017. The administrator stated that DM-C had ServSafe certification. The administrator said she had signed off on paperwork regarding the certified dietary manager training that week. The administrator stated that DM-C has access to the facility's contracted registered dietician, and the corporate registered dietitian if he has questions.	2 980	Administrator and/or designee will implement corrective action for this practice by: -Removing current Dietary Manager from role. Administrator and/or designee will assess residents having potential to being affected by this practice including: -All residents have potential to 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 of Minnesota will be recruited to fulfill the responsibilities of Dietary Director in a full time role. A registered dietitian reviews assessments and provides direction as it relates to resident nutrition and therapeutic diets. Administrator and Assistant Dietary Managers will oversee budget and purchasing of food and supplies, food preparation, service and storage during recruitment and	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 980	Continued From page 30 The facility's dietary director position description dated 2/19/13 included the requirement that dietary director must be a graduate of an approved Dietary Manager's course that meets State and Federal requirements. SUGGESTED METHOD OF CORRECTION: The Administrator or designee could develop, review, and/or revise policies and procedures to ensure the Dietary Manager has the proper qualifications for the position. The Administrator or designee could educate all appropriate staff on the policies and procedures. The Administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 980	onboarding. Administrator and/or designee will monitor corrective actions to ensure effectiveness of these actions including: -Monitoring will be reported to QAPI committee quarterly and as needed. The QAPI committee will make recommendations for ongoing monitoring.	
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a bedpan was stored appropriately for 1 of 1 residents (R40) reviewed for infection control. In addition, the facility failed to ensure soiled linen and incontinent products were properly handled and transported for 1 of 1 residents (R46) reviewed for activities of daily living. In addition, the facility	21375	Corrected.	6/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 31	21375		

failed to ensure hand hygiene was maintained for 2 of 4 residents (R89, R49) observed during personal cares.

Findings include:

On 4/24/18, at 1:05 p.m. R40 stated staff do not put the bedpan away after she has used it. R40 stated the bedpan was currently sitting on her bedside stand, and there are times staff put it on her over bed table.

R40's annual Minimum Data Set (MDS) dated 3/12/18, indicated diagnoses that included hemiplegia (paralysis on one side of the body) or hemiparesis (weakness on one side of the body). The MDS indicated R40 was cognitively intact. The MDS also indicated R40 had occasional bladder incontinence, and was always continent of bowel. The MDS further indicated R40 required extensive assistance with toilet use that included using the bedpan, and clothing adjustment.

On 4/24/18, at 1:58 p.m. an uncovered bedpan was observed placed on the top of R40's bedside stand. R40 stated it had been there since she had used it that morning. R40 stated staff had rinsed out the bedpan in the bathroom, and set it on the bedside stand. R40 stated the bedpan was left out most days either on her bedside stand, her over bed table, "Right next to my ice tea" or on her card table.

On 4/26/18, at 9:17 a.m. R40 stated it really bothered her when they put the used bedpan on the over bed table next to her ice tea and cookies. R40 further stated the over bed table was next to her bed, she only used the bedpan, and did not use the toilet. R40 stated it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21375	Continued From page 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.

The facility's Cleaning/Disinfecting Resident Care Equipment policy dated 6/5/17, directed bedpans should be rinsed with cool water. The surface should be washed with a disinfectant solution, rinsed with hot water, set out to dry, and stored in a cupboard.

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.

R46's Face Sheet dated 4/26/18, identified diagnoses that included generalized muscle weakness, and spinal stenosis.

R46's care plan dated 4/20/18, indicated R46 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.

On 4/24/18, at 9:56 a.m. nursing assistant (NA)-B was observed to walk out of R46's room holding a soiled incontinent pad and a towel in her gloved hand. NA-B walked down the hallway and into to the soiled utility room.
At 9:58 a.m. NA-B was interviewed and stated normally she would have the soiled incontinent pad in a plastic bag, carrying it not bagged this time was a "one time thing." NA-B verified the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 33	21375		

incontinent pad was soiled with urine. NA-B also stated she was not supposed to walk in the hallways wearing soiled gloves.

On 4/25/18, at 7:34 a.m. NA-A was observed go into R46's room and left the door open. From the hallway, NA-A was observed to approach R46 and stated she was going to change R46's incontinent brief, as R46 had requested to be changed. NA-A unfastened the incontinent brief with the door still open, removed the soiled incontinent brief, and threw it on the floor. NA-A provided pericare and applied a clean incontinent brief. NA-A then lowered the bed, covered R46, washed her hands hands and left the room. At 7:38 a.m. NA-A was interviewed. NA-A stated, "Normally we don't do that. [R46] insisted I had to change her right there and then. The trash can was not close, and at times I would set the pad inside the plastic bag at the bottom of the bed."

On 4/25/18, at 1:03 p.m. registered nurse (RN)-A stated she would expect staff to bag soiled incontinent products in the room, not to throw soiled incontinent products on the floor. RN-A also stated staff should not be walking in the hallways with gloves on.

On 4/25/18, at 1:37 p.m. the DON stated she would expect staff would not throw soiled incontinent products on the floor, and stated soiled incontinent products were to be bagged in the room before bringing them out of the room. The DON

The facility Linen Handling policy revised 3/20/17, directed staff to handle all soiled linen as though it was potentially infectious.

R89's Face Sheet printed on 4/26/18, identified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ____ B. WING ____	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 34	21375		

diagnoses that included chronic obstructive pulmonary disease (COPD), and dementia.

R89's annual MDS dated 2/19/18, indicated R89 had moderately impaired cognition, and required extensive assistance for transferring, personal hygiene and toileting. The MDS further indicated R89 was always incontinent of bladder, and frequently incontinent of bowel.

R89's care plan dated 9/30/14, indicated R89 had bowel incontinence related to immobility, congestive heart failure, diabetes and diuretics. R89's care plan directed staff to toilet every three hours during the day, and check/change every two hours during the night.

R89's Care Card (nursing assistant care guide) undated indicated R89 was frequently incontinent of bladder and bowel, and directed staff to toilet every three hours, and upon request.

On 4/25/18, at 7:43 a.m. NA-C and NA-D were observed to enter R89's room to perform morning cares. NA-C and NA-D lowered R89 onto the toilet with the assistance of a sit-to-stand machine. NA-C donned gloves and used toilet paper, then a warm wash cloth, to wipe bowel movement (BM) from R89's bottom. BM was visible on the toilet paper and the washcloth. NA-C used a towel to dry R89's bottom. NA-C doffed her gloves, and without performing hand hygiene, NA-C touched the sit-to-stand sling to attach it to the machine, touched the wheelchair handles to position the wheelchair below R89, touched the sling again to remove it from around R89, and straightened R89's dress.

On 4/25/18, at 12:56 p.m. NA-C stated she didn't know if she performed hand hygiene or not after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 35	21375		

providing incontinence care for R89.

On 4/25/18, at 1:13 p.m. RN-F confirmed hand hygiene should occur immediately after glove removal.

On 4/25/18, at 1:28 p.m. the DON confirmed hand hygiene should occur immediately after glove removal.

The facility's Hand Hygiene policy revised 5/8/17, directed hands should be washed after removing gloves.

R49's Face Sheet printed 4/26/17, indicated R49's diagnoses included vascular dementia, and unspecified osteoarthritis.

R49's significant change MDS dated 3/8/18, indicated R49 had severe cognitive impairment. The MDS also indicated R49 was frequently incontinent of bowel and bladder.

On 4/25/18, at 10:14 a.m. NA-F was observed preparing for morning cares for R49. NA-F used a radio to request assistance to get R49's incontinence brief changed, and to assist with using a mechanical lift to transfer R49 from bed to a wheelchair. At 10:21 a.m. NA-F lowered and flattened R49's bed, and loosened R49's soiled incontinent brief with gloved hands. NA-F used a cloth to wipe R49's periarea. NA-E rolled R49 onto his left side, while NA-F removed the wet incontinent brief and placed it in a bag in a trash can. NA-E proceeded to put a clean incontinent brief on R49. NA-F and NA-E doffed their gloves, and did not perform hand hygiene. NA-F and NA-E worked together to get a lift pad under R49, then used a lift to move him from the bed to his wheelchair. Once he was seated, NA-E removed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21375	Continued From page 36 the gown he wore as sleepwear, and NA-F put a shirt over his head. NA-E and NA-F both worked to get the shirt pulled down and situated appropriately on R49's body. NA-E then washed her hands. On 4/25/18, at 10:36 a.m. NA-E confirmed that she had failed to wash or sanitize her hands immediately after doffing her gloves. NA-E stated she usually washes her hands after removing her gloves, and has a small bottle of sanitizer in her pocket. On 4/25/18, at 10:38 a.m. the DON confirmed it was her expectation staff wash their hands after doffing soiled gloves. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff follow infection control procedures. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were	21630		6/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ____ B. WING ____	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21630	Continued From page 37	21630		

prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years.

B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure Fentanyl patches were accurately destroyed to prevent potential diversion for 1 of 1 resident (R59) reviewed for medication storage

Corrected.

Findings include:

R59's Face Sheet dated 9/8/17, indicated diagnoses that included muscle spasm, multiple sclerosis, and scoliosis.

R59's significant change Minimum Data Set (MDS) dated 3/14/18, indicated R59 received opiod medication, and identified R59 had indicated she had pain. R59 reported the pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

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VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

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21630	Continued From page 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's Physician's Orders dated 2/14/18, indicated R59 had an order for the Fentanyl patch (opiod pain medication patch) 75 microgram (mcg)/hour. Apply every 3 days.

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.

On 4/25/18, at 3:22 p.m. the director of nursing (DON) verified documentation lacked evidence of two nurses witnessing the destruction of used patches. The DON stated she was not sure where the Sharps containers were stored once removed from the medication cart while waiting pickup from an outside service for disposal. At 3:43 p.m. the DON stated Sharps containers were taken downstairs to a unsecured room until they were picked up for disposal. The DON stated RN-B was not following the facility policy for proper destruction of Fentanyl patches.

The facility's Fentanyl Patch Destruction policy dated February 2014, directed two licensed nurses or a trained medication aide (TMA) and licensed nurse would remove the patch from the resident. Staff that remove the patch will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21630	Continued From page 39 immediately destroy (waste) by flushing down the sewer system. Both staff removing and destroying/wasting will sign off in the electronic medication administration record. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure fentanyl patches were disposed of safely in order to prevent diversion. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21630		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure privacy was provided during cares for 1 of 1 residents (R46) reviewed for activities of daily living. In addition, the facility failed to ensure dignity was maintained by ensuring a urinary drainage bag was covered for 1 of 1 residents (R296) reviewed for urinary	21805	Corrected.	6/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 40	21805		

catheter.

Findings include:

R46's Face Sheet dated 4/26/18, identified diagnoses that included generalized muscle weakness,and spinal stenosis.

R46's quarterly Minimum Data Set (MDS) dated 2/23/18, indicated R46 had intact cognition, and required extensive assistance of one to two staff with activities of daily living (ADLs) including toilet use.

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.

On 4/25/18, at 7:34 a.m. nursing assistant (NA)-A was observed go into R46's room and left the door open. From the hallway, NA-A was observed to approach R46 and stated she was going to change R46's incontinent brief, as R46 had requested to be changed. NA-A unfastened the incontinent brief with the door still open, removed the soiled incontinent brief, provided pericare and applied a clean incontinent brief. NA-A then lowered the bed, covered R46, washed her hands hands and left the room. At 7:38 a.m. NA-A was interviewed. NA-A stated she was not able to shut the door to provide privacy while providing cares, as the E-Z stand lift was in the way. NA-A acknowledged the door should have been closed to provide for privacy.

On 4/25/18, at 10:50 a.m. when R46 stated it would be embarrassing if someone was able to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 41	21805		

see her from outside 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.

The facility's Dignity policy revised 10/23/17, directed staff to promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal cares and treatment procedures. In addition, the policy directed staff to help avoid things that could be demeaning to the residents such as helping the resident to keep urinary catheter bags covered.

R296's Face Sheet printed 4/26/18, indicated diagnoses that included 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.

On 4/24/18, at 8:44 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.

On 4/24/18, at 2:21 p.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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ___ B. WING ___	C 04/26/2018

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

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21805	Continued From page 42 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. On 4/25/18, at 9:24 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. On 4/26/18, at 8:52 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. 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. On 4/25/18, at 12:44 p.m. registered nurse (RN)-E stated catheter bags were not covered when a resident was in their room. On 4/26/18, at 9:31 a.m. the director of nursing (DON) stated she would expect catheter bags to be covered whether a resident was in their room or not, unless the resident stated they did not want it covered. The facility's Catheter Care Policy undated, directed staff to ensure drainage bags were not visible from the hallway. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: ______ B. WING ______	C 04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 43 develop, review, and/or revise policies and procedures to ensure residents are provided with privacy and are treated with dignity. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		