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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZLT6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00602

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/12/2016** (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)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room
* Code: **A, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 09/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/23/2016 (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
08/04/2016
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5414

Crest View Health center was not in substantial compliance with Federal participation requirements at the time of the June 16, 2016 Survey. On August 12, 2016, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on September 6, 2016, The Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the August 12, 2016 survey, effective July 26, 2016. Refer to the CMS-2567b for both health and life safety code.

Documentation supporting the facility's request for a continuing waiver involving life safety code deficiency cited at K023 was previously forwarded to the CMS Region V Office. Approval of the waiver request was recommended.

Effective July 26, 2016, the facility is certified for 92 skilled nursing facility beds.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245414

September 23, 2016

Ms. Katie Collins, Administrator
Viewcrest Health Center
3111 Church Street
Duluth, Minnesota 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 July 26, 2016 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.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K023.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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

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

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

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 6, 2016

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

RE: Project Number S5414027

Dear Ms. Collins:

On July 2, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 16, 2016. This survey found the most serious deficiencies to bewidespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On August 12, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on 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 June 16, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 26, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 16, 2016, effective July 26, 2016 and therefore remedies outlined in our letter to you dated July 2, 2016, will not be imposed.

Your request for a continuing waiver involving the life safety code deficiency cited under K23 at the time of the June 16, 2016 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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 related to this eNotice.

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245414 Y1	A. Building B. Wing Y2	8/12/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0280	Correction	ID Prefix F0323	Correction	ID Prefix F0333	Correction
Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.25(m)(2)	Completed
LSC	07/26/2016	LSC	07/26/2016	LSC	07/26/2016
ID Prefix F0371	Correction	ID Prefix F0441	Correction	ID Prefix F0465	Correction
Reg. # 483.35(i)	Completed	Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed
LSC	07/26/2016	LSC	07/26/2016	LSC	07/26/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TA/mm	09/06/2016	29433	08/12/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 6/16/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZLT6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00602

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/16/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **92** (L18)
13.Total Certified Beds **92** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room
* Code: **B, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NEII 07/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/02/2016 (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
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5414

On June 16, 2016 the Departments of Health and Public safety completed a recertification survey. Deficiencies were found at a scope and severity of level of F. The facility has been given an opportunity to correct before remedies would be imposed.

In addition at the time of the recertification survey an investigation of complaint number H5414050 was conducted and found to be unsubstantiated.

The facility is requesting an annual waiver of life safety code deficiency cited at K023 has been forwarded to the CMS Region V Office for their determination. Approval of the waiver has been recommended. Refer to the K84 justification page for the details of the waiver request.

Refer to the CMS 2567 for both health and life safety code along with the facility's plan plan of correction. Post Certification Revisit (PCR) to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 2, 2016

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

RE: Project Number S5414027, H5414050

Dear Ms. Collins:

On June 16, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the June 16, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5414027 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Phone: (218) 302 6151
Fax: (218) 723-2359
email: teresa.ament@state.mn.us

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 26, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 26, 2016 the following remedy will be imposed:

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

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 remedies be imposed:

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

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

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

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 16, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and

1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 16, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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.

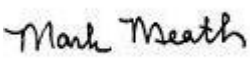
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4118 Fax: (612) 215-9697
email: mark.meath@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	06/16/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility'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. H Complaint H5414050 was investigated and not substantiated.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		7/26/16

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

Electronically Signed | 07/15/2016

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	245414	A. BUILDING _____ B. WING _____	06/16/2016

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 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the plan of care was revised to reflect interventions for falls for 1 of 3 residents (R30) reviewed for accidents. Findings include: R30's Face Sheet dated included diagnoses of dementia with Lewy bodies (a form of dementia that causes cognitive impairment, hallucinations, confusion, memory loss and delusions), anxiety disorder and macular degeneration. R30's quarterly review Minimum Data Set (MDS) dated 3/16/16, indicated R30 had adequate hearing, moderate vision impairment, was severely cognitively impaired and exhibited no mood or behavior symptoms. The MDS identified R30 required extensive assistance with bed mobility, transfers, wheelchair locomotion, dressing, toileting, and personal hygiene. The MDS also indicated R30 was frequently incontinent of urine and occasionally incontinent of bowel. The care plan for R30 dated 6/6/16, indicated R30 was at risk for falls related to cognitive deficits. Interventions included: - assist resident as needed with mobility and transfers - encourage resident to use call light for assistance - fall risk will be assessed every quarter and with	F 280	R30□s care plan was reviewed to ensure that all safety interventions were put into place and were reflected on the care plan. We will review residents who have fallen since 6/16/16 to ensure safety interventions that were put into place are reflected in their care plan. IDT team (including nurse managers) will be re-educated on need to update the care plan with all new safety interventions after each fall for all residents. Training will be completed by 7/22/16. Random audits of care plans will be conducted by DON/designee 2x/week x 2, then weekly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations for three months.	

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F 280	Continued From page 2 change of condition - keep call light within easy reach (resident has a pendent call light) - keep room free form clutter or obstacles - provide resident with verbal cues and reminders as needed - reorient resident to room - restorative exercise prn - Dycem between wheelchair and cushion to prevent cushion from sliding/slipping The care plan lacked any direction on the intervention to seat the resident away from the flowers or flower beds and plants. On 6/14/16, from 3:40 p.m. to 3:53 p.m. R30 was observed sleeping and seated in her wheelchair in a dining room without staff present and seated next to a flower bed. A review of falls indicated the following: On 5/5/16, a progress note indicated indicated R30 fell in the dining room after getting up from her wheelchair at the dining table. R30 tried to walk independently, lost her balance and fell backwards over the brick wall into a flower bed, landing on her buttocks. Visitors and staff assisted R30 to sit on the brick wall. A physician notification and order form dated 5/5/16, indicated R30 fell in dining room with no obvious injuries. On 5/25/16, a fall report indicated R30 lost her balance while ambulating in the dining room. R30 was alone and unattended. The fall was unwitnessed. The resident said she was trying to walk over to those plants around the table, falling ten feet from a transfer surface. The root cause of this fall was identified as the resident lost her	F 280		

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F 280	Continued From page 3 balance while trying to walk alone without assistance, and this was the resident's second fall in the dining room related to plants. The report indicated the care plan was being followed, and did not identify the care plan interventions in place at the time of the fall. The new intervention was to move the resident away from this particular area (the plants/flowers), as it seemed to be the focus of the falls. On 6/11/16, a fall report indicated R30 was found on the floor in her room kneeling in front of her wheelchair. R30 had been attempting self-transfer. R30 stated she was trying to use the commode. The root cause of the fall was identified as a possible slippage of the wheelchair cushion. A nonslip pad between the wheelchair and the cushion was directed as a new intervention. The report indicated the care plan was being followed, but did not describe interventions in place at the time of the fall. On 6/16/16, at 4:47 p.m. the director of nursing was interviewed and verified fall interventions for R30 included keeping R30 away from the flowers in the dining room. The facilty's care plan policy directed care plans to be revised by the nurse manager quarterly with care conferences. The policy further directed care plans to be updated by a registered nurse with changes in resident conditions and those changes communicated to all staff at shift changes.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		7/26/16

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F 323	Continued From page 4 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper interventions were provided to minimize the risk of falls for 1 of 3 residents (R30) reviewed for accidents. Findings include: R30's Face Sheet dated 8/2/07, included diagnoses of dementia with Lewy bodies (a form of dementia that causes cognitive impairment, hallucinations, confusion, memory loss and delusions), anxiety disorder and macular degeneration. R30's quarterly review Minimum Data Set (MDS) dated 3/16/16, indicated R30 had adequate hearing, moderate vision impairment, was severely cognitively impaired and exhibited no mood or behavior symptoms. The MDS identified R30 required extensive assistance with bed mobility, transfers, wheelchair locomotion, dressing, toileting, and personal hygiene. The MDS also indicated R30 was frequently incontinent of urine and occasionally incontinent of bowel. R30's Fall Risk assessment dated 12/29/15, indicated R30 was at a high risk for falls due to	F 323	R30□s care plan was reviewed to determine appropriateness of safety interventions. Resident hasn□t had any further attempts to self-transfer towards the brick wall or the plants since her move to her new seat in the same dining room and has been assessed to be safe in that area without supervision. We will review residents who have fallen since 6/16/16 to ensure safety interventions that were put into place are reflected in their care plan. IDT team (including nurse managers) will be re-educated on need to update the care plan with all new safety interventions after each fall for all residents. Training will be completed by 7/22/16. Random audits of care plans will be conducted by DON/designee 2x/week x 2, then weekly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations for three months.	

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F 323	Continued From page 5 impaired balance during transitions, use of antipsychotics, antidepressants, narcotic analgesics, and neuroleptics, incontinence, visual and cognitive impairment, cardiac disease, decline in functional status, arthritis, osteoporosis, dementia and depression. R30's care plan dated 6/6/16, indicated R30 was at risk for falls related to cognitive deficits. Interventions included: - assist resident as needed with mobility and transfers - encourage resident to use call light for assistance - fall risk will be assessed every quarter and with change of condition - keep call light within easy reach (resident has a pendent call light) - keep room free form clutter or obstacles - provide resident with verbal cues and reminders as needed - reorient resident to room - restorative exercise prn - Dycem between wheelchair and cushion to prevent cushion from sliding/slipping The care plan lacked any direction on the intervention to seat the resident away from the flowers or flowers and plants. On 6/14/16, from 3:40 p.m. to 4:06 p.m. R30 was observed sleeping and seated in her wheelchair next to a flower bed in the dining room without staff present. A review of R30's falls indicated the following: On 5/5/16, a progress note indicated indicated R30 fell in the dining room after getting up from	F 323		

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F 323	Continued From page 6	F 323		

her wheelchair at the dining table. R30 tried to walk independently, lost her balance and fell backwards over the brick wall into a flower bed, landing on her buttock. Visitors and staff assisted R30 to sit on the brick wall. A physician notification and order form dated 5/5/16, indicated R30 fell in dining room with no obvious injuries.

On 5/25/16, a fall report indicated R30 lost her balance while ambulating in the dining room. R30 was alone and unattended. The fall was unwitnessed. The resident said she was trying to walk over to those plants around the table, falling ten feet from a transfer surface. The root cause of this fall was identified as the resident lost her balance while trying to walk alone without assistance, and this was the resident's second fall in the dining room related to plants. The report indicated the care plan was being followed, and did not identify the care plan interventions in place at the time of the fall. The new intervention was to move the resident away from this particular area (the plants/flowers), as it seemed to be the focus of the falls.

On 6/11/16, a fall report indicated R30 was found on the floor in her room kneeling in front of her wheelchair and had been attempting self-transfer. R30 stated she was trying to use the commode. The root cause of the fall was identified as a possible slippage of the wheelchair cushion. A nonslip pad between the wheelchair and the cushion was directed as a new intervention. The report indicated the care plan was being followed, but did not describe interventions in place at the time of the fall.

On 6/15/16, at 8:39 a.m. until 9:48 a.m. R30 was observed sliding down in her wheelchair with her

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F 323	Continued From page 7	F 323		

back diagonal to the wheelchair back. R30 said she was "sloping" in her chair. R30 was wearing a pendant call light. R30 said she didn't know where her call light was.

On 6/15/16, at 8:44 a.m. nursing assistant (NA)-D was interviewed and asked if R30 knew how to find and use her call light. NA-D stated R30 sometimes knew how to use her call light, but not always.

On 6/15/16, at 1:54 p.m. NA-I was interviewed and stated direct care staff were made aware of changes in care plans and interventions per RN-C and by looking at the care plan when they start each day. NA-I said it had been a long period of time since R30 had fallen on the day shift, and the staff can tell when R30 is agitated.

On 6/15/16, at 2:28 p.m. licensed practical nurse (LPN)-A was interviewed and stated R30 had two falls in the last month. LPN-A said they had used Tab alarms (a monitor attached to clothing that alarms when it is pulled away from a magnet attached to a bed or chair) in the past, but stopped using these alarms when R30 had a few falls. LPN-A stated R30's interventions to prevent falls included monitoring her behavior, checking on the resident every two hours and toileting her every two hours. LPN-A said she did not know of the behaviors R30 exhibited before falls.

On 6/15/16, the director of nursing (DON) was interviewed and stated the fall that occurred on 5/5/16, was not technically a fall, since the resident only dropped about four inches onto the flower bed. The DON verified the staff called it a fall and did neurological checks.

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F 323	Continued From page 8 On 6/16/16, at 12:32 p.m. the DON was interviewed and stated R30's fall interventions included keeping R30 away from the flower beds in the dining room, not in direct view of the flower beds. On 6/16/16, at 1:47 p.m., RN-C was interviewed and said there were no interventions put in place after the 5/5/16, incident in the dining room, as the fall was not determined to be a fall. RN-C further stated R30 can be lucid at times, but usually not lucid. RN-C said R30 was found on the floor in the dining room on 5/25/16, trying to walk to the plants. RN-C said the intervention put in place after this fall was to seat R30 away from the plants. RN-C stated R30 fell on 6/11/16, when the wheelchair cushion slid out from under her. RN-C said the new interventions put in place after this fall included a fitting wheelchair cushion and a nonslip pad placed between the wheelchair and cushion. RN-C said R30 was more active in the past and was declining in her ability to ambulate. The facility's Falls Protocol policy dated 1/1/13, defined a fall as an unintentional change in position coming to rest on the ground, floor or onto the next lower surface. The policy further indicated direct care staff will be trained on the resident's falls care plan.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 333		7/26/16

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F 333	Continued From page 9 Based on observation, interview, and document review, the facility failed to ensure 1 of 5 residents (R97) reviewed for unnecessary medication was free from significant medication errors. Findings include: R97's Face Sheet indicated R97 admitted to the facility on 4/18/16. Admitting diagnosis included Atrial Fibrillation, chronic heart failure, and anemia. R97's admission minimum data set (MDS) dated 4/24/16, indicated she had intact cognition and was dependent on staff for all activities of daily living. R97's care plan dated 4/25/16, indicated anticoagulant therapy use and directed staff to monitor for signs of bleeding, protect her from injury and provide medications and labs as ordered. R97's EMAR (electronic medication administration record) Monthly Report For April, May, and June, 2016, indicated she received Coumadin (an anticoagulant medication used to prevent heart attacks, strokes, and blood clots in veins and arteries) daily during the month of April. During the month of May R97 received Coumadin on 5/1/16, 5/3-8 and 5/12- 5/30. A physician's order dated 5/9/16, directed the following: hold Coumadin today, change dose to 2.5 milligrams (mg) daily, recheck INR Thursday 5/12/16. The EMAR indicated R97 did not receive her Coumadin on 5/10/16, and 5/11/16. An Essentia Health Scheduled Fax Report dated 5/12/16, indicated an INR result of 1.3 which was below the therapeutic range of 2.0-3.0 for R97.	F 333	R97 eMAR was updated to have an ALERT that prompted staff to check the chart for a Coumadin dose to administer if one was not noted to give on the eMAR at HS. All residents that have Coumadin medication ordered were reviewed to ensure that all are currently receiving correct Coumadin dosing. They were all also reviewed to ensure that the ALERT was in place on the eMAR and what to do if a dose was not noted. Nurse Managers were trained on importance of scheduling the Coumadin ALERT on all new admissions taking Coumadin or residents new to taking this medication. All nurse managers were given the most updated admission checklist that prompts them to put in the ALERT and any old checklists were destroyed. Random audits of Coumadin dosing will be conducted by DON/designee 2x/week x 2, then weekly thereafter to ensure residents are correct Coumadin dosing. Audit results will be brought to the QAPI committee for review and further recommendations for six months. Training will be completed by 7/22/16.	

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F 333	Continued From page 10	F 333		

During the month of June, R97 received Coumadin 6/1/16-6/9/16. From 6/10, through 6/16/16, R97 did not receive her Coumadin dose.

A document titled Telephone, dated 5/19/16, indicated (R97) "appears to be very sensitive to Coumadin." A document titled Telephone, dated 6/7/16, faxed to the facility from Essentia Health Lakewalk Clinic indicated the following: Writer faxed orders for Coumadin on 6/6/16, twice "Apparently not received by Viewcrest." On-call physician dosed patient for the evening of 6/6/16. New orders with dosing instructions as follows: Coumadin 2.5 milligrams (mg) Monday and 2 mg rest of week. Recheck INR (international normalized ratio-used to determine the clotting tendency of blood) Friday 6/10/16. The order contained a facility signature 6/7/16, and two additional facility signatures on 6/8/16, but the order was never processed resulting in the missed Coumadin doses.

During an observation on 6/15/16, at 1:19 p.m. R97 was lying on her back in her room, she stated she did not want to answer any questions by the surveyors.

On 6/16/16, at 10:41 a.m. registered nurse (RN)-C was interviewed and stated R97 should be receiving Coumadin. She stated R97's last INR was on 6/6/16, and should have been rechecked on 6/10/16. RN-C stated this was not done and R97 had not received Coumadin since 6/10/16. RN-C stated she was not aware R97 had not been receiving her Coumadin prior to the interview with the surveyor.

During an interview on 6/16/16, at 12:11 p.m. nurse practitioner (NP)-A stated she was updated

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on the missed Coumadin doses and stated her INR should have been rechecked. She stated she was not sure if there were any repercussions and ordered an ultrasound to rule out a DVT (deep vein thrombosis-occurs when a blood clot forms in one or more of the deep veins in your body). NP-A stated the Coumadin clinic had been updated and would put her back on the medication. NP-A stated she felt the missed dose was likely due to a facility system problem.

An untitled document dated 6/16/16, indicated the following update to the physician: "A medication error was discovered, no Coumadin has been given since 6/6/16." The document contained a follow-up from the provider dated 6/16/16, that read as follows: Physicians orders: "Follow orders per Coumadin clinic." LLE (lower left extremity) US (ultrasound) r/o (rule out) DVT.

A facility Physician's Telephone Order, dated 6/16/16, directed: give Coumadin 4 mg Thursday and 3 mg rest of week. Recheck INR Monday 6/20/16. Give Lovenox (Lovenox injection is an anticoagulant used to prevent blood clots, which can lead to blood clots in the lungs) 90 mg subcutaneous every 12 hours with last dose being Monday 6/20/16, in morning.

During an interview on 6/16/16, at 12:51 p.m. the director of nursing (DON) stated the process for transcribing orders was a two person check system. She stated if a dose was missed the computer system should send an alert to notify the physician and get a new order. The DON stated the alert was missed for R97. She stated the facility would notify the physician right away if there were negative side effects of the missed medication.

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F 333	Continued From page 12 The facility policy and procedure Medication Orders dated 2/3/13, directed any drug that alters a resident's blood level and causes negative symptoms of toxicity would be a significant medication error. Examples of a drug that could alter blood level is Coumadin. If a resident's drug has been missed several times, this could be classified as a significant medication error.	F 333		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to refrigerate foods at the proper temperature, and failed to ensure dishes were dried in a sanitary manner. This practice had the potential to affect all 85 residents who received food items from the facility kitchen. Findings include: During a kitchen tour with the dietary manager (DM) on 6/13/16 at 11:40 a.m. the DM confirmed the following:	F 371	The facility□s three door refrigerator in the kitchen has been replaced. The facility will continue to monitor and log refrigerator temperatures. Adjustments will be made to temperature setting if temperature is outside of acceptable range, per policy. QAPI committee will review monthly report on refrigerator temperatures for six months.	7/26/16

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	245414	A. BUILDING _____ B. WING _____	06/16/2016

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 371	Continued From page 13 -The facility's three door refrigerator in the kitchen had a current temperature of 44 degrees. The cooler held beverages, supplements and other small, snack items for resident use (50 degrees Fahrenheit when rechecked on 6/16/16, at 2:32 p.m.). In an interview during the tour on 6/13/16, at 12:48 p.m. the DM stated they had ordered a new three door cooler, but could not get it through the kitchen doors. The new cooler was in the dry storage room, not convenient for staff use. The cooler that was currently in the kitchen is old, from the 1970's. The DM stated they have replaced the seals but there is no vacuum, so when one door shuts, another will open a little and the staff don't always notice. The DM stated the crew that uses an area or item is responsible for cleaning that item or area. The DM also stated that there is a cleaning chart. On 6/16/16, at 2:32 p.m. the DM stated the current temperature of the 3 door cooler in the kitchen was 50 degrees F. The DM stated the temps in the morning are usually within range, but as staff are in and out of the cooler throughout the day, the afternoon temperatures are usually above range. The DM stated the current temperature is 50 degrees, and it was probably about an hour since the staff had been opening that cooler. The DM stated he has told staff for years to watch for doors coming ajar when opening and shutting them. The facility policy titled Food Storage and Temperature dated 2/25/15, directed dietary employees shall check the thermometer in the unit refrigerators; the temperature should be within 32-42 degrees. (if temperatures are outside	F 371		

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F 371	Continued From page 14 that range, the employees should adjust the temperature accordingly.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		7/26/16

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F 441	Continued From page 15 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate hand hygiene was performed during and after resident cares for 2 of 6 residents (R90, R30) observed during cares. Findings include: R90's Face Sheet indicated R90's diagnoses included muscle weakness, heart failure, dementia, type 2 diabetes, back pain and rheumatoid arthritis. The significant change Minimum Data Set (MDS) dated 5/16/16, indicated R90's cognition was severely impaired. R90 needed the extensive assistance of staff with bed mobility, transfers, dressing, personal hygiene and eating. R90 was under Hospice care. On 6/15/16, at 10:00 a.m. nursing assistant (NA)-A was assisting R90 with morning cares. NA-A washed her hands and donned gloves. NA-A then emptied the urinary catheter drainage bag into a graduate, cleaned the drain end with an alcohol wipe, emptied and rinsed the graduate in the bathroom, returned the graduate to the bedside stand and removed her gloves. NA-A stated, "I have to go grab his linens" and exited and entered the room within 15 seconds. NA-A did not wash or sanitize her hands after removing the gloves when exiting or returning to the room. NA-A donned new gloves, lowered the head of	F 441	Training will be provided to all nursing and CNA staff on the need to wash or sanitize hands between glove changes and between dirty to clean cares. Training will be completed by 8/20/16. Random audits of cares including appropriate times for handwashing and glove changes will be completed by DON/designee 2x/week, then weekly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations for three months.	

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F 441	Continued From page 16	F 441		

the bed, removed R90's pants, pulled the urinary catheter drainage bag out of pant leg and put R90's socks on. NA-A then retrieved an incontinent brief and the clothes from the closet, put R90's pants on the lower legs, guided the urinary catheter drainage bag through the pant leg, lowered the incontinent brief, then washed R90's face and peri area. R90 was incontinent of stool. NA-A removed R90's incontinent brief and cleaned the buttocks. NA-A pulled up R90's brief and pants, rolled R90 side to side and placed the lift sling under R90. NA-A applied barrier cream to R90's peri area and removed her gloves. NA-A did not wash or sanitize her hands. NA-A applied R90's slippers. attached the lift sling to the lift, transferred R90 into the wheelchair with the assistance of another staff and disconnected the lift sling. NA-A changed R90's shirt, applied deodorant and hung the urinary catheter drainage bag under the wheelchair. NA-A brought R90 to the sink, donned gloves, brushed R90's (own) teeth and removed the gloves. NA-A did not wash or sanitize her hands. NA-A applied R90's oxygen nasal cannula and combed his hair. NA-A donned gloves, gathered the soiled linen and trash, put the supplies away and removed her gloves. NA-A then exited R90's room and went to the soiled utility room and sanitized her hand after she exited the utility room.

On 6/15/16, at 10:30 a.m. NA-A verified she did not wash or sanitize her hands between glove changes and when exiting R90's room. NA-A stated she cleaned her hands when entering and exiting because in between it was too hard to get the gloves on. NA-A stated that was the way she usually did it.

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F 441	Continued From page 17	F 441		

R30's Face Sheet included diagnoses of dementia with Lewy bodies (a form of dementia that causes cognitive impairment, hallucinations, confusion, memory loss and delusions), anxiety disorder, macular degeneration, osteoarthritis and COPD.

R30's quarterly review Minimum Data Set (MDS) dated 3/16/16, indicated R30 was severely cognitively impaired and required extensive assistance with bed mobility, dressing, toileting, and personal hygiene. The MDS also indicated R30 was frequently incontinent of urine and occasionally incontinent of bowel.

On 6/15/16, at 7:57 a.m. nursing assistant (NA)-I entered R30's room, washed her hands and donned gloves. NA-I applied incontinence briefs and pants to R30's lower legs and shoes to R30's feet while R30 was in bed. NA-I left overnight blue briefs on R30. NA-I called for assistance on a voice pager. NA-D entered R30's room, washed her hands and donned gloves. NA-I and NA-D assisted R30 to stand. R30's overnight blue briefs and bed pad were observed to be saturated with urine. NA-I assisted R30 to a commode, and R30 voided a small amount of urine. NA-D removed her gloves, washed her hands and left R30's room. NA-I removed R30's wet overnight briefs and washed R30's perineal area and buttocks with a wet washcloth. NA-I placed the washcloth in a basin of warm water and wiped R30's eyes.

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F 441	Continued From page 18	F 441		

NA-I washed R30's back, face and hands with the wet washcloth. NA-I did not change gloves throughout removing R30's wet briefs, wiping R30's eyes, washing R30's back, face and hands. NA-I emptied the commode, wiped out the wash basin, sprayed with water and hand-combed R30's hair. NA-I wore the same gloves throughout pericare, face/eye washing,assisting R30 with dressing, emptying the commode and combing R30's hair. NA-I removed her gloves and sanitized her hands with hand sanitizer in room after completing R30's cares.

At 8:19 a.m. NA-I was interviewed and confirmed she did not change gloves or wash her hands until cares were completed. NA-I said she should have changed gloves and washed her hands after performing pericare.

On 6/16/16, at 1:47 p.m. registered nurse (RN)-C was interviewed and stated staff must perform glove changes and handwashing after pericares. RN-C further stated cares should be done clean to dirty and never in reverse.

On 6/16/16, at 4:36 p.m. the director of nursing (DON) was interviewed and stated the staff should have performed handwashing and glove changes with R30's cares when moving from a dirty to clean area.

The facility policy and procedure on Infection Prevention and Control Program dated 1/16, directed staff to wash their hands before and after each resident contact, after touching any bodily substance or fluid, after handling contaminated items, and before putting on and removing gloves. The policy further directed staff to put on clean gloves before touching mucous

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F 441	Continued From page 19 membranes or anticipating contact with bodily fluids, secretions, excretions and contaminated surfaces. The policy directed staff to remove gloves promptly after use, and wash hands before touching non-contaminated items or environmental surfaces.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure doors, walls and floors were clean and in good repair for 16 of 35 resident rooms (Rooms 31, 32, 35, 36, 37, 38, 42, 43, 44, 55, 58, 69, 71, 75, 78, 83). In addition, the facility failed to ensure the kitchen environment was clean. Findings include: On 6/16/16, at 11:45 a.m. during an environmental tour with environmental services director (ESD) the following was noted: Room 31, the room and bathroom doors were scuffed along the bottom plastic covering. Room 32, the room and bathroom doors were scuffed along the bottom covering and the wood on the lower edges of the doors were chipped causing a rough and uncleanable surface.	F 465	The entry and bathroom doors plastic covering of room 31 was repaired. The entry and bathroom doors of rooms 32, 35, 36, 37, 38, 42, 43, 44, 58, 69, 71, 75, 78, 83 were repaired. In room 55, the wall next to sink, under towel dispenser, and a wall in the bathroom were cleaned and the area underneath the sink was cleaned. Doors requiring repair to maintain a smooth and cleanable surface has been added to the Preventative Maintenance Worksheet. Monthly audits addressing the condition of doors, floors, and walls will be completed by Administrator or designee. Quality Council will review audit results monthly for the next six months. The floor of the small dry storage room was swept and food splatters were washed off the walls. The shelves where pans were stored were cleaned. The	7/26/16

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F 465	Continued From page 20 Room 35, the room and bathroom doors were scuffed along the bottom covering and the wood on the lower edges of the doors were chipped causing a rough and uncleanable surface. Room 36, the room and bathroom doors were scuffed along the bottom covering and the wood on the lower edges of the doors were chipped causing a rough and uncleanable surface. Room 37, the room and bathroom doors were scuffed along the bottom covering and the wood on the lower edges of the doors were chipped causing a rough and uncleanable surface. Room 38, the room and bathroom doors were scuffed along the bottom covering and the wood on the lower edges of the doors were chipped causing a rough and uncleanable surface. Room 42, the room and bathroom doors were scuffed along the bottom covering and the wood on the lower edges of the doors were chipped causing a rough and uncleanable surface. Room 43, the room and bathroom doors were scuffed along the bottom covering and the wood on the lower edges of the doors were chipped causing a rough and uncleanable surface. Room 44, the room and bathroom doors were scuffed along the bottom covering and the wood on the lower edges of the doors were chipped causing a rough and uncleanable surface. Room 55, the wall next to sink, under towel dispenser, and a wall in bathroom had drip like stains running down. Under the sink was a	F 465	mixer base and top of the guard was cleaned and the mixer was covered. The fronts of drawers used to store breads were cleaned. The cleaning schedule was revised to include sweeping the small dry storage room floor daily, walls, shelves and drawers to be cleaned weekly, and the mixer to be cleaned after each use. Dietary Manager or designee will audit each of these areas weekly and report to QAPI committee monthly for six months.	

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F 465	Continued From page 21 circular brown area approximately five inches in diameter. Room 58, the room door edge at the bottom to approximately 18 inches up was chipped. The door also had an area was approximately eight inches long. The areas had exposed wood creating a rough and uncleanable surface. Room 69, the lower edge of the room door approximately two feet from the bottom had several chipped areas. One of the areas was approximately six inches long exposing the wood causing a rough and uncleanable surface. Room 71, the room door was scuffed along the bottom covering and the wood on the lower edges of the door was chipped causing a rough and uncleanable surface. Room 75, the outer edge of the room door at the bottom approximately six inches up had several chipped areas exposing the wood causing a rough and uncleanable surface. Room 78, the room door on the lower inner and outer edges approximately six inches up from the bottom had several chipped areas exposing the wood causing a rough and uncleanable surface. Room 83, on the room door near the lower hinge was a chipped area approximately six inches long, exposing the wood causing a rough and uncleanable surface. During the environmental tour the ESD stated resident rooms were checked monthly. Areas included were chipped paint, lights, call lights, etc. The ESD provided the Room Checklist for	F 465		

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F 465	Continued From page 22 March/April 2016, and May/June 2016. The March/April 2016, checklist indicated rooms 59 and 60 had nicked door edges. The ESD was not aware of the the other above noted areas. The facility's Maintenance policy updated 4/9/15, directed the ESD would perform monthly room and building inspections and log the areas in need of repair on the Preventive Maintenance Worksheet. When a resident was discharge or moved, maintenance would inspect the room and make repairs as needed. All staff should be attentive to the areas included but not limited to cleanliness, safety, areas needing repair, etc. and fill out a maintenance repair requisition form to notify maintenance of needed repair. During a kitchen tour with the dietary manager (DM) on 6/13/16 at 11:40 a.m. the DM confirmed the following: -The floor of the small dry storage room had debris and dirt, needing to be swept. In addition, there were food splatters on the walls. -The shelves where pans were stored had food residue (dried splatters and loose crumbs) on the length of the shelf edge, in front of the pans. -The mixer, stored for clean, was not covered and had food residue on its base and flour on top of the guard. -The front of drawers used to store breads had dried food splatters on them. In an interview during the tour on 6/13/16, at 12:48 p.m. the DM stated the crew that uses an area or item is responsible for cleaning that item or area. The DM also stated that there is a	F 465		

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F 465	Continued From page 23 cleaning chart. The facility policy titled, Cleaning and Sanitizing of Drawers/Shelves, dated 1/31/12, indicated drawers and shelves will be maintained in a clean and sanitary condition, free of soil and crumbs. The policy directed staff to complete cleaning per schedule and as shelves and drawers get soiled.	F 465		

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	245414	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/15/2016**

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K 000	INITIAL COMMENTS Building #1 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on June 15, 2016 . At the time of this survey, Viewcrest Health Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Building #1 Viewcrest Health Center, Building #1, is a 1-story building with a partial basement. The original building was constructed in 1960 with additions constructed in 1968, 2002 and 2008. The 1960 and the 1968 building is type II(111) construction. The 2002 building is two (2) story Type II(000), and the 2008 building is Type II(11) 2-story. Therefore, the 1960, 1968, and 2002 building was inspected as one building to Type II(000) construction. The 2008 building was inspected as a separate building. The building is fully protected by automatic fire sprinklers. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/18/2016

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 has a licensed capacity of 92 beds and had a census of 82 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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	245414	A. BUILDING **02 - VIEWCREST HEALTH CENTER** B. WING _____	**06/15/2016**

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
K 000	INITIAL COMMENTS Building #2 THIS INSPECTION ONLY COVERS THE 2008 ADDITION TO VIEWCREST HEALTH CENTER. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. THIS INSPECTION ONLY COVERS THE 2008 ADDITION TO VIEWCREST HEALTH CENTER. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on June 15, 2016 . At the time of this survey Viewcrest Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 NEW Health Care. 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		07/18/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to: 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. The 2008 addition, building #2, to the Viewcrest Health Center is a two (2) story building with no basement. The construction type is determined to be Type II(111) The building is separated from the rest of the facility by 2 hour fire rated construction , with a 1 & 1/2 hour rated fire door. The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The entire facility has a licensed capacity of 92 beds,	K 000		

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K 000	Continued From page 2 and the addition has a capacity of 22 beds that were all in use at the time of inspection. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 023 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined that the facility did not have two smoke compartments on every floor in accordance with 18.3.7.1, 18.3.7.2. This deficiency could affect half the residents in the event of an fire or an emergency. Findings include: On facility tour between the hours of 9:00 AM and 12:00 PM, in review of documentation and observation it was revealed that the 1st floor of the 2008 building did not have a smoke barrier in accordance with 18.3.7.1, 18.3.7.2.	K 023	Request extension of current waiver.	

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 A annual waiver is requested for K023 NFPA 101 Life Safety Code Standard: Smoke barriers are provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons regardless of use. Smoke barriers are also provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2	An Annual waiver is being requested for K023. A. Compliance with this provision would cause an unreasonable hardship because: 1. Viewcrest Health Center is committed to be in full compliance with the smoke compartment requirements of the code. To that end, plans were submitted for review and approval prior to construction to the Minnesota Department of Health Engineering Department and The Minnesota Department of Labor and Industry in 2006. 2. This would require us to no longer use the 21 resident rooms that are located in the lower level of the Mesa Atrium. The projected annual revenue loss would be $1,591,000 which is 20% of the facility's annual revenue. 3. Additional rooms are not available to relocate the residents living there. 4. Many of the residents living in the lower level Mesa addition have lived there many years and displacing them would negatively impact their social and mental well being. B. There will be no adverse effect on the building occupant's safety because: 1. The building is protected by a complete fire sprinkler system that complies with NFPA 13, 1999 Edition. 2. All sleeping rooms have smoke detectors as well as the above mentioned fire sprinklers. 3. The area is continuously staffed by nursing personnel. 4. The existing HVAC system ventilation fans do automatically shut down upon activation of the fire alarm system, or detection of smoke in the HVAC System. 5. Annual service and maintenance contracts exist to service all the facility's fire protection systems.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* Thomas Linhoff 12424	Title Fire Safety Supervisor	Office State Fire Marshal	Date 07/18/2016

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 2, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5414027, H5414050

Dear Ms. Collins:

The above facility was surveyed on June 13, 2016 through June 16, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5414027. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 at (218) 302-6151 or email: 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Reglation Division
Phone: (651) 201-4118 Fax: (651) 215-9697
email: mark.meath@state.mn.us

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 _____	06/16/2016

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

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2 000	Continued From page 1 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 6/13/16 through 6/16/16, 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 H5414050 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,	2 000		

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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		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the plan of care was revised to reflect interventions for falls for 1 of 3 residents (R30) reviewed for accidents. Findings include: R30's Face Sheet dated included diagnoses of dementia with Lewy bodies (a form of dementia that causes cognitive impairment, hallucinations, confusion, memory loss and delusions), anxiety disorder and macular degeneration.	2 570	Corrected.	7/26/16

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2 570	Continued From page 3 R30's quarterly review Minimum Data Set (MDS) dated 3/16/16, indicated R30 had adequate hearing, moderate vision impairment, was severely cognitively impaired and exhibited no mood or behavior symptoms. The MDS identified R30 required extensive assistance with bed mobility, transfers, wheelchair locomotion, dressing, toileting, and personal hygiene. The MDS also indicated R30 was frequently incontinent of urine and occasionally incontinent of bowel. The care plan for R30 dated 6/6/16, indicated R30 was at risk for falls related to cognitive deficits. Interventions included: - assist resident as needed with mobility and transfers - encourage resident to use call light for assistance - fall risk will be assessed every quarter and with change of condition - keep call light within easy reach (resident has a pendent call light) - keep room free form clutter or obstacles - provide resident with verbal cues and reminders as needed - reorient resident to room - restorative exercise prn - Dycem between wheelchair and cushion to prevent cushion from sliding/slipping The care plan lacked any direction on the intervention to seat the resident away from the flowers or flower beds and plants. On 6/14/16, from 3:40 p.m. to 3:53 p.m. R30 was observed sleeping and seated in her wheelchair in a dining room without staff present and seated next to a flower bed.	2 570		

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2 570	Continued From page 4 A review of falls indicated the following: On 5/5/16, a progress note indicated indicated R30 fell in the dining room after getting up from her wheelchair at the dining table. R30 tried to walk independently, lost her balance and fell backwards over the brick wall into a flower bed, landing on her buttocks. Visitors and staff assisted R30 to sit on the brick wall. A physician notification and order form dated 5/5/16, indicated R30 fell in dining room with no obvious injuries. On 5/25/16, a fall report indicated R30 lost her balance while ambulating in the dining room. R30 was alone and unattended. The fall was unwitnessed. The resident said she was trying to walk over to those plants around the table, falling ten feet from a transfer surface. The root cause of this fall was identified as the resident lost her balance while trying to walk alone without assistance, and this was the resident's second fall in the dining room related to plants. The report indicated the care plan was being followed, and did not identify the care plan interventions in place at the time of the fall. The new intervention was to move the resident away from this particular area (the plants/flowers), as it seemed to be the focus of the falls. On 6/11/16, a fall report indicated R30 was found on the floor in her room kneeling in front of her wheelchair. R30 had been attempting self-transfer. R30 stated she was trying to use the commode. The root cause of the fall was identified as a possible slippage of the wheelchair cushion. A nonslip pad between the wheelchair and the cushion was directed as a new intervention. The report indicated the care plan was being followed, but did not describe	2 570		

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2 570	Continued From page 5 interventions in place at the time of the fall. On 6/16/16, at 4:47 p.m. the director of nursing was interviewed and verified fall interventions for R30 included keeping R30 away from the flowers in the dining room. The facilty's care plan policy directed care plans to be revised by the nurse manager quarterly with care conferences. The policy further directed care plans to be updated by a registered nurse with changes in resident conditions and those changes communicated to all staff at shift changes. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to updating care plans. The DON or designee, could provide training for all nursing staff related to the timeliness of updating care plans. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by:	21015		7/26/16

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21015	Continued From page 6 Based on observation, interview and document review, the facility failed to refrigerate foods at the proper temperature, and failed to ensure dishes were dried in a sanitary manner. This practice had the potential to affect all 85 residents who received food items from the facility kitchen. Findings include: During a kitchen tour with the dietary manager (DM) on 6/13/16 at 11:40 a.m. the DM confirmed the following: -The facility's three door refrigerator in the kitchen had a current temperature of 44 degrees. The cooler held beverages, supplements and other small, snack items for resident use (50 degrees Fahrenheit when rechecked on 6/16/16, at 2:32 p.m.). In an interview during the tour on 6/13/16, at 12:48 p.m. the DM stated they had ordered a new three door cooler, but could not get it through the kitchen doors. The new cooler was in the dry storage room, not convenient for staff use. The cooler that was currently in the kitchen is old, from the 1970's. The DM stated they have replaced the seals but there is no vacuum, so when one door shuts, another will open a little and the staff don't always notice. The DM stated the crew that uses an area or item is responsible for cleaning that item or area. The DM also stated that there is a cleaning chart. On 6/16/16, at 2:32 p.m. the DM stated the current temperature of the 3 door cooler in the kitchen was 50 degrees F. The DM stated the temps in the morning are usually within range, but as staff are in and out of the cooler throughout the day, the afternoon temperatures are usually	21015	Corrected.	

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21015	Continued From page 7 above range. The DM stated the current temperature is 50 degrees, and it was probably about an hour since the staff had been opening that cooler. The DM stated he has told staff for years to watch for doors coming ajar when opening and shutting them. The facility policy titled Food Storage and Temperature dated 2/25/15, directed dietary employees shall check the thermometer in the unit refrigerators; the temperature should be within 32-42 degrees. (if temperatures are outside that range, the employees should adjust the temperature accordingly. SUGGESTED METHOD OF CORRECTION: The food service director or designee could review any policies, procedures or facility processes to ensure safe and sanitary food service and make any necessary revisions. Appropriate staff could be educated regarding any changes. The food service director or designee could develop audits to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
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	21375	Corrected.	7/26/16

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review, the facility failed to ensure appropriate hand hygiene was performed during and after resident cares for 2 of 6 residents (R90, R30) observed during cares.

Findings include:

R90's Face Sheet indicated R90's diagnoses included muscle weakness, heart failure, dementia, type 2 diabetes, back pain and rheumatoid arthritis.

The significant change Minimum Data Set (MDS) dated 5/16/16, indicated R90's cognition was severely impaired. R90 needed the extensive assistance of staff with bed mobility, transfers, dressing, personal hygiene and eating. R90 was under Hospice care.

On 6/15/16, at 10:00 a.m. nursing assistant (NA)-A was assisting R90 with morning cares. NA-A washed her hands and donned gloves. NA-A then emptied the urinary catheter drainage bag into a graduate, cleaned the drain end with an alcohol wipe, emptied and rinsed the graduate in the bathroom, returned the graduate to the bedside stand and removed her gloves. NA-A stated, "I have to go grab his linens" and exited and entered the room within 15 seconds. NA-A did not wash or sanitize her hands after removing the gloves when exiting or returning to the room. NA-A donned new gloves, lowered the head of the bed, removed R90's pants, pulled the urinary catheter drainage bag out of pant leg and put R90's socks on. NA-A then retrieved an incontinent brief and the clothes from the closet, put R90's pants on the lower legs, guided the urinary catheter drainage bag through the pant leg, lowered the incontinent brief, then washed R90's face and peri area. R90 was incontinent of

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stool. NA-A removed R90's incontinent brief and cleaned the buttocks. NA-A pulled up R90's brief and pants, rolled R90 side to side and placed the lift sling under R90. NA-A applied barrier cream to R90's peri area and removed her gloves. NA-A did not wash or sanitize her hands. NA-A applied R90's slippers. attached the lift sling to the lift, transferred R90 into the wheelchair with the assistance of another staff and disconnected the lift sling. NA-A changed R90's shirt, applied deodorant and hung the urinary catheter drainage bag under the wheelchair. NA-A brought R90 to the sink, donned gloves, brushed R90's (own) teeth and removed the gloves. NA-A did not wash or sanitize her hands. NA-A applied R90's oxygen nasal cannula and combed his hair. NA-A donned gloves, gathered the soiled linen and trash, put the supplies away and removed her gloves. NA-A then exited R90's room and went to the soiled utility room and sanitized her hand after she exited the utility room.

On 6/15/16, at 10:30 a.m. NA-A verified she did not wash or sanitize her hands between glove changes and when exiting R90's room. NA-A stated she cleaned her hands when entering and exiting because in between it was too hard to get the gloves on. NA-A stated that was the way she usually did it.

R30's Face Sheet included diagnoses of dementia with Lewy bodies (a form of dementia that causes cognitive impairment, hallucinations, confusion, memory loss and delusions), anxiety disorder, macular degeneration, osteoarthritis and COPD.

R30's quarterly review Minimum Data Set (MDS) dated 3/16/16, indicated R30 was severely cognitively impaired and required extensive

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21375	Continued From page 10 assistance with bed mobility, dressing, toileting, and personal hygiene. The MDS also indicated R30 was frequently incontinent of urine and occasionally incontinent of bowel. On 6/15/16, at 7:57 a.m. nursing assistant (NA)-I entered R30's room, washed her hands and donned gloves. NA-I applied incontinence briefs and pants to R30's lower legs and shoes to R30's feet while R30 was in bed. NA-I left overnight blue briefs on R30. NA-I called for assistance on a voice pager. NA-D entered R30's room, washed her hands and donned gloves. NA-I and NA-D assisted R30 to stand. R30's overnight blue briefs and bed pad were observed to be saturated with urine. NA-I assisted R30 to a commode, and R30 voided a small amount of urine. NA-D removed her gloves, washed her hands and left R30's room. NA-I removed R30's wet overnight briefs and washed R30's perineal area and buttocks with a wet washcloth. NA-I placed the washcloth in a basin of warm water and wiped R30's eyes. NA-I washed R30's back, face and hands with the wet washcloth. NA-I did not change gloves throughout removing R30's wet briefs, wiping R30's eyes, washing R30's back, face and hands. NA-I emptied the commode, wiped out the wash basin, sprayed with water and hand-combed R30's hair. NA-I wore the same gloves throughout pericare, face/eye washing,assisting R30 with dressing, emptying the commode and combing R30's hair. NA-I removed her gloves and sanitized her hands with hand sanitizer in room after completing R30's cares. At 8:19 a.m. NA-I was interviewed and confirmed she did not change gloves or wash her hands until cares were completed. NA-I said she should have changed gloves and washed her hands after performing pericare.	21375		

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21375	Continued From page 11 On 6/16/16, at 1:47 p.m. registered nurse (RN)-C was interviewed and stated staff must perform glove changes and handwashing after pericares. RN-C further stated cares should be done clean to dirty and never in reverse. On 6/16/16, at 4:36 p.m. the director of nursing (DON) was interviewed and stated the staff should have performed handwashing and glove changes with R30's cares when moving from a dirty to clean area. The facility policy and procedure on Infection Prevention and Control Program dated 1/16, directed staff to wash their hands before and after each resident contact, after touching any bodily substance or fluid, after handling contaminated items, and before putting on and removing gloves. The policy further directed staff to put on clean gloves before touching mucous membranes or anticipating contact with bodily fluids, secretions, excretions and contaminated surfaces. The policy directed staff to remove gloves promptly after use, and wash hands before touching non-contaminated items or environmental surfaces. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure proper hand hygiene was maintained. 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:	21375		

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21375	Continued From page 12 Twenty-One (21) Days	21375		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error	21545		7/26/16

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21545	Continued From page 13 report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 5 residents (R97) reviewed for unnecessary medication was free from significant medication errors. Findings include: R97's Face Sheet indicated R97 admitted to the facility on 4/18/16. Admitting diagnosis included Atrial Fibrillation, chronic heart failure, and anemia. R97's admission minimum data set (MDS) dated 4/24/16, indicated she had intact cognition and was dependent on staff for all activities of daily living. R97's care plan dated 4/25/16, indicated anticoagulant therapy use and directed staff to monitor for signs of bleeding, protect her from injury and provide medications and labs as ordered. R97's EMAR (electronic medication administration record) Monthly Report For April, May, and June, 2016, indicated she received Coumadin (an anticoagulant medication used to prevent heart attacks, strokes, and blood clots in veins and arteries) daily during the month of April.	21545	Corrected.	

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21545	Continued From page 14 During the month of May R97 received Coumadin on 5/1/16, 5/3-8 and 5/12- 5/30. A physician's order dated 5/9/16, directed the following: hold Coumadin today, change dose to 2.5 milligrams (mg) daily, recheck INR Thursday 5/12/16. The EMAR indicated R97 did not receive her Coumadin on 5/10/16, and 5/11/16. An Essentia Health Scheduled Fax Report dated 5/12/16, indicated an INR result of 1.3 which was below the therapeutic range of 2.0-3.0 for R97. During the month of June, R97 received Coumadin 6/1/16-6/9/16. From 6/10, through 6/16/16, R97 did not receive her Coumadin dose. A document titled Telephone, dated 5/19/16, indicated (R97) "appears to be very sensitive to Coumadin." A document titled Telephone, dated 6/7/16, faxed to the facility from Essentia Health Lakewalk Clinic indicated the following: Writer faxed orders for Coumadin on 6/6/16, twice "Apparently not received by Viewcrest." On-call physician dosed patient for the evening of 6/6/16. New orders with dosing instructions as follows: Coumadin 2.5 milligrams (mg) Monday and 2 mg rest of week. Recheck INR (international normalized ratio-used to determine the clotting tendency of blood) Friday 6/10/16. The order contained a facility signature 6/7/16, and two additional facility signatures on 6/8/16, but the order was never processed resulting in the missed Coumadin doses. During an observation on 6/15/16, at 1:19 p.m. R97 was lying on her back in her room, she stated she did not want to answer any questions by the surveyors. On 6/16/16, at 10:41 a.m. registered nurse (RN)-C was interviewed and stated R97 should	21545		

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21545	Continued From page 15 be receiving Coumadin. She stated R97's last INR was on 6/6/16, and should have been rechecked on 6/10/16. RN-C stated this was not done and R97 had not received Coumadin since 6/10/16. RN-C stated she was not aware R97 had not been receiving her Coumadin prior to the interview with the surveyor. During an interview on 6/16/16, at 12:11 p.m. nurse practitioner (NP)-A stated she was updated on the missed Coumadin doses and stated her INR should have been rechecked. She stated she was not sure if there were any repercussions and ordered an ultrasound to rule out a DVT (deep vein thrombosis-occurs when a blood clot forms in one or more of the deep veins in your body). NP-A stated the Coumadin clinic had been updated and would put her back on the medication. NP-A stated she felt the missed dose was likely due to a facility system problem. An untitled document dated 6/16/16, indicated the following update to the physician: "A medication error was discovered, no Coumadin has been given since 6/6/16." The document contained a follow-up from the provider dated 6/16/16, that read as follows: Physicians orders: "Follow orders per Coumadin clinic." LLE (lower left extremity) US (ultrasound) r/o (rule out) DVT. A facility Physician's Telephone Order, dated 6/16/16, directed: give Coumadin 4 mg Thursday and 3 mg rest of week. Recheck INR Monday 6/20/16. Give Lovenox (Lovenox injection is an anticoagulant used to prevent blood clots, which can lead to blood clots in the lungs) 90 mg subcutaneous every 12 hours with last dose being Monday 6/20/16, in morning. During an interview on 6/16/16, at 12:51 p.m. the	21545		

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21545	Continued From page 16 director of nursing (DON) stated the process for transcribing orders was a two person check system. She stated if a dose was missed the computer system should send an alert to notify the physician and get a new order. The DON stated the alert was missed for R97. She stated the facility would notify the physician right away if there were negative side effects of the missed medication. The facility policy and procedure Medication Orders dated 2/3/13, directed any drug that alters a resident's blood level and causes negative symptoms of toxicity would be a significant medication error. Examples of a drug that could alter blood level is Coumadin. If a resident's drug has been missed several times, this could be classified as a significant medication error. SUGGESTED METHOD OF CORRECTION: The administrator and consultant pharmacist could review and revise policies and procedures to ensure facility was free of medication errors. The consultant pharmacist could inservice licensed staff to provide medications without error. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.	21665		7/26/16

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21665	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure doors, walls and floors were clean and in good repair for 16 of 35 resident rooms (Rooms 31, 32, 35, 36, 37, 38, 42, 43, 44, 55, 58, 69, 71, 75, 78, 83). In addition, the facility failed to ensure the kitchen environment was clean. Findings include: On 6/16/16, at 11:45 a.m. during an environmental tour with environmental services director (ESD) the following was noted: Room 31, the room and bathroom doors were scuffed along the bottom plastic covering. Room 32, the room and bathroom doors were scuffed along the bottom covering and the wood on the lower edges of the doors were chipped causing a rough and uncleanable surface. Room 35, the room and bathroom doors were scuffed along the bottom covering and the wood on the lower edges of the doors were chipped causing a rough and uncleanable surface. Room 36, the room and bathroom doors were scuffed along the bottom covering and the wood on the lower edges of the doors were chipped causing a rough and uncleanable surface. Room 37, the room and bathroom doors were scuffed along the bottom covering and the wood on the lower edges of the doors were chipped causing a rough and uncleanable surface. Room 38, the room and bathroom doors were	21665	Corrected.	

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21665	Continued From page 18 scuffed along the bottom covering and the wood on the lower edges of the doors were chipped causing a rough and uncleanable surface. Room 42, the room and bathroom doors were scuffed along the bottom covering and the wood on the lower edges of the doors were chipped causing a rough and uncleanable surface. Room 43, the room and bathroom doors were scuffed along the bottom covering and the wood on the lower edges of the doors were chipped causing a rough and uncleanable surface. Room 44, the room and bathroom doors were scuffed along the bottom covering and the wood on the lower edges of the doors were chipped causing a rough and uncleanable surface. Room 55, the wall next to sink, under towel dispenser, and a wall in bathroom had drip like stains running down. Under the sink was a circular brown area approximately five inches in diameter. Room 58, the room door edge at the bottom to approximately 18 inches up was chipped. The door also had an area was approximately eight inches long. The areas had exposed wood creating a rough and uncleanable surface. Room 69, the lower edge of the room door approximately two feet from the bottom had several chipped areas. One of the areas was approximately six inches long exposing the wood causing a rough and uncleanable surface. Room 71, the room door was scuffed along the bottom covering and the wood on the lower edges of the door was chipped causing a rough	21665		

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21665	Continued From page 19 and uncleanable surface. Room 75, the outer edge of the room door at the bottom approximately six inches up had several chipped areas exposing the wood causing a rough and uncleanable surface. Room 78, the room door on the lower inner and outer edges approximately six inches up from the bottom had several chipped areas exposing the wood causing a rough and uncleanable surface. Room 83, on the room door near the lower hinge was a chipped area approximately six inches long, exposing the wood causing a rough and uncleanable surface. During the environmental tour the ESD stated resident rooms were checked monthly. Areas included were chipped paint, lights, call lights, etc. The ESD provided the Room Checklist for March/April 2016, and May/June 2016. The March/April 2016, checklist indicated rooms 59 and 60 had nicked door edges. The ESD was not aware of the the other above noted areas. The facility's Maintenance policy updated 4/9/15, directed the ESD would perform monthly room and building inspections and log the areas in need of repair on the Preventive Maintenance Worksheet. When a resident was discharge or moved, maintenance would inspect the room and make repairs as needed. All staff should be attentive to the areas included but not limited to cleanliness, safety, areas needing repair, etc. and fill out a maintenance repair requisition form to notify maintenance of needed repair. During a kitchen tour with the dietary manager (DM) on 6/13/16 at 11:40 a.m. the DM confirmed	21665		

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21665	Continued From page 20 the following: -The floor of the small dry storage room had debris and dirt, needing to be swept. In addition, there were food splatters on the walls. -The shelves where pans were stored had food residue (dried splatters and loose crumbs) on the length of the shelf edge, in front of the pans. -The mixer, stored for clean, was not covered and had food residue on its base and flour on top of the guard. -The front of drawers used to store breads had dried food splatters on them. In an interview during the tour on 6/13/16, at 12:48 p.m. the DM stated the crew that uses an area or item is responsible for cleaning that item or area. The DM also stated that there is a cleaning chart. The facility policy titled, Cleaning and Sanitizing of Drawers/Shelves, dated 1/31/12, indicated drawers and shelves will be maintained in a clean and sanitary condition, free of soil and crumbs. The policy directed staff to complete cleaning per schedule and as shelves and drawers get soiled. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible.	21665		

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21665	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		