

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 29, 2020

Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

RE: CCN: 245414 Cycle Start Date: August 13, 2020

Dear Administrator:

On September 3, 2020, we notified you a remedy was imposed. On October 16, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 7, 2020.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective September 18, 2020 be discontinued as of October 7, 2020. (42 CFR 488.417 (b))

However, as we notified you in our letter of September 3, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 18, 2020. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

it Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 29, 2020

Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

Re: Reinspection Results Event ID: IIUP12

Dear Administrator:

On October 8, 2020 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 13, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Electronically delivered

September 3, 2020

Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

RE: CCN: 245414 Cycle Start Date: August 13, 2020

Dear Administrator:

On August 13, 2020, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

#### REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 18, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 18, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 18, 2020.

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

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 18, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Viewcrest Health Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 18, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

## 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

> Email: teresa.ament@state.mn.us Phone: (218) 302-6151 Fax: (218) 723-2359

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

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

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 13, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

#### **APPEAL RIGHTS**

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

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

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

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

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm">https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</a>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CON	E SURVEY IPLETED
		245414	B. WING				C /13/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2020
VIEWCR	EST HEALTH CENTE	P		3	3111 CHURCH STREET		
				0	DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 0	00			
	survey was comple complaint investiga not to be in complia Requirements for L	h 8/13/20, an abbreviated ted at your facility to conduct a tion. Your facility was found ance with 42 CFR Part 483, ong Term Care Facilities.					
		plaints were found to be 14066C and H5414067C.					
		plaints were found to be 15414068C and H5414069C.					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
5 000	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with					0/10/00
F 622 SS=D	Transfer and Disch CFR(s): 483.15(c)(		F 6	522			9/18/20
	remain in the facility discharge the resid (A) The transfer or resident's welfare a cannot be met in th (B) The transfer or	ity requirements- permit each resident to y, and not transfer or ent from the facility unless- discharge is necessary for the and the resident's needs e facility; discharge is appropriate					
	ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGN	NAIUKE		TITLE		(X6) DATE 09/11/2020

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.

PRINTED: 09/15/2020

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/15/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245414	B. WING	. <u> </u>		( 08/1	) 13/2020
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTEI	R			3111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	because the resident sufficiently so the re- services provided b (C) The safety of in- endangered due to status of the resident (D) The health of in- otherwise be endant (E) The resident ha- appropriate notice, under Medicare or IN- Nonpayment applie submit the necessar payment or after the Medicare or Medicar resident refuses to resident who becom admission to a facil resident only allowar or (F) The facility cease (ii) The facility may resident while the a § 431.230 of this ch- exercises his or her discharge notice from 431.220(a)(3) of this discharge or transfe or safety of the resis facility. The facility tra- resident under any in paragraphs (c)(1) section, the facility tra-	ht's health has improved esident no longer needs the y the facility; dividuals in the facility is the clinical or behavioral nt; dividuals in the facility would gered; s failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. s if the resident does not ry paperwork for third party e third party, including aid, denies the claim and the pay for his or her stay. For a nes eligible for Medicaid after ity, the facility may charge a able charges under Medicaid; es to operate. not transfer or discharge the ppeal is pending, pursuant to apter, when a resident right to appeal a transfer or om the facility pursuant to § s chapter, unless the failure to er would endanger the health dent or other individuals in the must document the danger er or discharge would pose.	F	522			

If continuation sheet Page 2 of 33

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		. 0938-039 TE SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	CON	<b>IPLETED</b>
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		245414	B. WING _			/13/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ξ	
VIEWCR	EST HEALTH CENTE	R		3111 CHURCH STREET DULUTH, MN 55811		
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F 622	Continued From pa	age 2	F 62	22		
		appropriate information is	1 02			
		he receiving health care				
	institution or provid					
	(i) Documentation must include:	in the resident's medical record				
		ne transfer per paragraph (c)(1)				
	(i) of this section.					
	(B) In the case of p	paragraph (c)(1)(i)(A) of this				
		c resident need(s) that cannot				
		mpts to meet the resident				
	facility to meet the	vice available at the receiving				
		tion required by paragraph (c)				
		n must be made by-				
		physician when transfer or				
		sary under paragraph (c) (1)				
	(A) or (B) of this se	en transfer or discharge is				
		aragraph (c)(1)(i)(C) or (D) of				
	this section.					
		vided to the receiving provider				
		imum of the following:				
		ation of the practitioner care of the resident.				
		sentative information including				
	contact information					
	(C) Advance Direct					
		uctions or precautions for				
	ongoing care, as a (E) Comprehensive					
		sary information, including a				
		it's discharge summary,				
	consistent with §48	33.21(c)(2) as applicable, and				
		ntation, as applicable, to ensure				
	a safe and effective	e transition of care. NT  is not met as evidenced				
	by:	INT IS NOT THET AS EVIDENCED				
		v and document review, the		It is the policy of Viewcrest He	alth Care	
		nmunicate a resident's current		Center to ensure that all reside		

If continuation sheet Page 3 of 33

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	Сом	E SURVEY PLETED
		245414	B. WING			C 13/2020
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
VIEWCR	EST HEALTH CENTE	R		3111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 622	of 4 residents (R20 transfer, and disch Findings include: R200's Face Shee R200 was admitted diagnoses included skin of scalp and n by excess fluid trand diabetes, and aner R200's General Nu dated 7/7/20, indica skin breakdown, de after lying for 5 hou (tailbone) after 3 hou	e to the receiving facility for 1 00) reviewed for admission, arge. t printed 8/13/20, indicated d to the facility on 7/1/20, and d squamous cell carcinoma of eck, edema (swelling caused oped in your body's tissues), nia. urse's Observation (GNO) ated R200 was at low risk for eveloped redness on the spine urs, and on the coccyx ours of sitting. R200 areas of areas of thin skin, and had nd a cancerous lesion on his R200 had edema of both lower mpression stockings. R200's document any open lesions n. ated 7/16/20, indicated R200 breakdown related to y, and had an impaired skin en area, lacked identification of	F 622	discharged with the appropriat documentation as well as ens receiving facility or agency rec appropriate documentation of discharge plan of care. Resid was discharged from the facilit 7/30/2020. All residents who from the facility have the poten impacted. The facility dischar policy as well as the discharge care document were reviewed appropriate. The facility RN M discharged R200 was provide re-education on the need to ca sections of the discharge plan including the skin assessment discharge on 9/11/2020. All R managers were given education discharge planning process, in completing a skin assessment discharge and documenting th condition upon discharge. Th of Nursing or designee will au- discharge transfer records for then 50% of discharges for the to ensure compliance discharge documentation of skin conditio of all audits will be reviewed b Assurance Performance Impre Committee (QAPI).	uring the eives the ent R200 ty on discharge ntial to be ge planning e plan of and remain lanager who d omplete all of care prior to N on on the ncluding t prior to he skin he Director dit all one month, ree months ge on. Results y the Quality	

If continuation sheet Page 4 of 33

		AND HUMAN SERVICES			FORM	09/15/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245414	B. WING			C 13/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VIEWCRI	EST HEALTH CENTER	R		3111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 622	Continued From pa	ge 4	F 622	2		
		ion Report With Images dated ked any indication of skin s right shin.				
	7/21/20, indicated F cancerous lesion or	ion Report With Images dated R200 continued with a n his head, but lacked any oncerns on R200's right shin.				
	indicated R200 arriv 7/30/20, with an ope measuring 2.5 inche necrotic area, and y addition, R200 had	th the State Agency (SA) ved at the receiving facility on en area on the right shin es by 1.5 inches, with a yellow, draining tissue. In edema of both his legs, and ression stockings on (stockings dema).				
	indicated R200 wou assisted living facilit one to two weeks. F indicated R200 had	conference note dated 7/15/20, uld be discharged to an ty which had an opening in R200's care conference note a few bruises, a cancerous along with compression ips to his legs.				
		otes dated 7/23/20, indicated charged to an assisted living				
		otes from 7/23/20, through cumentation of any skin in conditions.				
		d 7/29/20, indicated R200's conditions was not				

If continuation sheet Page 5 of 33

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/15/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
VIEWCRE	EST HEALTH CENTER	R			3111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	registered nurse (R lacked documentati condition. R200's nurse practi Transfer Sheet date seven days prior to bruises on his arms cancerous lesion or indicate the date of Resident Transfer S had compression st be put on in the a.m ointment for wound The skin document living facility on 7/30 shin open area was communicated to th The photos of R200 the date of his disch admission to the as R200 had a large ul some depth, irregul with a possible dark yellow draining tissu erythema (redness) had swollen lower le further had a dark li open area and knee On 8/13/20, at 12:5 representative (RR) RR-C stated R200 to but when he transfe was found to have a	arge Plan of Care signed by N)-B and dated 7/30/20, ion of R200's current skin et d7/29/20, with data for the 7/28/20, indicated R200 had and on his left thigh, with a in the scalp, though did not the skin observations. R200's Sheet further indicated R200 tocking to lower extremities to n. and off in the p.m., and an care. ation received by the assisted D/20, indicated R200's right in the documented, and not he assisted living. D's right shin dated 7/30/20, harge from the facility and esisted living facility, indicated located near the upper edge, ue on the lower edge, with light on the lateral edge. R200 egs with dry, scaly skin. R200 inear dark area between the	F	622			

If continuation sheet Page 6 of 33

		AND HUMAN SERVICES				FORM	09/15/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		245414	B. WING				C 13/2020
NAME OF F	PROVIDER OR SUPPLIER	L		S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
VIEWCR	EST HEALTH CENTE	R			3111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	transfer form, and s the area. On 8/13/20, at 1:27 stated she had wor aware of any sores On 8/13/20, at 2:22 been notified of an RN-A stated they ha living facility about to of discharge, had re documentation, and documentation, and documentation of a verified R200's skin should be noted on care and was not. F wound should have form, and was not. assessment should discharge. On 8/13/20, at 2:45 been filling in for the that day, and did not verified she did not did not know if R20 the wound on his he fill out the discharge signed it. RN-B stat status of the skin on RN-B stated the as about a wound, so a and asked staff. St on R200's shin whe On 8/13/20, at 3:03	Icer was not included on the she had not been notified of "p.m. nursing assistant (NA)-C ked with R200, and was not , other than on his head. "p.m. RN-A stated she had not ulceration of R200's skin. ad been called by the assisted the wound on his leg the day eviewed R200's d did not find any wound on R200's shin. RN-A n status and documentation the post discharge plan of RN-A verified R200's head e been documented on the RN-A further stated a skin I have been done prior to p.m. RN-B stated she had e RN manager on R200's unit of know the resident. RN-B do a skin assessment, and 0 had any wounds, other than ead. RN-B stated she did not e plan of care, and she just ted she should have put the n the form, even if it was clear. sisted living facility had called she checked documentation, taff did not remember a wound en they got him dressed.	F	522			
		status should be included on					

If continuation sheet Page 7 of 33

	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	09/15/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245414	B. WING			C 13/2020
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R		3111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 622 F 686 SS=D	the post discharge was not documente stated skin should b On 8/14/20, at 9:50 director (ALD) state about R200's skin of arrived at their facill looked at him right a "Stage 3 diabetic draining tissue, and stated RR-C was an it, stating it was neg status was not com stated R200 was be was healing well. A compression stocki were very swollen. The facility policy D reviewed/amended complete a discharg summary of the res discharge, with an a and provided to the Treatment/Svcs to I CFR(s): 483.25(b)(1) §483.25(b) Skin Inte §483.25(b)(1) Press Based on the comp resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that t	plan of care, and verified it d on R200's form. The DON be checked before discharge. am. assisted living facility d she was very concerned condition on his shin when he ity. ALD stated the nurse when he got there, and found ulcer" on his shin with yellow, I necrosis in the center. ALD in RN, and was very upset by glect. ALD stated R200's skin municated to the facility. ALD eing seen by wound care, and ALD stated R200 did not have ngs on either, and his legs ischarge Planning 1/17, directed nursing to ge plan of care with a final ident 's status at the time of assessment of the resident, facility receiving services. Prevent/Heal Pressure Ulcer 1)(i)(ii) egrity sure ulcers. rehensive assessment of a	F 622			9/18/20

Facility ID: 00602

If continuation sheet Page 8 of 33

		(X2) MU				0938-039
F CORRECTION	IDENTIFICATION NUMBER:	· ·				LETED
					С	
	245414	B. WING				3/2020
ROVIDER OR SUPPLIER		<u> </u>	ST		•	
	_		31	11 CHURCH STREET		
EST HEALTH CENTE	ĸ		D	ULUTH, MN 55811		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETIO DATE
•	-	F 6	86			
	INT IS NOT THET AS EVIDENCED					
	tion interview and document			It is the policy of Viewerest Health Car	~	
					i i t	
developing pressui	e uicers.					
Findings include:						
r mungs meluue.						
R201's Eace Sheet	printed 8/13/20 indicated					
buok pulli						
R201's quarterly M	inimum Data Set (MDS) dated			•		
					vill	
				•		
R201 required one	person assist for bed mobility,			place. The resident is also noted to		
toileting, and two a	ssist for transfers. The MDS			refuse toileting and repositioning at time	es,	
indicated R201 was	s at risk for pressure ulcers,			facility will review a risk versus benefit		
					า	
•				out of work on an LOA, she will be		
was treated with to	pical medications.					
<b>D004</b>						
					5	
					ary	
				program. All nursing staff will be provide		
	OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER EST HEALTH CENTE SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From particles (EACH DEFICIENC' REGULATORY OR L Continued From particles with professional si promote healing, p new ulcers from de This REQUIREME by: Based on observa review, the facility f pressure relieving i 1 of 3 (R201) resid developing pressur Findings include: R201's Face Sheet R201's Guarterly M 7/17/20, indicated F and had no rejection assessment period R201's quarterly M 7/17/20, indicated F and had no rejection assessment period R201's quarterly M 7/17/20, indicated F and had no rejection assessment period R201 required one toileting, and two a indicated R201 was had no current press skin concerns . Th pressure relief devise was treated with to R201's care plan re was at risk for skin incontinent of urine R201 required physiturning and reposit	OF DEFICIENCIES FORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         245414         ROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 8 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.         This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement identified pressure relieving intervention of repositioning for 1 of 3 (R201) residents who was at risk for developing pressure ulcers.         Findings include:         R201's Face Sheet printed 8/13/20, indicated R201's diagnoses included Parkinson's disease (progressive nervous system disorder that affects movement), diabetes mellitus type 2, and low back pain.         R201's quarterly Minimum Data Set (MDS) dated 7/17/20, indicated R201 was cognitively intact and had no rejection of cares during the assessment period. The MDS further identified R201 required one person assist for bed mobility, toileting, and two assist for transfers. The MDS indicated R201 was at risk for pressure ulcers, had no current pressure ulcers, or other identified skin concerns . The MDS indicated R201 had pressure relief devices in chair and mattress, and was treated with topical medications.         R201's care plan revised 8/12/20, identified R201 was at risk for skin breakdown and was incontinent of urine. R201's care plan revealed R201's care plan revised 8/12/20, identified R201 was at	OF DEFICIENCIES F CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MUL A. BUILDI         PROVIDER OR SUPPLIER       245414       B. WING         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIC TAG         Continued From page 8 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.       F 6         This REQUIREMENT is not met as evidenced by:       Based on observation, interview, and document review, the facility failed to implement identified pressure relieving intervention of repositioning for 1 of 3 (R201) residents who was at risk for developing pressure ulcers.       Findings include:         R201's Face Sheet printed 8/13/20, indicated R201's diagnoses included Parkinson's disease (progressive nervous system disorder that affects movement), diabetes mellitus type 2, and low back pain.       R201's quarterly Minimum Data Set (MDS) dated 7/17/20, indicated R201 was cognitively intact and had no rejection of cares during the assessment period. The MDS further identified R201 required one person assist for bed mobility, toileting, and two assist for transfers. The MDS indicated R201 was at risk for pressure ulcers, had no current pressure ulcers, or other identified skin concerns . The MDS indicated R201 had pressure relief devices in chair and mattress, and was treated with topical medications.         R201's care plan revised 8/12/20, identified R201 was at risk for skin breakdown and was incontinent of urine. R201's care plan revealed R201 required physical assistance of two staff for turning and repositioning, and requp	OF DEFICIENCIES F CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLI A. BUILDING         ROVIDER OR SUPPLIER       245414       B. WING         EST HEALTH CENTER       ST SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 8 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:       F 686         Based on observation, interview, and document review, the facility failed to implement identified pressure relieving intervention of repositioning for 1 of 3 (R201) residents who was at risk for developing pressure ulcers.       F         Findings include:       R201's Face Sheet printed 8/13/20, indicated R201's diagnoses included Parkinson's disease (progressive nervous system disorder that affects movement), diabetes mellitus type 2, and low back pain.       R201's quarterly Minimum Data Set (MDS) dated 7/17/20, indicated R201 was cognitively intact and had no rejection of cares during the assessment period. The MDS further identified R201 required one person assist for bed mobility, toileting, and two assist for transfers. The MDS indicated R201 was at risk for pressure ulcers, had no current pressure ulcers, or other identified skin concerns . The MDS indicated R201 had pressure relief devices in chair and mattress, and was treated with topical medications.         R201's care plan revised 8/12/20, identified R201 was at risk for skin breakdown and was incontinent of urine. R201's care plan revealed R201' required physical assistance of two	or DEFICIENCIES FORRECTION       (X1) PROVIDERSUPPLIER/CLA DENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION       (X3)         REVIDER OR SUPPLIER       245414       B. WING       (X3)         STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHURCH STREET DULUTH, IMN 55811       STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHURCH STREET DULUTH, IMN 55811       (X3)         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED DE YFULL RECULATORY OR USC DENTIFYING INFORMATION)       PREVIX TAG       PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY)         Continued From page 8 neccessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new uclers from developing.       F 686         Findings include:       F       686         Findings include:       F 101 (State Correct To ensure that all residents rece the necessary care and services preve and treat pressure ulcers. The facility developing pressure ulcers.       F 686         Findings include:       F       F 686       Correct to ensure that all residents rece the necessary care and services preve and treat pressure ulcers. The facility would care nurse conducted a skin assessment and receiter to ensure the appropriate. Resident 8201; s care plan revised 8/13/20, indicated R201 required one person assist for bed mobility, toliciting, and two assist for transfers. The MDS indicated R201 was at risk for skin breakdown and was incontinent of urine. R201's care plan revised 8/12/20, identified R201 was at risk for skin breakdown and was incontinent of urine. R201's care plan revised 8/12/20, identified R201 requ	OCT DEFICIENCIES       (X1) PROVIDERSUPPLIERCLATION NUMBER:       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION         ROWIDER OR SUPPLIER       245414       (X2) WULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION         ROWIDER OR SUPPLIER       245414       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION         SIMMARY STATEMENT OF DEFICIENCIES       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION         SIMMARY STATEMENT OF DEFICIENCIES       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION         SIMMARY STATEMENT OF DEFICIENCIES       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION         SIMMARY STATEMENT OF DEFICIENCIES       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION         SIMMARY STATEMENT OF DEFICIENCIES       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION         Commits       (X2) AND MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION         Commits       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION         Commits       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION         Commits       (X2) MU

Facility ID: 00602

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		AND HUMAN SERVICES			FORM	09/15/2020 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245414	B. WING			C 13/2020
NAME OF	PROVIDER OR SUPPLIER		· [	STREET ADDRESS, CITY, STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R		3111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	repositioning. R201's nursing ass 8/10/20, directed st every two hours, an void, 8 p.m. for BM R201's Tissue Tolet how long of an inter for lying or sitting) of R201's coccyx deve reddened area afte On 8/11/20, at 9:47 exited R201's room and garbage and vor repositioned, chang morning and planne recliner chair. -9:51 a.m. NA-A en delivered a fresh cu room. R201 was no repositioning, and r her back. -10:34 a.m. the diret R102's room, talked and exited the room toileting or reposition lying on her back. -11:37 a.m. staff en delivered meal tray being late, set up m R201 was not offer and remained in he -11:42 a.m. NA-A en delivered a piece of per R201's request	istant care sheet printed aff to turn and reposition R201 ad toilet R201 at 8:00 a.m. to and every two hours. rance (TT, an assessment of rval the resident can tolerate lated 2/28/20, indicated eloped a non-blanchable r 2 hours of lying, and sitting. a.m. nursing assistant (NA)-A with a bag of soiled linens erbalized to NA-B, R201 was ged and washed up for the ed to get her up soon in her tered R201's room and up of ice water and exited the ot offered toileting or emained in her bed lying on ector of nursing (DON) entered d with R201 for a few minutes h. R201 was not offered oning, and remained in her bed tered R201's room and and apologized for lunch heal tray and exited the room. ed toileting or repositioning, r bed lying on her back. ntered R201's room and f cake, set up chips and salsa and exited the room. R201 eting or repositioning, and	F 680	and toilet residents per their plan of The Director of Nursing (DON) or designee will audit repositioning schedules for all residents with pre- ulcers and a minimum of four at ris residents weekly x4 weeks then mo x3 months to ensure compliance. If of all audits will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI).	ssure k onthly Results	

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	09/15/2020 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	0	(X3) DATI COM	E SURVEY IPLETED
		245414	B. WING	;				C 13/2020
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STAT	E, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R			3111 CHURCH STREET DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPF	BE	(X5) COMPLETION DATE
F 686	<ul> <li>-12:20 p.m. the acti R201 room and talk appointment, scheo significant other, an not offered toileting remained in her bea -12:30 p.m. the AD notified R201 they with her significant R201 was not offer and remained in her -12:40 p.m. the AD up the IPad for a vis significant other and not offered toileting remained in her bea -1:00 p.m. the AD ef for R201 to finish her room. R201 was not repositioning, and r her back.</li> <li>-1:05 p.m. the assis (ADON) and DON of reposition and asser request. R2 was ref</li> <li>R201 was not offered and remained in her 9:47 a.m. to 1:07 p.</li> <li>On 8/11/20, at 12:2 repositioned and cf NA-A viewed her nut that she kept in her to be turned and re and toileted at 8 a.r and every two hour on repositioning R2</li> </ul>	vities director (AD) entered sed about a beautician luling time to see R201's d exited the room. R201 was or repositioning, and d lying on her back. entered R201's room and were arranging a video chat other and exited the room. ed toileting or repositioning, r bed lying on her back entered R201's room and set deo chat with R201's d exited the room. R201 was or repositioning, and d lying on her back. ntered R20's room and waited er video chat and exited the ot offered toileting or emained in her bed lying on stant director of nursing entered R201's room to the set R201	F	586				

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		AND HUMAN SERVICES				FORM	09/15/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245414	B. WING	i			C 13/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VIEWOP	EST HEALTH CENTE	P		3	3111 CHURCH STREET		
VIEWOR				0	DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 686	Continued From pa	qe 11	F	586			
	her recliner chair. I another resident's r	NA-A proceeded to go into room with the mechanical lift repositioning to R201					
	toileting times were log kept at the nurs	7 p.m. NA-B stated residents documented on the toileting ing desk. NA-B stated ing log, it was documented ted at 9:20 a.m.					
	nursing (ADON) wa completed continuo R201 had not been and R201's skin ne	3 a.m. assistant director of as notified surveyor had bus observations of R201, repositioned since 9:20 a.m., eded to be assessed by a RN. ff to assist with repositioning check her skin.					
	was observed lying R201's lunch tray re and director of nurs room and explained and check her skin mess in her pants" At 1:07 p.m., the AI changed R201's into observed to be soil peri area appeared R201's skin to cocco with redness noted provided incontinen R201's buttocks, co there were no open coccyx skin color w DON applied a star periarea and buttoo	a.m. upon entrance, R201 on her back on her IPAD. emained in room. The ADON sing (DON) entered R201's d they needed to reposition her . R201 stated she "had a and needed to be changed. DON and DON proceeded and continent brief which was ed of urine and stool. R201's to be dry, pink in color. eyx was observed to be intact to coccyx. After the DON at cares, The ADON assessed bocyx, and back and confirmed hed areas and stated R201's ras "pink and blanchable." The hadard barrier cream to R201's to ks, and a clean incontinent ed lying on back and head of					

DEPARTMENT OF HEALTH AND HUMAN S CENTERS FOR MEDICARE & MEDICAID S				FORM	09/15/2020 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU AND PLAN OF CORRECTION IDENTIFICATION		. ,	PLE CONSTRUCTION	Сом	E SURVEY PLETED	
245	6414	B. WING		C 08/13/2020		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
VIEWCREST HEALTH CENTER			3111 CHURCH STREET DULUTH, MN 55811			
(X4) ID SUMMARY STATEMENT OF DEFIC PREFIX (EACH DEFICIENCY MUST BE PRECED TAG REGULATORY OR LSC IDENTIFYING IN	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
<ul> <li>F 686 Continued From page 12 bed was elevated and talked with A giving R201's chair in room to her other.</li> <li>On 8/11/20, at 1:17 p.m. ADON sta at risk for pressure ulcer developm required every two hour reposition stated she would have expected st timely repositioning as directed on plan.</li> <li>On 8/13/20, at 4:06 p.m. the DON R201's had blanchable redness to after not being turned or reposition hours. The DON stated it was her staff to follow the resident's plan of pressure ulcer prevention. The DO R201's care plan and nursing assis sheet directed staff to turn and rep every two hours to prevent skin bree The facility policy Skin Ulcer Protoo indicated tissue tolerance test dete individual's turning and reposition st The facility policy Urinary Incontine undated, directed nursing assistant will be utilized and kept updated, to nursing assistants are aware of the current toileting needs, including th incontinence products, and plans t complications of urinary incontinents Ss=G CFR(s): 483.40</li> <li>§483.40 Behavioral health services Each resident must receive and th provide the necessary behavioral health services</li> </ul>	significant ated R201 was bent and ing. RN-A taff to provide R201's care confirmed her coccyx red for over 3 expectation of f care for DN verified stant care osition R201 eakdown. col undated, ermines an schedule. ence Program t care sheets o ensure the e resident's ne use of o prevent ice.	F 680			9/18/20	

Facility ID: 00602

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		& MEDICAID SERVICES	1				0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION (	(X3) DATE SURV COMPLETE	
		245414	B. WING			08/1	C  3/2020
NAME OF F	ROVIDER OR SUPPLIER			ę	TREET ADDRESS, CITY, STATE, ZIP CODE	00/1	0/2020
VIEWCR	EST HEALTH CENTE	R		;	3111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 740	Continued From pa	ige 13 r maintain the highest	F 7	740			
	practicable physica well-being, in accor assessment and pl encompasses a res mental well-being, v limited to, the preve and substance use This REQUIREMEN by: Based on observat review, the facility f a comprehensive c interventions to add included behavioral safe environment, a social interactions t well-being and prev 1 residents (R201) and suicide attemp psychosocial and p she attempted suic Findings include: R201's Face Sheet R201's Gagnoses i avoidant personalit disorder (a group o cause unexplained major depression, a (progressive nervor movement). R201's quarterly Mi	I, mental, and psychosocial dance with the comprehensive an of care. Behavioral health sident's whole emotional and which includes, but is not ention and treatment of mental			It is the policy of Viewcrest Health C Center to ensure that all residents re- the necessary behavioral health care services to attain or maintain the hig practicable physical, mental, and psychosocial wellbeing. The facility and procedure on behavioral health was reviewed and updated along wit facility policy on psychosocial wellbe assessment. The facility social work were provided with education on the behavioral health care policy as well assessments are required when a resident returns from the hospital on 9/10/20 by the administrator. Reside R201 is a current resident in the faci Resident R201 was hospitalized for suicidal ideation on 6/8/20, at the tim this incident the resident was not not have lost consciousness and had no or symptoms of physical harm from incident. R201 is followed by her pri care physician and nurse practitione her mental health needs. R201 has declined outside behavioral health care services in the past. The resident's	eceive e and hest policy care th the ing cers which ent ility. ne of ted to o signs the imary er for are	
	and was mildly dep R201's care plan da	ressed. ated 7/21/20, identified R201			plan and care card were updated to include suicidal ideation along with interventions for staff to use when th	e	

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES	1				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3)	COMP	SURVEY LETED
		245414	B. WING _			C 08/1	3/2020
NAME OF	PROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R			11 CHURCH STREET ULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETIO DATE
F 740	Continued From page 14 was at risk for alteration in psychosocial well-being related to restriction on visitation due to COVID-19. The care plan dated further indicated R201 preferred activities in her room, and directed activity staff/volunteers to visit during daily rounds to provide socialization. R201's care plan lacked identification of suicidal ideation.		F 74	0	resident expresses self-harm. R201 a completed a No Self-Harm Contract or 8/18/20 that identifies resources that c	n	
					8/18/20 that identifies resources that c be used if the resident is having a Behavioral Health Crisis. The facility S completed a psychosocial wellbeing assessment on R201 on 8/21/20 as we as updating the resident care plan. Th	SW	
	R201's nursing assistant care sheet printed 8/10/20, lacked identification of R201's suicidal ideation, and lacked staff direction on what to do when R201 expressed thoughts of self-harm.			is a potential for all residents who are experiencing isolation to exhibit signs of depression and or suicidal ideation. A residents were reviewed for risk factor 8/10/20 by the interdisciplinary team.	of		
	social service direct indicated R201 was Health Questionnal presence and seve R201's mood was	ssessment completed by the ctor (SS)-A dated 4/27/20, s cognitively intact, Patient ire (PHQ-9, a screening for the erity of depression) indicated normal and further indicated			Resident's that scored above a nine or the PHQ9 assessment will be followed minimum of weekly by the facility socia workers. Any resident that expresses suicidal ideation will have a safety contract put into place and their physic	d a al cian	
	depressed due to h	the past week she felt more her family being unable to visit. lentification of R201's recent			will be notified. The facility Administrat or designee will audit all PHQ9 assessments completed for one month then 50% for three months to ensure compliance. Results of all audits will b	h, pe	
	On 6/8/20, an Incident Details report revealed R201 was in her room when she attempted to strangle herself with a stretch band (Theraband) that was attached to the mobility bar on her bed. The report indicated the Theraband was removed from R201's neck, and R201 was taken to the hospital by ambulance. The incident report revealed R201 was placed on 15 minute checks.				reviewed by the facility Quality Assurar Performance Improvement Committee (QAPI). Corrected by 9/18/20.		
	On 6/18/20, a hosp Discharge Summa the emergency roo Theraband around herself. The summ	bital Behavioral Health ry indicated R201 was seen in m after being found with a her neck in attempt to kill ary further indicated nursing 8201 had been making suicidal					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/15/2020 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245414	B. WING	;			C 13/2020
NAME OF	PROVIDER OR SUPPLIER		-	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R			3111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 740	statements two wee felt they could not k found with the Ther was admitted to a n stabilization, medica assessment. The h indicated at the time condition had impro- discharge to nursing follow up with prima On 6/24/20, a provi- physician visit via Z R201 was tearful the expressed a lot of s was being quaranti- in her old familiar ro- missed so much, ev- expressed a friend deteriorated, and he she was unable to on note further indicate point earlier in the r- of self-harm with a and lead to an inpa- unit from June 11-1 received psychothe adjustments. The n emotionally distress compose herself, b conversation. R201 the director of nursi plan was R201 wou quarantine period e outdoor visits with h On 8/10/20, at 3:52 was interviewed an	eks prior to her attempt, and eep R201 safe after being aband around her neck. R201 nental health unit for ation management, and ospital Discharge Summary e of discharge, R201's oved and was stable and g home and instructed to ary care provider within 5 days. der note indicated R201 had a oom visit. The note indicated rough much of the visit, and sadness. R201 expressed she ned, and would rather be back oom. R201 stated, "I've verything is gone." R201 of hers health had e was in a nursing home, and communicate with him. The ed R201's distress reached a nonth that lead to an attempt Theraband around her neck, tient stay on the psychiatry 9, 20. During that stay, R201 rapy, and had medication ote indicated R201 was sed, and she struggled to ut was able to carry on a 's physician discussed with ng (DON), and the facility's ild return to her room after nded, and R201 would have	F	740			

Facility ID: 00602

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		AND HUMAN SERVICES				FORM	: 09/15/2020 APPROVED . 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245414	B. WING	i			C 13/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
VIEWCR	EST HEALTH CENTE	R		-	3111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 740	lack of contact from for her. FM-A state depression for man several losses inclu family members, an her home and not b communicate with H expressed concern stated R201 recent to strangle herself v FM-A stated R201 s suicidal ideation ab attempt. FM-A state dangerous items fro R201 on 15 minute expressed self-ham practitioner (NP) may the facility talked ab with a mental health never happened. F go out to appoint have to go to a diffe days. FM-A stated her last hospitalizate for R201 mentally. family during this que surrounded by her unaware if the facilit video visit for mental stated she thought commit suicide it we lived in the communi- would be at her age stated she felt R20 again. On 8/11/20, at 3:47 and stated she had	the outside also was difficult of R201 had a history of by years, and had experienced ading the death of immediate and the most recent loss was	F	740			

Facility ID: 00602

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	·····	CO	MPLETED
		245414	B. WING			08	/13/2020
NAME OF F	PROVIDER OR SUPPLIER	•	· · · · · · · · · · · · · · · · · · ·	STF	REET ADDRESS, CITY, STATE, ZIP CODE	-	
VIEWCR	EST HEALTH CENTE	R		311 DU			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 740	F 740 Continued From page 17 heart attack. R201 stated the doctor was called, and was told R201 was having an anxiety attack. R201 stated it was upsetting that she had not been able to see her significant other since he was admitted to a nursing home. R201 stated staff were going to try and arrange an outside visit with R201's significant other sometime next week. R201 expressed feeling lonely and isolated since no one could leave their rooms, and all activities had stopped. R201 stated she was very close with her family, and talked with her daughter daily. R201 stated she video chatted with her daughter a couple of times, and they had two outdoor visits. R201 became teary eyed, and stated she felt like she had missed so much, and the summer was gone. R201 stated she struggled with depression for many years, and now she had so much time on her hands to think and stare at the four walls within her room. R201 stated no one came to her room to visit		F 7	40			
	and walked out. R Parkinson's diseas or knit, but could si paper. R201 state snowflakes becaus R201 further expla herself with the exe therapy a couple of she told staff she v	ked in, did what they had to do 201 stated she had e and could no longer crochet till make snowflakes from d she was unable to make the se staff took her scissors away. ined she had tried to strangle ercise band she received from f months ago. R201 stated vas going to kill herself, but how. R201 stated staff took					
	her scissors away phone base, becau stated if she wante use the cords from and proceeded to p side table between R201 stated she w	and removed her cordless use of the cords. R201 further ed to strangle herself she would the desk phone staff gave her, point at the desk phone on the her recliner chair and bed. ras currently not seeing a ider, and she would not leave					

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		AND HUMAN SERVICES				FORM	09/15/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245414	B. WING				C 13/2020
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R			111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 740	isolation unit and qu stated she could no she had a psychiatr September, and sh private room with a have to go to the is visited with the NP her concern of feeli lonely. R201 stated going to be schedu her personal items meeting had not be R201 stated the da herself she was fee and stated staff bou around 11:00 a.m. a again until the nurs with the Theraband R201 stated her far hospitalization to st and go on the intern to occupy her time. Review of R201's p 7/29/20, revealed th - 4/19/20, R201 ver had a plan, but wou stated, "You'll take in notified, clonazepar for a one time dose minute checks. The family was updated were decreased to of the shift. -4/20/20, SS-A spol	he would have to go to the barantine for 14 days. R201 of handle that. R201 stated ric appointment scheduled for e was told since she was in a private bath, she would not olation unit. R201 stated she via video chat, and expressed ng anxious, depressed and d she was told a meeting was led to see if she could have returned, and stated the en scheduled as of date. y she attempted to strangle ling very alone and isolated, ught in her lunch that day and did not come in her room ing assistant (NA) found her around her neck at 4:00 p.m. mily bought her an IPad after ay connected, play Scrabble, net, otherwise she had nothing rogress notes from 4/19/20, to he following: balized she was suicidal and id not elaborate further and it away from me." The NP was m (tranquilizer) was increased a, and R201 was placed on 15 e note further indicated R201's , and R201 safety checks 30 minute checks for the rest ke with R201's daughter	F	740			
		ke with R201's daughter hange.  The note lacked					

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		AND HUMAN SERVICES				FORM	09/15/2020 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATI COM	0938-0391 E SURVEY PLETED
		245414	B. WING				C 13/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
VIEWCR	EST HEALTH CENTE	R			111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 740	indication SS-A had daughter regarding her current state of - 4/21/20, SS-A spo on room change. T SS-A had a convers suicidal thoughts, o health. - 4/30/20, R201 exp sad all of the time. NP was contacted t and her non-compli note lacked indicati addressed. - 5/27/20, R201 was morning due to hea out and was being s to an assisted living registered nurse (R did not want to live if she had a plan to she had nothing to she may do it. R20 checks and R201's R201's daughter pla afternoon. - 5/28/20, SS-A mer recent days of feelin suicidal thoughts at "cannot live like this anxiety of not being other. SS-A discuss R201's significant of	a conversation with R201's R201's suicidal thoughts or mental health. We with R201 and followed up The note lacked any indication sation with R201 regarding r her current state of mental oressed to the nurse of feeling The note further indicated the to address R201 blood sugars fance with dietary choices. The on R201's mood was s "very depressed" that wing her house was cleared sold, and her boyfriend moved g facility. R201 expressed to N)-C she felt hopeless, and anymore. RN-C asked R201 hurt herself, and R201 stated hurt herself, with otherwise 1 was put on 15 minute safety daughter was updated. anned a window visit for that t with R201 and discussed ng down. R201 denied any that time and stated she s." R201 expressed increased able to see her significant sed arranging a Zoom visit with	F 7	740			

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		AND HUMAN SERVICES				FORM	09/15/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245414	B. WING				C 13/2020
NAME OF F	PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R			111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 740	Continued From par checks, had spoker visit with the NP wh and her depression indication if R201's addressed any suid new interventions. - 6/8/20, R201 was band around her ne mobility bar. R201 v tightly trying to strat indicated the stretch had a reddened mar R201 stated she wa Potential harmful its R201's room, family ordered R201 to be department. R201 checks until the am - 6/9/20, SS-A spoker regarding R201's re having her bed held daughter stated she R201 had been in a not made any recent hurt herself. - 6/9/20, R201 was home. R201 stated were helping with h	age 20 n with family, and had a Zoom nich addressed blood sugars, n. The note lacked any NP changed any medications, cidal ideations, or added any found by a NA with a stretch eck which was attached to the was pulling the stretch band ngle herself. The note further h band was removed, R201 ark all around her neck, and as trying to kill herself. ems were removed from y was notified, and the NP e sent to emergency was placed on 15 minute	F 7	740			
	going down that roa						

		AND HUMAN SERVICES				FORM	09/15/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI COM	E SURVEY PLETED
		245414	B. WING				C 13/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R			3111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 740	hospital, until six da - 6/25/20, Interdisci R201's medications weight, non-complia indicated no MDS of information on R20 -7/4/20, R201 was of of being alone in he indicated R201 requ with her for a while. talked until R201 fe -7/7/20, R201 state was taking were ma more tired than usu appetite. The note f explained R201 wa but had an increase update the physicia -7/10/20, IDT review pain medications. T R201's mental heal -7/10/20, a progress the facility and left a nurse manager. FM stated her anxiety m The note further inco R201's medications to give the medications	return to the facility from the ays later. plinary Team (IDT) reviewed and blood glucose levels, ance with dietary choices and concerns. The IDT lacked any 1's mental health. crying and stated she was sick er room. The note further uested the nurse to sit and talk The nurse sat with R201 and It better. d the new medications she aking her fell more depressed, tal, and gave her a loss of further indicated the nurse s not on any new medications, e dosages and she would in. wed and discussed R201's The IDT did not address	F 7	740			
	staff she needed a note further indicate	mental health doctor. The ed R201 stated she did not re, then denied that statement					

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		AND HUMAN SERVICES					FORM	09/15/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245414	B. WING	i				C 13/2020
NAME OF F	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		•••	
VIEWCR	EST HEALTH CENTE	R			111 CHURCH STREET DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD	BE	(X5) COMPLETION DATE
F 740	• · · · · · · · · · · · · · · · · · · ·	-	F	740				
	nursing (ADON). R removed due to it h suicidal ideations. T requested R201 to	per and assistant director of 201's bed remote was aving a cord and R201 having Fhe NP was notified and be seen by her that next day.						
	document R201's b	ed to continue to monitor and behaviors and sleep patterns dered Zofran for nausea.						
	-7/27/20, the Spiritu R201.	al Director (SP) visited with						
	IDT and FM-A via p	uarterly care conference with whone included a review of activities, and R201 recently d.						
	review indicated on dose increase in a to suicidal thoughts	Psychotropic medication 4/3/20, R201's had a onetime medication (unnamed) related a. Review further indicated be crying and depressed on and 7/16.						
	health service, suic	ord lacked evidence of mental ide prevention evaluation and documentation of supporting and participation.						
	stated the only in-he Bingo. Bingo cons from room to room the resident's door. were not interacting Bingo except to let something. AA-A s	7 a.m. activities aide (AA)-A ouse activity for residents was sisted of activities staff going marking the Bingo cards on AA-A verified activity staff g with the residents during the residents know if they won tated activity staff were not he resident's rooms for						

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		AND HUMAN SERVICES				FORM	09/15/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY IPLETED
		245414	B. WING	i			C 13/2020
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
VIEWCR	EST HEALTH CENTE	R			111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 740	activities due to CC month activities sto residents were very without activities, an anything. AA-A sta screening staff and bringing residents of staff were being him front door which we activities with reside On 8/12/20, at 10:1 (RN)-D stated she we depression and atte further stated R201 comments to her. If interventions includ with cords from R20 R201's desk phone R201's reach. On 8/12/20, at 10:4 she was unsure how The DON stated the to determine when return items that has and stated R201 was stated R201 had no about harming hers recognize when R2 teary-eyed. The DO R201 frequently, pr and R201 had Zoor stated staff visits we visit logs outside of DON stated anytim- room, they were to stated R201 didn't st	OVID-19. AA-A stated the first opped was terrible, the y upset and had a hard time nd now they do not say ted activity staff were busy visitors at the front door, and on outside visits. AA-A stated ed to do the screening at the build allow more time for	F 7	740			

Facility ID: 00602

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		AND HUMAN SERVICES					M APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	<u> </u>
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		` '		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	245414		B. WING			C 08/13/2020	
NAME OF I	PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	B			3111 CHURCH STREET		
					DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 740	Continued From pa	ge 24	F7	740	5		
	were taken away.						
	phone was put out of maintenance did no The DON further st with R201 recently, have all of her items further stated she of rounded scissors for was important to he assessment had no determine R201's ni self-harm. On 8/12/20, at 12:0 aware R201's histo- ideation. SS-A stat frequently, but did no conversations in R2 stated she did not of assessment to asse or complete a depre- verbalized suicidal in R201 was receiving	<ul> <li>9 a.m. the DON stated R201's of R201's reach, and ot give R201 the desk phone. arted the NP did a Zoom visit and the NP stated R201 could s returned to her. The DON could try plastic scissors or or R201, if making snowflakes er. The DON stated an ot been completed to nental health status or risks of</li> <li>6 p.m. SS-A stated she was ry of depression and suicidal ed she met with R201 not chart her visits or 201's medical record. SS-A conduct any formal ess R201's suicide risk level, ession assessment after R201 ideations. SS-A was unsure if g any outside mental health</li> </ul>					
	stated it had been were sidents since CO group activities, and their rooms. AD-A so on additional respond and packages to re and visitors at the fing group activities had and there were no h	a.m. activities director (AD)-A very frustrating for staff and VID-19 restrictions of stopping d residents being restricted to stated activity staff had taken nsibilities like delivering mail sidents, and screening staff ront door. AD-A stated all stopped since COVID-19, nallway activities occurring. nt activities included delivering					

Facility ID: 00602

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PRINTED: 09/15/2020

		AND HUMAN SERVICES				FORM	: 09/15/2020 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1)           PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DAT COM	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
	245414		B. WING	i		C 08/13/2020	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VIEWCREST HEALTH CENTER				-	111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 740	eenanaea riem pa	-	F	740			
	dropping off puzzle and crafts the resid their rooms. AD-A allowed to go into re AD-A stated Zoom the main focus for a requests from famil department current visits, and more we residents had comp activities like they w accommodate resid the restrictions set R201 used to play of had expressed frus have regular Bingo AD-A stated activity more if requested. could provide one-of just talking if that w of depression and i staff were being hir time and opportunit AD-A stated activity records on resident AD-A stated R201 I three outdoor visits On 8/12/20, at 4:02 again. RN-D stated R201's ambulatory since COVID-19. F her family every da with them daily, but which seemed to her On 8/13/20, at 10:4	nt rooms, putting items away, s, books, crossword puzzles, lents could do independently in stated activity staff were not esident rooms until recently. visits and outdoor visits were activities due to the high lies. AD-A stated the activity ly had two IPads for Zoom ere on order. AD stated blained about not having were used to, and staff tried to dents, but it was difficult due to by the facility. AD-A stated dice, paint, attend Bingo, and strations of not being able to or see her significant other. v staff could visit with R201 AD-A stated activity staff on-one visits doing crafts or ould help with R201's feelings solation. AD-A stated more ed, which would allow more ties for resident activities. v staff don't chart or keep t's participation in an activity. has had window visits, two or , and Zoom visits with family. P.m. RN-D was interviewed she noticed a decline in status and being weepier RN-D stated R201 used to see y, and now she only talked trecently started outdoor visits elp with R201's mood.					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		FORM APPRO VB NO. 0938-03	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL		(X3) DATE SURVEY COMPLETED	
245414 B. WING		C 08/13/2020	
NAME OF PROVIDER OR SUPPLIER S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIXTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉT	
<ul> <li>F 740 Continued From page 26 F 740 wanting to die, which she reported to nursing. H-A stated when R201 made those comments, H-A would talk with R201 about positive things like her family, which seemed to help. H-A stated R201 stated she missed going to Bingo, socializing with other residents, and was going stir crazy.</li> <li>On 8/13/20, at 1:48 p.m. the spiritual coordinator (SC)-A stated she worked 3 days a week, not full days, and visited with residents. SP-A stated she recently had a leave. SP-A stated she tried to check on R201 at least once a week, but had not seen her for a while because she had been on leave. SP-A stated she did not always chart her visits with the residents because a lot of the time she was just stopping by to say "hi." SP-A stated she had seen more depression in the residents since COVID-19. SP-A stated the focus was on nursing for the residents, and more focus needed to be on the mental health of the residents, and taking a holistic approach. SP-A further stated she tried to help out the activities department were shorthanded, and had additional responsibilities added to their day that did not involve activities with the residents. SP-A stated there were a few residents that really struggled with depression, and identified R201 as being one of them. SP-A stated she wanted to get those residents together wearing masks, and social distancing for their mental health. SP-A further stated groups of any kind were not permitted in the facility.</li> <li>On 8/13/20, at 4:06 p.m. the ADON stated she was working the day R201 attempted to strangle herself. The ADON stated staff stayed with R201 until the ambulance arrived, family was notified, and R201 was transported to the hospital. The</li> </ul>			

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						0. 0938-039
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		. ,	IPLE CONSTRUCTION	· · ·	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN			С
		245414	B. WING		08	/13/2020
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•	10,2020
		_		3111 CHURCH STREET		
VIEWCR	EST HEALTH CENTE	R		DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 740	Continued From pa	age 27	F 74	10		
1 / 10		was aware of R201's previous	F / 4	40		
		ut R201 had no plan. The				
		ents were to stay in their				
		ay activities were canceled				
		e policy. The ADON stated staff				
		few residents outside for N stated isolation could impact				
		sion, and it was difficult to				
		e residents safe from				
	COVID-19 and soc	ialization. The ADON stated				
		out to appointments were put				
	on contact precaut exposure outside c	ions due to the risk of f the facility.				
		) p.m. another interview was DON. The DON stated she				
		diately by the ADON of R201's				
		ne DON stated she instructed				
	staff to call 911, no	tified R201's medical provider				
		ced R201 on 15 minute				
		left the building. The DON				
		en R201 returned to the facility entially harmful items from				
		replace the call light with a call				
		The DON stated she would				
		ensive assessment to be				
		week of R201's hospital				
		verified R201 was not seen by nor had a comprehensive				
		eted to determine R201's new				
		mission. The DON stated				
		ager visited with her every day,				
		1 frequently after R201's				
		ough documentation in R201's record (EMR) did not support				
		ted back in April 2020, R201				
		to harm herself. The DON				
	stated R201's med	ical provider was notified, and				
	R201's care plan d	irected staff to watch for signs				

If continuation sheet Page 28 of 33

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SU COMPLET         NAME OF PROVIDER OR SUPPLIER       245414       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SU COMPLET         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       08/13/2	STATEMENT					0		APPROVED 0938-0391
245414         B. WING         08/13/2           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         08/13/2			· /		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	245414		B. WING			08/13/2020		
	NAME OF P	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VIEWCREST HEALTH CENTER DULUTH, MN 55811	VIEWCREST HEALTH CENTER					3111 CHURCH STREET DULUTH, MN 55811		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BECOTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)CO	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
<ul> <li>F 740 Continued From page 28 and symptoms of depression, and to allow R201 to talk. The DON further stated R201 (did not have a plan to end her life, and no updates were made to R201's care plan at that time. The DON stated R201's care plan should have been updated in April after R201 expressed suicidal ideation. The DON stated updating R201's care plan and nursing assistant care sheets were important so staff knew what was going on with R201, and to ensure R201's safety. The DON verified R201's care plan was not updated following her suicide attempt, and stated it should have been updated. The DON stated upon R201's return from the hospital, staff were informally educated on R201 suicide attempt by memo and meetings. The DON stated R201 had not been by a mental health provider since R201 returned from the mental health unit, and further stated R201 had an appointment scheduled in September (three months after R201's suicide attempt). The DON stated group and hallway activities were canceled, and further stated R201's activities included one-on-one visits, outdoor and Zoom visits with family, and R201 recently received her own IPad. The DON stated R201's suicidal ideation, depression, or overall mental health status. The DON stated R201's activities included one-on-one visits, outdoor and Zoom visits with family, and R201 recently received her own IPad. The DON stated flor have an assessment to determine resident's suicidal ideation, depression, or overall mental health status. The DON stated the facility did not have an assessment to determine resident's suicidal ideation risks, and recently found a suicidal ideation risks, and recently found a suicidat ideation risks, and recently fou</li></ul>	F 740	and symptoms of d to talk. The DON fu a plan to end her lift to R201's care plan s April after R201 ex DON stated updatin nursing assistant c staff knew what wa ensure R201's safe care plan was not u attempt, and stated The DON stated up hospital, staff were suicide attempt by DON stated R201 f health provider sind mental health unit, an appointment scl months after R201' stated group and h canceled, and furth socialization by act to resident rooms, and outside visits. activities included o Zoom visits with fair received her own If notes from 6/25/20 suicidal ideation, do health status. The have an assessme suicidal ideation ris suicide contract on On 8/13/20, at 5:48 if a resident verbali themselves, she we	lepression, and to allow R201 urther stated R201 did not have fe, and no updates were made in at that time. The DON stated hould have been updated in pressed suicidal ideation. The ng R201's care plan and are sheets were important so is going on with R201, and to ety. The DON verified R201's updated following her suicide d it should have been updated. bon R201's return from the informally educated on R201 memo and meetings. The had not been seen by a mental ce R201 returned from the and further stated R201 had heduled in September (three 's suicide attempt). The DON allway activities were her stated resident's received ivity staff delivering packages offering snacks, and Zoom The DON stated R201's one-on-one visits, outdoor and mily, and R201 recently Pad. The DON verified IDT , did not address R201's epression, or overall mental DON stated the facility did not nt to determine resident's ks, and recently found a -line.	F 7	740			

Facility ID: 00602

If continuation sheet Page 29 of 33
		<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION		0. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED
				···		С
		245414	B. WING		08/13/2020	
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI		•	10/2020
				3111 CHURCH STREET		
VIEWCR	EST HEALTH CENTE	R		DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
= = 40						
F 740	• · · · · · · · · · · · · · · · · · · ·	-	F 74	10		
		ster further stated an				
		be completed to determine the				
		s, safety checks would be				
		bjects would be removed from				
		medical provider and family				
		The administrator stated safety emoved after the nurse or SS-A				
		dent to determine if there was				
		, or if the resident needed to be				
		. The administrator stated				
		ompleted a depression				
		ntify if there were other areas				
		201 expressed suicidal				
		inistrator stated she would				
		ensive assessment to be				
		201's return from the hospital				
		day, by SS-A to create a new				
	baseline and identi	fy any concerns. The				
		d she expected care plans to				
		y resident changes, and				
		e plan should have been				
		verbalized suicidal thoughts				
		The administrator stated they				
		nced a resident attempt to				
		d did not have any formal				
		ls to assess a resident's risk d suicidal ideation. The				
		d staff were not formally				
		to do if a resident verbalized				
		The administrator stated staff				
		eporting the smaller things like				
		t's mood closely with				
		s. The administrator stated				
		ered mental health services in				
	the past, and R201	declined. The administrator				
		ide documentation to support				
		ferrals for mental health				
		The administrator verified				
	R201 was not reco	iving mental health services at	1			1

If continuation sheet Page 30 of 33

		AND HUMAN SERVICES				FORM	09/15/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245414	B. WING				C 13/2020
NAME OF	PROVIDER OR SUPPLIER		[	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		_		3'	111 CHURCH STREET		
VIEWCR	EST HEALTH CENTE	R		D	DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 740	that time, and had a September. The ac mental health pract visits for another re have requested R2/ administrator stated of hiring more staff time for resident ac activities for screen administrator stated resident rooms for a activity staff passed books to the reside the focus for the ac on Zoom meetings administrator stated their rooms as long were social distance stated staff had bee their rooms, and ne The facility provided provided to staff for suicidal ideation: M Administrator dated reminded staff after exercise bands wou residents rooms. Th a resident had a me adverse side effects changes in sleep/ea anxiety, mania, pan suicidal thoughts/id The facility policy S revised date 4/17, o 1. Residents obser 911	an appointment scheduled for dministrator stated there was a itioner who made in-house sident, and the facility could 01 to be seen. The d the facility was in the process so the activity staff had more stivities instead of using ing staff and visitors. The d activity staff were allowed in one-on-one activities, and d out mail, art projects, and nts. The administrator stated stivities department had been and outdoor visits. The d residents were allowed out of a sthey wore a mask, and ing. The administrator further en used to keeping residents in eed to be re-educated. d the following on education residents that expressed emo From The Desk Of The d 6/22/20, and 6/29/20, r an incident with a resident, uld no longer be stored in the he memo also reminded staff if edication change to watch for s including but not limited to ating habits, depression, nic attacks, restlessness, or eation to notify the nurse.		740			

If continuation sheet Page 31 of 33

		AND HUMAN SERVICES			FORM	09/15/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DATI COM	E SURVEY IPLETED
		245414	B. WING			C 13/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R		3111 CHURCH STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 740	suicidal talk or beha such to the nurse in 3. Employee to ren charge nurse asses plan, remove all eq and/cause harm, i.e and begin 15 minut 4. Charge nurse to Administrator, Direc Services, and Clerg 5. Nursing person suicide threat and to resident's behavior 6. Resident's may there is a potential others. 7. An assessment be made by the interventions that m the recurrence of su plans will be develor interventions. 8. Document all the plan. The facility policy C Process undated, w status is properly as practicable function maintained. The po- Nursing Departme modifying, adding, to Additional Vulnerab Behavior, and Safe -Activity Departmer	avior of a resident must report in charge immediately. main with the resident until the ss. Determine if resident has a uipment that could be used e. sharps, cords, belts, etc., the visual checks on resident. to contact resident's Physician, ctor of Nursing, Social gy (if appropriate). hel will be informed of the o report changes in the immediately. be temporarily secluded if of danger to him/herself or of the resident's behavior will erdisciplinary care plan team of such incident to determine hay be necessary to prevent uch threats. Revised care oped to reflect such e above and update the care comprehensive Care Planning vas to ensure each resident's ssessed and that the highest hal status can be attained and olicy directed the following: nt will be responsible for updating the following focuses: oility Areas (if applicable), ty. nt in collaboration with Social ponsible for modifying, ing focus:	F 74			

If continuation sheet Page 32 of 33

DEPARTMENT OF HEALTH CENTERS FOR MEDICAR					FORM	09/15/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
	245414	B. WING	;			_ 13/2020
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
VIEWCREST HEALTH CENTE	R			3111 CHURCH STREET DULUTH, MN 55811		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	I IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
Departments will s link interventions p resident's function needed on the car The Director of So undated, indicated standard of the DS provide individual, designed to impro- reduce the psycho The facility policy of	Social Service, Activity schedule new interventions or previously scheduled to improve ing or minimize decline as	F 7	740			

Facility ID: 00602

If continuation sheet Page 33 of 33



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 3, 2020

Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

Re: State Nursing Home Licensing Orders Event ID: IIUP11

Dear Administrator:

The above facility was surveyed on August 10, 2020 through August 13, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

Viewcrest Health Center September 3, 2020 Page 2

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Teresa Ament, Unit Supervisor Email: teresa.ament@state.mn.us Phone: (218) 302-6151 Fax: (218) 723-2359

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE COMP	SURVEY LETED
		00602	B. WING		08/1	) 3/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	<u></u>	
		3111 CHU	RCH STREE			
VIEWCR	EST HEALTH CENTE	DULUTH,	MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a	nether a violation has been				
	that was violated du corrected.	uring the initial inspection was				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	survey was conduc with State Licensur	rS: n 8/13/20, an abbreviated ted to determine compliance e. Your facility was found to be vith the MN State Licensure.				
	SUBSTANTIATED:	laints were found to be H5414066C and H5414067C				
Minnesota D	epartment of Health	ER/SUPPLIER REPRESENTATIVE'S SIGI		TITLE		(X6) DATE
	ically Signed					09/11/20

STATE FORM

If continuation sheet 1 of 32

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00602	B. WING		C 08/13/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	2	URCH STREE I, MN 55811	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLE	
2 000	Continued From pa	ge 1	2 000			
	with licensing order	s issued.				
		laints were found to be ED: H5414068C and				
	signature is not req page of state form. Please indicate you	ed in ePOC and therefore a uired at the bottom of the first r electronic plan of correction wed these orders, and identify will be corrected.				
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900		9/18/20	
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which	r.			
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	ho has pressure sores y treatment and services to event infection, and prevent veloping.				
	by: Based on observati review, the facility f	ent is not met as evidenced on, interview, and document ailed to implement identified ntervention of repositioning for		Corrected in federal deficiencies.		

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	COMI	E SURVEY PLETED
		00602			08/	13/2020
	PROVIDER OR SUPPLIER	3111 CH	DDRESS, CITY, ST URCH STREET			
VIEWCR	EST HEALTH CENTE	R	, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 2	2 900			
	1 of 3 (R201) resid developing pressur	ents who was at risk for e ulcers.				
	Findings include:					
	R201's diagnoses i (progressive nervo	t printed 8/13/20, indicated ncluded Parkinson's disease us system disorder that affects es mellitus type 2, and low				
	7/17/20, indicated I and had no rejection assessment period R201 required one toileting, and two a indicated R201 was had no current pres- skin concerns. The	inimum Data Set (MDS) dated R201 was cognitively intact on of cares during the I. The MDS further identified person assist for bed mobility, ssist for transfers. The MDS is at risk for pressure ulcers, asure ulcers, or other identified the MDS indicated R201 had tices in chair and mattress, and pical medications.				
	was at risk for skin incontinent of urine R201 required phys turning and reposit hour toileting R201	evised 8/12/20, identified R201 breakdown and was a R201's care plan revealed sical assistance of two staff for ioning, and required every two I's care plan directed staff to if he refused toileting or				
	8/10/20, directed st every two hours, ar	istant care sheet printed taff to turn and reposition R201 nd toilet R201 at 8:00 a.m. to and every two hours.				
an a sata D	how long of an inte	rance (TT, an assessment of rval the resident can tolerate dated 2/28/20, indicated				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	Сом	E SURVEY PLETED C
	00602		B. WING		08/	13/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	URCH STREET , MN 55811	T		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 3	2 900			
		eloped a non-blanchable r 2 hours of lying, and sitting.				
	exited R201's room and garbage and vere repositioned, chang morning and planner recliner chair. -9:51 a.m. NA-A end delivered a fresh cur room. R201 was no repositioning, and r her back. -10:34 a.m. the direct R102's room, talked and exited the room toileting or reposition lying on her back. -11:37 a.m. staff end delivered meal tray being late, set up m R201 was not offered and remained in her -11:42 a.m. NA-A end delivered a piece of per R201's request was not offered toilet remained in her bed -12:20 p.m. the acti R201 room and talk appointment, sched significant other, an not offered toileting remained in her bed -12:30 p.m. the AD notified R201 they with her significant	vities director (AD) entered ked about a beautician Juling time to see R201's ad exited the room. R201 was or repositioning, and				

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00602		CONSTRUCTION	`́сом	E SURVEY PLETED C 13/2020
AME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IEWCREST HEALTH CENTE	R	URCH STREET , MN 55811	г		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
up the IPad for a v significant other ar not offered toileting remained in her be -1:00 p.m. the AD for R201 to finish f room. R201 was r repositioning, and her back. -1:05 p.m. the assi (ADON) and DON reposition and ass request. R2 was r R201 was not offe and remained in he 9:47 a.m. to 1:07 p On 8/11/20, at 12:2 repositioned and c NA-A viewed her n that she kept in her to be turned and re and toileted at 8 a. and every two hou on repositioning R busy morning and her recliner chair. another resident's and did not provide following the interv On 8/11/20, at 12:2 toileting times were log kept at the nurs according the toile R201 was last toile	<ul> <li>entered R201's room and set ideo chat with R201's nod exited the room. R201 was g or repositioning, and ed lying on her back.</li> <li>entered R20's room and waited her video chat and exited the not offered toileting or remained in her bed lying on a stant director of nursing entered R201's room to ess R201's skin per surveyors emained lying on her back.</li> <li>red toileting or repositioning, er bed lying on her back from o.m.</li> <li>28 p.m. NA-A stated she hanged R201 at 9:20 a.m. ursing assistant care sheet r pocket and stated R201 was epositioned every two hours, m. to void and 8 p.m. for BM, rs. NA-A stated she was late 201 because it had been a planned to get R201 up soon in NA-A proceeded to go into room with the mechanical lift e repositioning to R201 riew.</li> <li>87 p.m. NA-B stated residents e documented on the toileting sing desk. NA-B stated ting log, it was documented</li> </ul>				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00602	B. WING		08/13/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	URCH STREET , MN 55811	r		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	age 5 as notified surveyor had	2 900			
	completed continue R201 had not been and R201's skin ne RN went to find sta R201 so she could On 8/11/20, at 1:05 was observed lying R201's lunch tray n and director of nurs room and explained and check her skin mess in her pants" At 1:07 p.m., the Al changed R201's into observed to be soil peri area appeared R201's skin to cocc with redness noted provided incontinen R201's buttocks, co there were no oper coccyx skin color w DON applied a star periarea and buttoc brief. R201 remain bed was elevated a giving R201's chair other. On 8/11/20, at 1:17 at risk for pressure required every two stated she would h	bus observations of R201, repositioned since 9:20 a.m., reded to be assessed by a RN. ff to assist with repositioning				
		p.m. the DON confirmed able redness to her coccyx				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		00602	B. WING			C 08/13/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE			
/IEWCR	EST HEALTH CENTE	R	RCH STREET MN 55811				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 900	after not being turn hours. The DON s staff to follow the re pressure ulcer prev R201's care plan a sheet directed staff every two hours to The facility policy S indicated tissue toke individual's turning The facility policy L undated, directed r will be utilized and nursing assistants current toileting neu incontinence produ complications of ur SUGGESTED MET The Director of Nur develop, review, ar procedures to ensu services are provid to prevent develop ulcers. The Director of Nur educate all appropri procedures. The Director of Nur	ed or repositioned for over 3 tated it was her expectation of esident's plan of care for vention. The DON verified nd nursing assistant care if to turn and reposition R201 prevent skin breakdown. Skin Ulcer Protocol undated, erance test determines an and reposition schedule. Urinary Incontinence Program bursing assistant care sheets kept updated, to ensure the are aware of the resident's eds, including the use of locts, and plans to prevent	2 900				
	(21) days.	R CORRECTION: Twenty-one					
21475	MN Rule 4658.100 General Requireme	5 Subp. 1 Social Services:	21475			9/18/20	

STATE FORM

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		B) DATE SURVEY COMPLETED C
	00602	B. WING		08/13/2020
PROVIDER OR SUPPLIER				
EST HEALTH CENTE	3		ĒT	
SUMMARY STA	•		PROVIDER'S PLAN OF CORRECTION	(X5)
		PREFIX TAG		E COMPLET
Continued From pa	ge 7	21475		
home must have ar department or prog related social servic nursing home must collaborate with out who is in need of ac	n organized social services ram to provide medically ces to each resident. A make referrals to or side resources for a resident dditional mental health,			
by: Based on interview facility failed to com status on discharge of 4 residents (R20	and document review, the municate a resident's current to the receiving facility for 1 0) reviewed for admission,		Corrected in federal deficiencies.	
Findings include:				
R200 was admitted diagnoses included skin of scalp and ne by excess fluid trap	to the facility on 7/1/20, and squamous cell carcinoma of eck, edema (swelling caused ped in your body's tissues),			
dated 7/7/20, indica skin breakdown, de after lying for 5 hou (tailbone) after 3 ho dry, flaky skin with a areas of bruising ar head. In addition, F extremities with cor	ted R200 was at low risk for veloped redness on the spine rs, and on the coccyx ours of sitting. R200 areas of areas of thin skin, and had a cancerous lesion on his R200 had edema of both lower npression stockings. R200's			
	OF CORRECTION PROVIDER OR SUPPLIER EST HEALTH CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa Subpart 1. Genera home must have ar department or prog related social servic nursing home must collaborate with out who is in need of ac substance abuse, of This MN Requireme by: Based on interview facility failed to com status on discharge of 4 residents (R200 transfer, and dischar Findings include: R200's Face Sheet R200's Face Sheet R200's General Nur dated 7/7/20, indica skin breakdown, de after lying for 5 hou (tailbone) after 3 hou dry, flaky skin with a areas of bruising ar head. In addition, F extremities with cor GNO notes did not	OF CORRECTION       IDENTIFICATION NUMBER:         00602       00602         PROVIDER OR SUPPLIER       STREET AD         EST HEALTH CENTER       3111 CHU DULUTH,         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 7       Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services.         This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to communicate a resident's current status on discharge to the receiving facility for 1 of 4 residents (R200) reviewed for admission, transfer, and discharge.	OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING       00602     B. WING	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         00602       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SIMMARY STATEMENT OF DEFICIENCY       3111 CHURCH STREET DULUTH, MN 55811         SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLD BI (EACH ORRECTIVE ACTION SHOLD BI (EACH ORRECTIVE ACTION SHOLD BI (EACH ORRECTIVE ACTION SHOLD BI (EACH ORRECTIVE ACTION SHOLD BI CONTINUED FOR page 7       21475         Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services.       Corrected in federal deficiencies.         This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to communicate a resident's current status on discharge to the receiving facility or 1 of 4 residents (R200) reviewed for admission, transfer, and discharge.       Corrected in federal deficiencies.         Findings include:       R200's Face Sheet printed 8/13/20, indicated R200 was admitted to the facility on 71/20, and diagnoses included squamous cell carcinoma of skin of scalp and neck, edema (swelling caused by excess fluid trapped in your body's tissues), diabetes, and anemia.       R200's General Nurse's Observation (GNO) dated 7/7/20, indicated R200 was at low risk for skin breakdown, developed redness on the sp

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00602	B. WING		08/	13/2020
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
VIEWCR	EST HEALTH CENTE	R	JRCH STREE1 , MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21475	Continued From pa	ige 8	21475			
	was at risk for skin decreased mobility,	ated 7/16/20, indicated R200 breakdown related to , and had an impaired skin en area, lacked identification of pairment.	F			
	7/1/20, indicated R2	ion Report With Images dated 200 had bruises on arms, legs incerous lesion on his head.				
	7/8/20, indicated R2 his head. R200's s	ion Report With Images dated 200 had a cancerous lesion on kin report lacked any oncerns on R200's right shin.				
		ion Report With Images dated ked any indication of skin s right shin.				
	7/21/20, indicated F cancerous lesion of	ion Report With Images dated R200 continued with a n his head, but lacked any oncerns on R200's right shin.				
	indicated R200 arriv 7/30/20, with an op- measuring 2.5 inch necrotic area, and y addition, R200 had	th the State Agency (SA) ved at the receiving facility on en area on the right shin es by 1.5 inches, with a yellow, draining tissue. In edema of both his legs, and ression stockings on (stockings idema).				
	indicated R200 wou assisted living facili one to two weeks. I indicated R200 had	conference note dated 7/15/20, uld be discharged to an ty which had an opening in R200's care conference note I a few bruises, a cancerous along with compression ips to his legs.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMI	E SURVEY PLETED
		00602	B. WING			C 1 <b>3/2020</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	URCH STREET I, MN 55811	г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21475	Continued From pa	age 9	21475			
		otes dated 7/23/20, indicated scharged to an assisted living				
		otes from 7/23/20, through cumentation of any skin in conditions.				
		d 7/29/20, indicated R200's conditions was not				
	registered nurse (R	arge Plan of Care signed by N)-B and dated 7/30/20, ion of R200's current skin				
	Transfer Sheet date seven days prior to bruises on his arms cancerous lesion of indicate the date of Resident Transfer S had compression s	itioner signed Resident ed 7/29/20, with data for the 7/28/20, indicated R200 had s and on his left thigh, with a n the scalp, though did not the skin observations. R200' Sheet further indicated R200 tocking to lower extremities to n. and off in the p.m., and an l care.				
	living facility on 7/3	ation received by the assisted 0/20, indicated R200's right s not documented, and not ne assisted living.				
	the date of his disc admission to the as R200 had a large u some depth, irregul	D's right shin dated 7/30/20, harge from the facility and ssisted living facility, indicated Iceration on the right shin with lar edges, and moist tissue ker area near the upper edge,				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00602	(X2) MULTIPLE A. BUILDING: B. WING		Сом	E SURVEY PLETED C 13/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	TATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	3111 CHU	RCH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21475	yellow draining tisst erythema (redness) had swollen lower li further had a dark li open area and knee On 8/13/20, at 12:5 representative (RR) RR-C stated R200 but when he transfe was found to have a was draining. RR-C regarding R200's ul transfer form, and s the area. On 8/13/20, at 1:27 stated she had word aware of any sores. On 8/13/20, at 2:22 been notified of an RN-A stated they ha living facility about to of discharge, had re documentation, and documentation of a verified R200's skin should be noted on care and was not. F wound should have form, and was not. assessment should discharge. On 8/13/20, at 2:45 been filling in for the that day, and did not	ue on the lower edge, with light on the lateral edge. R200 egs with dry, scaly skin. R200 near dark area between the e. 4 p.m. R200's resident -C was interviewed by phone. was treated well at the facility, erred to the assisted living, he an ulcer on his right shin that C stated the information cer was not included on the she had not been notified of p.m. nursing assistant (NA)-C ked with R200, and was not other than on his head. p.m. RN-A stated she had not ulceration of R200's skin. ad been called by the assisted he wound on his leg the day eviewed R200's	21475			

Iinnesota Department of H TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED
	00602	B. WING			13/2020
AME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IEWCREST HEALTH CENTE	R	JRCH STREET , MN 55811	r		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21475 Continued From p	age 11	21475			
fill out the discharge signed it. RN-B sta status of the skin of RN-B stated the at about a wound, so and asked staff. So on R200's shin wh On 8/13/20, at 3:0 (DON) verified skin the post discharge was not document stated skin should On 8/14/20, at 9:5 director (ALD) stat about R200's skin arrived at their fac looked at him right a "Stage 3 diabetic draining tissue, an stated RR-C was at it, stating it was ne status was not cor stated R200 was b was healing well. compression stock were very swollen. The facility policy I reviewed/amended complete a dischar summary of the re discharge, with an and provided to th	head. RN-B stated she did not ge plan of care, and she just ated she should have put the on the form, even if it was clear ssisted living facility had called she checked documentation, staff did not remember a wound en they got him dressed. 3 p.m. the director of nursing n status should be included on plan of care, and verified it ed on R200's form. The DON be checked before discharge. 0 am. assisted living facility ed she was very concerned condition on his shin when he lity. ALD stated the nurse when he got there, and found c ulcer" on his shin with yellow, d necrosis in the center. ALD an RN, and was very upset by glect. ALD stated R200's skin municated to the facility. ALD weing seen by wound care, and ALD stated R200 did not have dings on either, and his legs Discharge Planning d 1/17, directed nursing to rge plan of care with a final sident 's status at the time of assessment of the resident, e facility receiving services. THOD OF CORRECTION: Social Services Director,				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00602		(X	3) DATE SURVEY COMPLETED C 08/13/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS. CITY.	STATE, ZIP CODE	
		3111 CHU	RCH STREE		
VIEWCR	EST HEALTH CENTE	DULUTH,	MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
21475	ensure accurate dis completed and prior safe and appropriat The Administrator, 3 Director of Nursing appropriate staff on The Administrator, 3 Director of Nursing monitoring systems compliance. TIME PERIOD FOF (21) days.	e policies and procedures to scharge summaries are or to discharge to ensure a te discharge. Social Services Director, or designee could educate all the policies and procedures. Social Services Director, or designee could develop to ensure ongoing R CORRECTION: Twenty-one	21475		
21810	Residents of HC Fa Subd. 6. Appropr residents shall have medical and persor needs. Appropriate care designed to er highest level of phy This right is limited reimbursable by pu	riate health care. Patients and e the right to appropriate hal care based on individual e care for residents means hable residents to achieve their sical and mental functioning. where the service is not blic or private resources.	21810		9/18/20
	by: Based on observati review, the facility fa a comprehensive ca interventions to add included behavioral safe environment, a social interactions t	ent is not met as evidenced on, interview, and document ailed to ensure development of are plan, and implement lress suicidal ideation that health services, provision of a and meaningful activities and o promote psychosocial rent a suicide attempt for 1 of		Corrected in federal deficiencies.	

If continuation sheet 13 of 32

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00602			08/	13/2020
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
VIEWCR	EST HEALTH CENTE	R	JRCH STREE1 , MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21810	Continued From pa	ge 13	21810			
	and suicide attempt psychosocial and p	reviewed for suicidal ideations t. This resulted in actual hysical harm for R201 when ide by strangulation.				
	Findings include:					
	R201's diagnoses i avoidant personality disorder (a group o cause unexplained major depression, a (progressive nervou movement).	printed 8/13/20, indicated ncluded suicide attempt, y disorder, somatoform f psychological disorders that physical symptoms), anxiety, and Parkinson's disease us system disorder that affects				
		nimum Data Set (MDS) dated R201's was cognitively intact, ressed.				
	was at risk for alter well-being related to to COVID-19. The indicated R201 pre- and directed activity daily rounds to prov	ated 7/21/20, identified R201 ation in psychosocial o restriction on visitation due care plan dated further ferred activities in her room, y staff/volunteers to visit during vide socialization. R201's care cation of suicidal ideation.				
	8/10/20, lacked iden ideation, and lacked	istant care sheet printed ntification of R201's suicidal d staff direction on what to do sed thoughts of self-harm.				
	social service direc indicated R201 was Health Questionnai presence and seve	ssessment completed by the tor (SS)-A dated 4/27/20, s cognitively intact, Patient re (PHQ-9, a screening for the rity of depression) indicated normal and further indicated				

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		00602	B. WING		08/	13/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	JRCH STREET			
		DULUTH	, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21810	Continued From pa	ge 14	21810			
	depressed due to h	the past week she felt more er family being unable to visit. entification of R201's recent				
	R201 was in her roo strangle herself with that was attached to The report indicated from R201's neck, a hospital by ambular	ent Details report revealed om when she attempted to h a stretch band (Theraband) o the mobility bar on her bed. d the Theraband was removed and R201 was taken to the nce. The incident report placed on 15 minute checks.				
	Discharge Summar the emergency roor Theraband around herself. The summa home staff noted R statements two were felt they could not k found with the Ther was admitted to a r stabilization, medic assessment. The h indicated at the time condition had impro- discharge to nursin	ital Behavioral Health ry indicated R201 was seen in m after being found with a her neck in attempt to kill ary further indicated nursing 201 had been making suicidal eks prior to her attempt, and seep R201 safe after being raband around her neck. R201 nental health unit for ation management, and ospital Discharge Summary e of discharge, R201's oved and was stable and g home and instructed to ary care provider within 5 days.				
	physician visit via Z R201 was tearful th expressed a lot of s was being quarantii in her old familiar ro missed so much, e expressed a friend	der note indicated R201 had a coom visit. The note indicated irough much of the visit, and sadness. R201 expressed she ned, and would rather be back com. R201 stated, "I've verything is gone." R201 of hers health had e was in a nursing home, and				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
		00602	B. WING	B. WING 08/13/2			
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
VIEWCR	EST HEALTH CENTE	R	RCH STREET MN 55811				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PRÉFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLET DATE	
21810	Continued From pa	ige 15	21810				
	note further indicate point earlier in the r of self-harm with a and lead to an inpa unit from June 11-1 received psychothe adjustments. The n emotionally distress compose herself, b conversation. R201 the director of nursi plan was R201 wou quarantine period e outdoor visits with r On 8/10/20, at 3:52 was interviewed an difficult time being i lack of contact from for her. FM-A state depression for man several losses inclu family members, ar her home and not b communicate with r expressed concern stated R201 recent to strangle herself w FM-A stated R201 s suicidal ideation ab attempt. FM-A state dangerous items fro R201 on 15 minute expressed self-harr practitioner (NP) m the facility talked at	p.m. family member (FM)-A d stated R201 was having a solated to her room, and the n the outside also was difficult ed R201 had a history of ny years, and had experienced uding the death of immediate nd the most recent loss was					
		M-A stated R201 refused to					
		ents, and feared R201 would					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	Сом	E SURVEY PLETED C
		00602	B. WING		08/13/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	3	RCH STREET MN 55811	r		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21810	days. FM-A stated her last hospitalizat for R201 mentally. family during this que surrounded by her unaware if the facilit video visit for mental stated she thought commit suicide it we lived in the commune would be at her age stated she felt R200 again. On 8/11/20, at 3:47 and stated she felt R200 again. On 8/11/20, at 3:47 and stated she had until 4:00 a.m., and heart attack. R201 and was told R201 R201 stated it was been able to see her was admitted to a r staff were going to with R201's signific week. R201 express isolated since no or and all activities har was very close with her daughter daily. chatted with her da they had two outdoor eyed, and stated sh much, and the sum she struggled with or and now she had set think and stare at th	ge 16 erent room to quarantine for 14 R201 had to quarantine after ion which was a difficult time R201 was unable to see uarantine, and was not bersonal items. FM-A was ty attempted to arrange a al health services. FM-A if R201 would attempt to buld have been when R201 hity, and FM-A never thought it e in a nursing home. FM-A 1 would attempt to end her life p.m. R201 was interviewed been awake from 1:00 a.m. thought she was having a stated the doctor was called, was having an anxiety attack. upsetting that she had not er significant other since he fursing home. R201 stated try and arrange an outside visit ant other sometime next ased feeling lonely and he could leave their rooms, d stopped. R201 stated she her family, and talked with R201 stated she video ughter a couple of times, and or visits. R201 became teary the felt like she had missed so mer was gone. R201 stated depression for many years, o much time on her hands to be four walls within her room.	21810	DEFICIENCY)		
innesota D	think and stare at th R201 stated no one	ne four walls within her room. e came to her room to visit ed in, did what they had to do				

	NT OF DEFICIENCIES I OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C	
		00602	B. WING 08/*			
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	JRCH STREET	Г		
		DULUTH	, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21810	Continued From pa	ige 17	21810			
	or knit, but could st paper. R201 stated snowflakes becaus R201 further explai herself with the exec therapy a couple of she told staff she w would not tell them her scissors away a phone base, becau stated if she wanter use the cords from and proceeded to p side table between R201 stated she wa mental health provi the facility in fear sl isolation unit and qu stated she could no she had a psychiati September, and sh private room with a have to go to the is visited with the NP her concern of feeli lonely. R201 stated going to be schedu her personal items meeting had not be R201 stated the da herself she was fee and stated staff bou around 11:00 a.m. a again until the nurs with the Theraband R201 stated her far hospitalization to st	e and could no longer crochet ill make snowflakes from d she was unable to make the e staff took her scissors away. ned she had tried to strangle ercise band she received from months ago. R201 stated vas going to kill herself, but how. R201 stated staff took and removed her cordless use of the cords. R201 further d to strangle herself she would the desk phone staff gave her boint at the desk phone on the her recliner chair and bed. as currently not seeing a der, and she would not leave he would have to go to the uarantine for 14 days. R201 ot handle that. R201 stated ric appointment scheduled for e was told since she was in a private bath, she would not olation unit. R201 stated she via video chat, and expressed and anxious, depressed and d she was told a meeting was led to see if she could have returned, and stated the een scheduled as of date. y she attempted to strangle eling very alone and isolated, ught in her lunch that day and did not come in her room ing assistant (NA) found her l around her neck at 4:00 p.m. mily bought her an IPad after ay connected, play Scrabble, net, otherwise she had nothing	,			

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y
		00602	B. WING		C 08/13/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	JRCH STREE1 , MN 55811	r		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMP THE APPROPRIATE DAT	PLET
21810	Continued From pa	age 18	21810			
	Review of R201's progress notes from 4/19/20, to 7/29/20, revealed the following:					
	had a plan, but wou stated, "You'll take notified, clonazepar for a one time dose minute checks. The family was updated	balized she was suicidal and uld not elaborate further and it away from me." The NP was m (tranquilizer) was increased a, and R201 was placed on 15 e note further indicated R201's l, and R201 safety checks 30 minute checks for the rest	5			
	regarding a room c indication SS-A had	ke with R201's daughter hange. The note lacked d a conversation with R201's R201's suicidal thoughts or mental health.				
	on room change. T SS-A had a conver	oke with R201 and followed up The note lacked any indication sation with R201 regarding or her current state of mental				
	sad all of the time. NP was contacted and her non-compl	pressed to the nurse of feeling The note further indicated the to address R201 blood sugars iance with dietary choices. The ion R201's mood was				
	morning due to hea out and was being to an assisted living registered nurse (R did not want to live	s "very depressed" that aring her house was cleared sold, and her boyfriend moved g facility. R201 expressed to RN)-C she felt hopeless, and anymore. RN-C asked R201 hurt herself, and R201 stated				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COMI	E SURVEY PLETED
		00602	B. WING			1 <u>3/2020</u>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	JRCH STREET , MN 55811	Ţ		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21810	Continued From pa	ge 19	21810			
	she may do it. R20 checks and R201's	hurt herself, with otherwise 11 was put on 15 minute safety daughter was updated. anned a window visit for that				
	recent days of feeli suicidal thoughts at "cannot live like this anxiety of not being	t with R201 and discussed ng down. R201 denied any that time and stated she s." R201 expressed increased able to see her significant sed arranging a Zoom visit with other.				
	checks, had spoke visit with the NP wh and her depression indication if R201's	s taken off of 15 minute safety n with family, and had a Zoom nich addressed blood sugars, n. The note lacked any NP changed any medications, sidal ideations, or added any				
	band around her ne mobility bar. R201 v tightly trying to strat indicated the stretc had a reddened ma R201 stated she wa Potential harmful ite R201's room, family ordered R201 to be	found by a NA with a stretch eck which was attached to the was pulling the stretch band ngle herself. The note further h band was removed, R201 ark all around her neck, and as trying to kill herself. ems were removed from y was notified, and the NP e sent to emergency was placed on 15 minute ibulance arrived.				
	regarding R201's re having her bed held daughter stated sho	te with R201's daughter ecent suicidal attempt, and d. The note indicated R201's e talked to R201 daily, and felt a better mood, and R201 had				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00602	B. WING			C 13/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	URCH STREET , MN 55811	r		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21810	Continued From pa	age 20	21810			
	not made any recei hurt herself.	nt comments about wanting to				
	still had thoughts of	al social worker stated R201 f harming herself, and the g for in-house placement.				
	home. R201 stated were helping with h	s readmitted to the nursing d the two new medications her depression, she denied rm, and stated did not plan on ad again.				
		rogress notes lacked any follow return to the facility from the ays later.	,			
	R201's medications weight, non-complia	plinary Team (IDT) reviewed s and blood glucose levels, ance with dietary choices and concerns. The IDT lacked any 1's mental health.				
	of being alone in he indicated R201 req	crying and stated she was sick er room. The note further uested the nurse to sit and talk . The nurse sat with R201 and elt better.				
	was taking were ma more tired than usu appetite. The note explained R201 wa	ed the new medications she aking her fell more depressed, ual, and gave her a loss of further indicated the nurse is not on any new medications, e dosages and she would an.				
		wed and discussed R201's The IDT did not address Ith.				

INNESOTA DEPARTMENT OF H ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	СОМ	E SURVEY PLETED	
	00602	B. WING			08/13/2020	
ME OF PROVIDER OR SUPPLIE	R STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
EWCREST HEALTH CENT	FR	URCH STREET I, MN 55811	r			
REFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21810 Continued From p	page 21	21810				
the facility and lef nurse manager. F stated her anxiety The note further in R201's medication to give the medication to give the medication to give the medication staff she needed note further indications want to live anymite to the nurse manain nursing (ADON). removed due to it suicidal ideations requested R201 the -7/16/20, NP order document R201's for 14 days, and of -7/27/20, the Spir R201. -7/29/20, R201's of IDT and FM-A viain medications, diet, received a new IF On 7/7/20, R201's review indicated of dose increase in a to suicidal though R201 was noted to 7/4, 7/7, 7/10, 7/1	Psychotropic medication on 4/3/20, R201's had a onetime a medication (unnamed) related ts. Review further indicated o be crying and depressed on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
	00602	B. WING			13/2020
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
VIEWCREST HEALTH CENTE	R	RCH STREET MN 55811			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21810 Continued From pa assessments, and activity interactions	documentation of supporting	21810			
stated the only in-h Bingo. Bingo com from room to room the resident's door were not interactin Bingo except to let something. AA-A allowed to go into the activities due to CO month activities star residents were ver without activities, a anything. AA-A star screening staff and bringing residents staff were being hi front door which w activities with reside On 8/12/20, at 10: (RN)-D stated she depression and att further stated R20 comments to her. interventions inclue with cords from R2 R201's desk phone R201's reach. On 8/12/20, at 10:4	<ul> <li>17 a.m. activities aide (AA)-A nouse activity for residents was asisted of activities staff going marking the Bingo cards on . AA-A verified activity staff g with the residents during the residents know if they won stated activity staff were not he resident's rooms for DVID-19. AA-A stated the first opped was terrible, the y upset and had a hard time nd now they do not say ated activity staff were busy d visitors at the front door, and on outside visits. AA-A stated red to do the screening at the build allow more time for ents.</li> <li>19 a.m. registered nurse was aware of R201's empt to end her life. RN-D 1 had never made suicidal RN-D stated R201 safety ded removal of unsafe items 201's room. RN-D then placed a down to the floor, out of</li> <li>46 p.m. the DON stated R201 w R201 got the desk phone.</li> </ul>				

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C	
	00602	B. WING			13/2020
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
/IEWCREST HEALTH CENTER	2	RCH STREET MN 55811			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
recognize when R20 teary-eyed. The DC R201 frequently, pro and R201 had Zoon stated staff visits we visit logs outside of DON stated anytime room, they were to a stated R201 didn't s being able to make were taken away. On 8/12/20, at 11:19 phone was put out of maintenance did no The DON further sta with R201 recently, have all of her items further stated she c rounded scissors fo was important to he assessment had no determine R201's m self-harm. On 8/12/20, at 12:00 aware R201's histor ideation. SS-A state frequently, but did n conversations in R2 stated she did not c assessment to asse or complete a depre verbalized suicidal i R201 was receiving	elf, and staff were able to 01 felt depressed and DN stated staff visited with ovided one-on-one activities, n and outdoor visits. The DON ere documented on the room the resident's doors. The e anyone enters a resident's sign in and out. The DON start complaining about not snowflakes until her scissors 9 a.m. the DON stated R201's of R201's reach, and t give R201 the desk phone. arted the NP did a Zoom visit and the NP stated R201 could s returned to her. The DON ould try plastic scissors or rr R201, if making snowflakes er. The DON stated an t been completed to nental health status or risks of 6 p.m. SS-A stated she was ry of depression and suicidal ed she met with R201 iot chart her visits or 201's medical record. SS-A	21810			

3111 CHURCH STREET	ECTION	C 13/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE VIEWCREST HEALTH CENTER ULUTH, MN 55811 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRE	ECTION	10/2020
VIEWCREST HEALTH CENTER     3111 CHURCH STREET DULUTH, MN 55811       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECT		
VIEWCREST HEALTH CENTER     DULUTH, MN 55811       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECT		
TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE API DEFICIENCY)		(X5) COMPLET DATE
21810   Continued From page 24   21810		
stated it had been very frustrating for staff and residents since COVID-19 restricted to their rooms. AD-A stated activity staff had taken on additional responsibilities like delivering mail and packages to residents, and screening staff and visitors at the front door. AD-A stated all group activities had stopped since COVID-19, and there were no hallway activities occurring. AD-A stated resident activities included delivering packages to resident rooms, putting items away, dropping off puzzles, books, crossword puzzles, and crafts the resident activities due to the high requests from families. AD-A stated the activity AD-A stated Zoom visits and outdoor visits were the main focus for activities due to the high requests from families. AD-A stated the activity department currently had two IPads for Zoom visits, and more were on order. AD stated residents had complained about not having activities like they were used to, and staff tried to accommodate residents, but it was difficult due to the restrictions set by the facility. AD-A stated R201 used to play dice, paint, attend Bingo, and had expressed frustrations of not being able to have regular Bingo or see her significant other. AD-A stated activity staff could visit with R201 more if requested. AD-A stated activity steff could provide one-on-one visits doing crafts or just talking if that would help with R201's feelings of depression and isolation. AD-A stated more staff were being hired, which would allow more time and opportunities for resident activities. AD-A stated activity staff don't chart or keep records on resident's participation in an activity. AD-A stated 201 has had windw visits, two or three outdoor visits, and Zoom visits with family. On 8/12/20, at 4:02 p.m. RN-D was interviewed		

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		00602	B. WING			13/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	2	IRCH STREET MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21810	Continued From pa	ge 25	21810			
	R201's ambulatory since COVID-19. F her family every day with them daily, but which seemed to he On 8/13/20, at 10:4 stated R201 had may wanting to die, which stated when R201 r would talk with R20 family, which seemed stated she missed g	she noticed a decline in status and being weepier RN-D stated R201 used to see y, and now she only talked recently started outdoor visits elp with R201's mood. 4 p.m. housekeeper (H)-A ade comments to her about th she reported to nursing. H-A nade those comments, H-A 1 about positive things like her ed to help. H-A stated R201 going to Bingo, socializing with d was going stir crazy.				
	(SC)-A stated she w days, and visited wi recently had a leave check on R201 at leave seen her for a while leave. SP-A stated visits with the reside she was just stoppin she had seen more since COVID-19. S nursing for the reside to be on the mental taking a holistic app she tried to help our much as she could, were shorthanded, responsibilities add involve activities with there were a few re with depression, an of them. SP-A state	p.m. the spiritual coordinator vorked 3 days a week, not full th residents. SP-A stated she e. SP-A stated she tried to east once a week, but had not e because she had been on she did not always chart her ents because a lot of the time ng by to say "hi." SP-A stated depression in the residents SP-A stated the focus was on dents, and more focus needed health of the residents, and broach. SP-A further stated t the activities department and had additional ed to their day that did not th the residents. SP-A stated sidents that really struggled d identified R201 as being one ed she wanted to get those wearing masks, and social				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00602	B. WING			13/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	JRCH STREET MN 55811	r		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
21810	Continued From pa	ge 26	21810			
	stated groups of an the facility.	y kind were not permitted in				
	herself. The ADON until the ambulance and R201 was trans ADON stated she w suicidal ideation, bu ADON stated reside rooms and all hallw per corporate office rotated and took a f activities. The ADO a resident's depress balance keeping the COVID-19 and soci residents that went on contact precauti exposure outside o On 8/13/20, at 4:40	p.m. another interview was				
	was notified immed suicidal attempt. Th staff to call 911, not and family, and plac checks until R201 b stated the plan whe was to remove pote R201's room, and r	DON. The DON stated she iately by the ADON of R201's ne DON stated she instructed ified R201's medical provider ced R201 on 15 minute eff the building. The DON on R201 returned to the facility entially harmful items from eplace the call light with a call				
	expect a comprehe completed within a return. The DON v SS-A until 6/25/20, assessment comple baseline after read	The DON stated she would nsive assessment to be week of R201's hospital erified R201 was not seen by nor had a comprehensive eted to determine R201's new nission. The DON stated ager visited with her every day,				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	СОМІ (	E SURVEY PLETED
		00602	D. WING		08/13/202	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
VIEWCR	EST HEALTH CENTE	R	JRCH STREE1 , MN 55811	ſ		
(X4) ID	SI IMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	COMPLET DATE
21810	Continued From pa	ge 27	21810			
	hospital return, alth electronic medical r that. The DON stat verbalized wanting stated R201's medi R201's care plan di and symptoms of d to talk. The DON fu a plan to end her lif to R201's care plan R201's care plan sh April after R201 exp DON stated updatir nursing assistant ca staff knew what was ensure R201's safe care plan was not u attempt, and stated The DON stated up hospital, staff were suicide attempt by r DON stated R201 h health provider sinc mental health unit, a an appointment sch months after R201's stated group and ha canceled, and furth socialization by acti to resident rooms, o and outside visits. T activities included o	1 frequently after R201's ough documentation in R201's record (EMR) did not support ted back in April 2020, R201 to harm herself. The DON cal provider was notified, and rected staff to watch for signs epression, and to allow R201 orther stated R201 did not have e, and no updates were made at that time. The DON stated hould have been updated in pressed suicidal ideation. The ng R201's care plan and are sheets were important so s going on with R201, and to sty. The DON verified R201's updated following her suicide d it should have been updated. on R201's return from the informally educated on R201 memo and meetings. The had not been seen by a mental ce R201 returned from the and further stated R201 had heduled in September (three s suicide attempt). The DON allway activities were er stated resident's received vity staff delivering packages offering snacks, and Zoom The DON stated R201's one-on-one visits, outdoor and nily, and R201 recently Pad The DON verified IDT				

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00602	B. WING		C 08/13	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
		_ 3111 CHU	JRCH STREET	г		
VIEWCR	EST HEALTH CENTE	R DULUTH	, MN 55811			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21810	Continued From pa	ige 28	21810			
	suicide contract on	-line.				
	if a resident verbali	p.m. the administrator stated zed wanting to harm				
	with the resident, a	ould expect the nurse to talk nd find out if the resident had ster further stated an				
	assessment would be completed to determine the		•			
		level of seriousness, safety checks would be initiated, harmful objects would be removed from				
	the room, and the r	nedical provider and family				
		The administrator stated safety emoved after the nurse or SS-A				
		dent to determine if there was				
		or if the resident needed to be	)			
		. The administrator stated properties of a depression				
		ntify if there were other areas				
		01 expressed suicidal				
		inistrator stated she would ensive assessment to be				
		201's return from the hospital				
	right away, within a	day, by SS-A to create a new				
		fy any concerns. The				
		d she expected care plans to y resident changes, and				
		e plan should have been				
	updated after R201	verbalized suicidal thoughts				
		The administrator stated they				
	-	iced a resident attempt to				
		d did not have any formal s to assess a resident's risk				
		d suicidal ideation. The				
		d staff were not formally				
		o do if a resident verbalized				
		he administrator stated staff				
		eporting the smaller things like t's mood closely with				
		s. The administrator stated				
		ered mental health services in				

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00602	B. WING			C 13/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	JRCH STREET , MN 55811	r		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21810	Continued From pa	age 29	21810			
	was unable to provi the facility made ref services for R201. R201 was not recei that time, and had a September. The ac mental health pract visits for another re have requested R2 administrator stated of hiring more staff time for resident ac activities for screen administrator stated resident rooms for activity staff passed books to the reside the focus for the ac on Zoom meetings administrator stated their rooms as long were social distanc stated staff had bee their rooms, and ne The facility provided provided to staff for suicidal ideation: M Administrator dated resident had a me adverse side effects changes in sleep/ea anxiety, mania, par suicidal thoughts/id	declined. The administrator ide documentation to support ferrals for mental health The administrator verified iving mental health services at an appointment scheduled for dministrator stated there was a titioner who made in-house sident, and the facility could 01 to be seen. The d the facility was in the process so the activity staff had more stivities instead of using ning staff and visitors. The d activity staff were allowed in one-on-one activities, and d out mail, art projects, and ents. The administrator stated stivities department had been and outdoor visits. The d residents were allowed out of a sthey wore a mask, and ing. The administrator further en used to keeping residents in eed to be re-educated. d the following on education r residents that expressed lemo From The Desk Of The d 6/22/20, and 6/29/20, r an incident with a resident, uld no longer be stored in the he memo also reminded staff if edication change to watch for s including but not limited to ating habits, depression, nic attacks, restlessness, or leation to notify the nurse.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00602	B. WING		08/13/202	
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	RCH STREET MN 55811	Γ		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLET DATE
21810	Continued From pa	ige 30	21810			
	revised date 4/17, of 1. Residents obser 911 2. Any employee h suicidal talk or beha such to the nurse in 3. Employee to ren- charge nurse asses plan, remove all eq and/cause harm, i.e and begin 15 minut 4. Charge nurse to Administrator, Direc Services, and Clerg 5. Nursing personn suicide threat and t resident's behavior 6. Resident's may there is a potential others. 7. An assessment be made by the interventions that m the recurrence of su plans will be develor interventions. 8. Document all the plan. The facility policy C Process undated, w status is properly as practicable function maintained. The po- Nursing Departme modifying, adding, m	directed: rved attempting suicide call earing or observing any avior of a resident must report in charge immediately. main with the resident until the ss. Determine if resident has a uipment that could be used e. sharps, cords, belts, etc., te visual checks on resident. o contact resident's Physician, ctor of Nursing, Social gy (if appropriate). hel will be informed of the o report changes in the immediately. be temporarily secluded if of danger to him/herself or of the resident's behavior will erdisciplinary care plan team of such incident to determine hay be necessary to prevent uch threats. Revised care				
	Behavior, and Safe	ty.				
	-Activity Departmer	nt in collaboration with Social				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C
		00602	B. WING			13/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	JRCH STREET , MN 55811	r		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21810	Service will be resp updating the followi Psycho-Social/Activ -Nursing, Dietary, S Departments will so link interventions pr resident's functionin needed on the care The Director of Soc undated, indicated standard of the DSS provide individual, f designed to improv reduce the psychos The facility policy of and Activities were the facility. SUGGESTED MET The director of nurs review and/or revise ensure residents re health services. The DON or design appropriate staff on The DON or design system to ensure o	onsible for modifying, ng focus: vities. Social Service, Activity chedule new interventions or reviously scheduled to improve ng or minimize decline as plan. cial Services Job description the responsibilities and S for resident services were to family, and group services e social functioning and social problems of residents. In Behavioral Health Services requested and not provided by THOD FOR CORRECTION: sing (DON) or designee could e policies and procedures to receive adequate behavioral the policies/procedures.	<i>,</i>			