DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 18, 2020

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

RE: CCN: 245414
Cycle Start Date: October 29, 2020

Dear Administrator:

On November 20, 2020, we notified you a remedy was imposed. On December 17, 2020 the Minnesota Department 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 December 10, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 4, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 20, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 4, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 10, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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.

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

Electronically delivered
November 20, 2020

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

RE: CCN: 245414
Cycle Start Date: October 29, 2020

Dear Administrator:

On October 29, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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 January 4, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 4, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 4, 2021.

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 January 4, 2021, 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 January 4, 2021. 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
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

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 April 29, 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 Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	C 10/29/2020

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

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F 000	INITIAL COMMENTS On 10/27/20, through 10/29/20, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5414073C The following complaints were found to be UNSUBSTANTIATED: H5414071C, H5414072C As a result of the investigation other deficiencies were also identified. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to	F 690		12/10/20

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

Electronically Signed | 11/30/2020

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F 690	Continued From page 1 maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure toileting assistance was offered as directed by the care plan for 1 of 3 residents (R5) reviewed for bowel and bladder incontinence. Findings include:	F 690	It is the policy of Viewcrest Health Care Center to ensure that all residents receive the necessary care and services to maintain bowel and bladder continence. The facility policy and procedure on urinary incontinence programs was reviewed and remains appropriate.	

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F 690	Continued From page 2 R5's Face Sheet dated 10/29/20, indicated R5's diagnoses included neurogenic bowel (loss of normal bowel function), neuromuscular dysfunction of the bladder, and intracranial injury (traumatic brain injury). R5's quarterly Minimum Data Set (MDS) dated 9/2/20, identified R5 was cognitively intact. R5's MDS further identified he was frequently incontinent of bowel and bladder. R5's care plan dated 1/6/20, indicated R5 had bowel incontinence related to a traumatic brain injury. The care plan directed staff to toilet R5 every two to three hours, and upon request. R5's Group Sheet (nursing assistant care guide) dated 10/27/20, directed staff to offer R5 toileting "around" 8:00 a.m., every two hours, and per request. On 10/27/20, at 3:16 p.m. R5 was observed seated in a wheelchair near the entry to his room. The right upper thigh of R5's sweatpants appeared damp. At 3:23 p.m. a staff person approached R5 and asked how he was doing. R5 stated, "Horrible." The staff person walked away from R5 and stated, "That's something." At 3:25 p.m. the director of nursing (DON) approached R5 and asked how he was doing. R5 stated his call light was on for "over an hour." R5's call light was noted to be on. At this time, a staff person assisted R5 to his room and closed the door. At 3:42 p.m. R5 was again observed seated in a wheelchair near the entry to his room. R5 was wearing a different pair of pants. On 10/28/20, at 8:51 a.m. R5 was continuously	F 690	Resident R5 was noted to be occasionally incontinent of bladder and would refuse toileting at times. He was able to call for assistance for toileting when needed. The resident's care plan and care card had not been updated to reflect these changes. Resident R5 was discharged from the facility on 11/3/2020. All residents who require assistance with toileting and have bladder incontinence may be affected by this practice. All RN managers were provided with re-education regarding the need to ensure that all bowel and bladder programs are documented correctly in the resident's care plan and care card on 11/30/2020. All residents who require assistance with toileting or have incontinence will have their care plan and care card reviewed to ensure accuracy with current toileting programs. All nursing staff will be re-educated on the need to follow the care card for all toileting programs. The DON or designee will complete toileting audits a minimum of three times per week for four weeks on alternating shifts to ensure compliance. Results of all audits will be reviewed by the facility quality assurance performance improvement program. Corrected by 12/10/2020.	

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F 690	Continued From page 3	F 690		

observed. R5 was observed seated in a wheelchair, and was near a window in his room. At this time, staff approached R5's door and partially closed it. Staff did not enter R5's room. At 8:54 a.m. R5 opened his room door and remained seated in his wheelchair near the entry to his room. At 9:33 a.m. a staff person approached R5 and asked him to put a mask on. R5 took a mask, which was hanging on the left side of his wheelchair, and put it on his face. R5 remained seated in his wheelchair near the entry of his room. At 10:23 a.m. registered nurse (RN)-A approached R5 and spoke to him in the hallway. Toileting was not offered at this time. R5 remained seated in his wheelchair near the entry to his room. At 10:36 a.m. a staff nurse entered R5's room entry and stated she needed to take his blood sugar. R5 wheeled partially into his room, and the staff nurse checked R5's blood sugar. The staff nurse then administered insulin to R5's right arm. The staff nurse exited R5's room, and R5 again wheeled near the entry to his room. An activities aide then approached R5 and told him today's word was "temple." At 11:10 a.m. a staff person approached R5 and asked what type of juice he wanted. R5 responded, "Orange juice." At 11:11 a.m. a staff-person entered R5's room and placed a meal tray on a bedside table. Staff exited the room, and R5 wheeled towards a bedside table, and began eating. At 11:35 a.m. R5 appeared to finish his meal and attempted to pick up a napkin off of the floor. R5 had not been offered toileting in the two hours and forty-five minutes since the continuous observation began.

On 10/28/20, at 11:36 a.m. an interview was conducted with nursing assistant (NA)-A. NA-A stated she last toileted R5 at 7:30 a.m. when she

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F 690	Continued From page 4	F 690		

got him ready for the day. NA-A stated R5 was to be toileted every two hours.

On 10/29/20, at 10:02 a.m. an interview was conducted with licensed practical nurse (LPN)-A. LPN-A stated R5 was occasionally incontinent, and he was to be toileted every two hours.

On 10/29/20, at 10:02 a.m. an interview was conducted with NA-B. NA-B stated R5 was incontinent, but he was getting better at using a urinal. NA-B stated R5 was to be asked if he needed to use the bathroom every two hours. NA-B stated she sometimes needed to tell R5 he needed to be "changed" because he was wet, and refused assistance.

On 10/29/20, at 10:14 a.m. an interview was conducted with NA-C. NA-C stated R5 was incontinent, but had been using a urinal more. NA-C stated R5 was to be toileted every two hours.

On 10/29/20, at 10:25 a.m. an interview was conducted with RN-A. RN-A stated R5 was incontinent, and was to be toileted every two hours. RN-A stated R5 knew when he was incontinent and requested assistance. RN-A stated R5 would refuse toileting if he didn't need it.

On 10/29/20, at 11:06 a.m. an interview was conducted with the DON. The DON stated R5 was incontinent at times, and stated he was to be toileted every two hours. The DON stated R5 would "call" when he needed to go to the bathroom, however, staff needed to check him to make sure he was not incontinent.

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F 690	Continued From page 5 The facility policy St. Francis Health Services of Morris Urinary Incontinence Program reviewed/amended 4/6/15, directed, "Each resident who is incontinent will be identified, assessed, and provided appropriate care and services to achieve or maintain their greatest level of continence. Each resident will receive the appropriate care and services to prevent incontinence related complications to the extent possible."	F 690		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		12/10/20

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F 880	Continued From page 6 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was maintained during personal cares to prevent the potential for cross contamination/infection for 1 of 3 residents (R4) reviewed for activities of daily living (ADLs). Findings include: R4's Face Sheet printed 10/29/20, indicated R4's diagnoses included history of urinary tract infection, and multiple sclerosis (disease where nerve cells in the brain and spinal cord are damaged). R4's quarterly Minimum Data Set (MDS) dated 9/28/20, identified R4 had no cognition impairment. R4's care plan initiated 8/22/18, indicated R4 required extensive assist with toileting and incontinence cares. R4's care plan revised 5/8/19, indicated R4 had history of urinary tract infection, and directed staff to check and change her incontinent brief every 3 hours. . On 10/28/20, at 7:49 a.m. during continuous observation, nursing assistant (NA)-C answered R4's call light. R4 was heard telling NA-C she had a bowel movement (BM) and needed to be cleaned. NA-C used alcohol based hand rub (ABHR) and then proceeded to don a gown and gloves. NA-C entered R4's room and stated she was also going to complete R4's morning cares. While R4 was lying in bed on her back, NA-C gathered a white washcloth, an incontinent brief, and clean clothing. NA-C rolled R4 into her right	F 880	It is the policy of Viewcrest Health Care Center to establish and maintain an infection control program that is designed to help prevent the development and transmission of communicable diseases and infections. Resident R4 remains in the facility and has had no recent infections as a result of the incident. This practice could potentially affect all residents in the nursing facility. The facility policy and procedure on hand hygiene was reviewed by the facility Director of Nursing (DON) and Infection Preventionist and was found to meet CDC guidance. Per the directed plan of correction the facilities Quality Assurance and Performance Improvement Committee will conduct a root cause analysis (RCA) to identify the problem(s) that resulted in the deficiency and develop a corrective action plan to prevent reoccurrence. The facility Administrator will provide training to the Infection Preventionist and the Director of Nursing on 11/30/20. All staff who interact with resident□s will be provided re-education on hand hygiene via; instructional education online as well as verbal and written education. Hand hygiene competencies will be reviewed with all staff a minimum of upon hire and annually. The DON, Infection Preventionist or designee will complete audits of infection control on all shifts every day for one week. This will continue to until 100% compliance is achieved. In addition the facility will continue with	

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	245414	A. BUILDING _____ B. WING _____	C 10/29/2020

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F 880	Continued From page 8 side and begin removing her incontinent brief. R4 had a large bowel movement, and NA-C began cleaning R4's perineal area with the washcloth. R4 started having another bowel movement, and NA-C instructed R4 to roll onto her back to finish. Using her soiled gloves, NA-C adjusted her eye protection. NA-C waited a few minutes, then turned R4 back onto her right side. NA-C walked to the sink wearing her soiled gloves, stated she needed a clean washcloth, and opened cabinet drawers with her soiled gloves. NA-C grabbed a clean washcloth and completed R4's peri care. NA-C disposed of R4's soiled incontinent brief, then adjusted her eye protection. NA-A placed a clean incontinent brief on R4, and dressed her. With the same soiled gloves, NA-C brushed R4's hair. R4 stated to NA-C that she wanted to get up into her wheelchair. NA-C stated she would need to go get another staff to assist with the transfer. NA-C removed her soiled gloves, and without performing hand hygiene, placed them in the waste basket, and tied up the garbage bag. NA-C removed her gown, picked up the garbage bag and exited R4's room. NA-C walked down the hallway to the soiled linen room, placed the garbage bag into a larger garbage can, and exited the soiled linen room. NA-C did not perform hand hygiene. NA-C walked to the stainless steel meal cart, pulled on the handle to open the cart, and then closed the door of the meal cart. On 10/28/20, at 8:12 a.m. NA-C was interviewed, and stated she had not performed hand hygiene or changed gloves during and following incontinence care. NA-C also stated she should not have exited R4's room without performing hand hygiene nor should she have touched the meal cart handle without performing hand	F 880	regularly scheduled infection control audits. The facility Quality Assurance Performance improvement committee will review all elements of the plan of correction to ensure compliance. Corrected by 12/10/202	

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F 880	Continued From page 9	F 880		

hygiene. NA-C stated hand hygiene was important to prevent the spread of infection.

On 10/29/20, at 10:44 a.m. register nurse (RN-B) stated staff were to be changing gloves and performing hand hygiene to prevent spread of infection while performing personal cares. RN-B further stated staff were to remove personal protective equipment (PPE) and perform hand hygiene upon exiting a resident's room to prevent the spread of infection.

On 10/29/20, at 11:14 a.m. the director of nursing (DON) stated hand hygiene needed to be performed between glove changes. The DON stated when providing cares for residents, infection control measures such as glove changes and hand washing were important to prevent the spread of infection. The DON stated cross contamination and spread of infection to other residents could occur if proper hand hygiene was not followed when providing cares.

The facility policy Hand Hygiene revised 5/8/17, directed hand hygiene will be performed by staff routinely to prevent and control the spread of infection. The policy directed staff to perform hand washing before and after direct care as well as after removing gloves and gowns. The policy further directed staff to complete handwashing prior to preparing or handing food and equipment.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 20, 2020

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

Re: State Nursing Home Licensing Orders
Event ID: SYBF11

Dear Administrator:

The above facility was surveyed on October 26, 2020 through October 29, 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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

Teresa Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

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

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/27/20, through 10/29/20, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 910	Continued From page 1	2 910		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure toileting assistance was offered as directed by the care plan for 1 of 3 residents (R5) reviewed for bowel and bladder incontinence. Findings include: R5's Face Sheet dated 10/29/20, indicated R5's diagnoses included neurogenic bowel (loss of normal bowel function), neuromuscular dysfunction of the bladder, and intracranial injury (traumatic brain injury). R5's quarterly Minimum Data Set (MDS) dated 9/2/20, identified R5 was cognitively intact. R5's MDS further identified he was frequently	2 910	See federal POC.	12/10/20

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2 910	Continued From page 2 incontinent of bowel and bladder. R5's care plan dated 1/6/20, indicated R5 had bowel incontinence related to a traumatic brain injury. The care plan directed staff to toilet R5 every two to three hours, and upon request. R5's Group Sheet (nursing assistant care guide) dated 10/27/20, directed staff to offer R5 toileting "around" 8:00 a.m., every two hours, and per request. On 10/27/20, at 3:16 p.m. R5 was observed seated in a wheelchair near the entry to his room. The right upper thigh of R5's sweatpants appeared damp. At 3:23 p.m. a staff person approached R5 and asked how he was doing. R5 stated, "Horrible." The staff person walked away from R5 and stated, "That's something." At 3:25 p.m. the director of nursing (DON) approached R5 and asked how he was doing. R5 stated his call light was on for "over an hour." R5's call light was noted to be on. At this time, a staff person assisted R5 to his room and closed the door. At 3:42 p.m. R5 was again observed seated in a wheelchair near the entry to his room. R5 was wearing a different pair of pants. On 10/28/20, at 8:51 a.m. R5 was continuously observed. R5 was observed seated in a wheelchair, and was near a window in his room. At this time, staff approached R5's door and partially closed it. Staff did not enter R5's room. At 8:54 a.m. R5 opened his room door and remained seated in his wheelchair near the entry to his room. At 9:33 a.m. a staff person approached R5 and asked him to put a mask on. R5 took a mask, which was hanging on the left side of his wheelchair, and put it on his face. R5 remained seated in his wheelchair near the entry	2 910		

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2 910	Continued From page 3	2 910		

of his room. At 10:23 a.m. registered nurse (RN)-A approached R5 and spoke to him in the hallway. Toileting was not offered at this time. R5 remained seated in his wheelchair near the entry to his room. At 10:36 a.m. a staff nurse entered R5's room entry and stated she needed to take his blood sugar. R5 wheeled partially into his room, and the staff nurse checked R5's blood sugar. The staff nurse then administered insulin to R5's right arm. The staff nurse exited R5's room, and R5 again wheeled near the entry to his room. An activities aide then approached R5 and told him today's word was "temple." At 11:10 a.m. a staff person approached R5 and asked what type of juice he wanted. R5 responded, "Orange juice." At 11:11 a.m. a staff-person entered R5's room and placed a meal tray on a bedside table. Staff exited the room, and R5 wheeled towards a bedside table, and began eating. At 11:35 a.m. R5 appeared to finish his meal and attempted to pick up a napkin off of the floor. R5 had not been offered toileting in the two hours and forty-five minutes since the continuous observation began.

On 10/28/20, at 11:36 a.m. an interview was conducted with nursing assistant (NA)-A. NA-A stated she last toileted R5 at 7:30 a.m. when she got him ready for the day. NA-A stated R5 was to be toileted every two hours.

On 10/29/20, at 10:02 a.m. an interview was conducted with licensed practical nurse (LPN)-A. LPN-A stated R5 was occasionally incontinent, and he was to be toileted every two hours.

On 10/29/20, at 10:02 a.m. an interview was conducted with NA-B. NA-B stated R5 was incontinent, but he was getting better at using a urinal. NA-B stated R5 was to be asked if he

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2 910	Continued From page 4	2 910		

needed to use the bathroom every two hours. NA-B stated she sometimes needed to tell R5 he needed to be "changed" because he was wet, and refused assistance.

On 10/29/20, at 10:14 a.m. an interview was conducted with NA-C. NA-C stated R5 was incontinent, but had been using a urinal more. NA-C stated R5 was to be toileted every two hours.

On 10/29/20, at 10:25 a.m. an interview was conducted with RN-A. RN-A stated R5 was incontinent, and was to be toileted every two hours. RN-A stated R5 knew when he was incontinent and requested assistance. RN-A stated R5 would refuse toileting if he didn't need it.

On 10/29/20, at 11:06 a.m. an interview was conducted with the DON. The DON stated R5 was incontinent at times, and stated he was to be toileted every two hours. The DON stated R5 would "call" when he needed to go to the bathroom, however, staff needed to check him to make sure he was not incontinent.

The facility policy St. Francis Health Services of Morris Urinary Incontinence Program reviewed/amended 4/6/15, directed, "Each resident who is incontinent will be identified, assessed, and provided appropriate care and services to achieve or maintain their greatest level of continence. Each resident will receive the appropriate care and services to prevent incontinence related complications to the extent possible."

SUGGESTED METHOD OF CORRECTION: The director or nursing could review/revise bowel

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2 910	Continued From page 5 and bladder assessment policies and procedures, educate staff, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 910		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was maintained during personal cares to prevent the potential for cross contamination/infection for 1 of 3 residents (R4) reviewed for activities of daily living (ADLs). Findings include: R4's Face Sheet printed 10/29/20, indicated R4's diagnoses included history of urinary tract infection, and multiple sclerosis (disease where nerve cells in the brain and spinal cord are damaged). R4's quarterly Minimum Data Set (MDS) dated 9/28/20, identified R4 had no cognition impairment. R4's care plan initiated 8/22/18, indicated R4 required extensive assist with toileting and	21375	See federal POC	12/10/20

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21375	Continued From page 6	21375		

incontinence cares. R4's care plan revised 5/8/19, indicated R4 had history of urinary tract infection, and directed staff to check and change her incontinent brief every 3 hours. .

On 10/28/20, at 7:49 a.m. during continuous observation, nursing assistant (NA)-C answered R4's call light. R4 was heard telling NA-C she had a bowel movement (BM) and needed to be cleaned. NA-C used alcohol based hand rub (ABHR) and then proceeded to don a gown and gloves. NA-C entered R4's room and stated she was also going to complete R4's morning cares. While R4 was lying in bed on her back, NA-C gathered a white washcloth, an incontinent brief, and clean clothing. NA-C rolled R4 into her right side and begin removing her incontinent brief. R4 had a large bowel movement, and NA-C began cleaning R4's perineal area with the washcloth. R4 started having another bowel movement, and NA-C instructed R4 to roll onto her back to finish. Using her soiled gloves, NA-C adjusted her eye protection. NA-C waited a few minutes, then turned R4 back onto her right side. NA-C walked to the sink wearing her soiled gloves, stated she needed a clean washcloth, and opened cabinet drawers with her soiled gloves. NA-C grabbed a clean washcloth and completed R4's peri care. NA-C disposed of R4's soiled incontinent brief, then adjusted her eye protection. NA-A placed a clean incontinent brief on R4, and dressed her. With the same soiled gloves, NA-C brushed R4's hair. R4 stated to NA-C that she wanted to get up into her wheelchair. NA-C stated she would need to go get another staff to assist with the transfer. NA-C removed her soiled gloves, and without performing hand hygiene, placed them in the waste basket, and tied up the garbage bag. NA-C removed her gown, picked up the garbage bag and exited R4's room. NA-C walked down the

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21375	Continued From page 7	21375		

hallway to the soiled linen room, placed the garbage bag into a larger garbage can, and exited the soiled linen room. NA-C did not perform hand hygiene. NA-C walked to the stainless steel meal cart, pulled on the handle to open the cart, and then closed the door of the meal cart.

On 10/28/20, at 8:12 a.m. NA-C was interviewed, and stated she had not performed hand hygiene or changed gloves during and following incontinence care. NA-C also stated she should not have exited R4's room without performing hand hygiene nor should she have touched the meal cart handle without performing hand hygiene. NA-C stated hand hygiene was important to prevent the spread of infection.

On 10/29/20, at 10:44 a.m. register nurse (RN-B) stated staff were to be changing gloves and performing hand hygiene to prevent spread of infection while performing personal cares. RN-B further stated staff were to remove personal protective equipment (PPE) and perform hand hygiene upon exiting a resident's room to prevent the spread of infection.

On 10/29/20, at 11:14 a.m. the director of nursing (DON) stated hand hygiene needed to be performed between glove changes. The DON stated when providing cares for residents, infection control measures such as glove changes and hand washing were important to prevent the spread of infection. The DON stated cross contamination and spread of infection to other residents could occur if proper hand hygiene was not followed when providing cares.

The facility policy Hand Hygiene revised 5/8/17, directed hand hygiene will be performed by staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: _____ B. WING _____	C 10/29/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 8 routinely to prevent and control the spread of infection. The policy directed staff to perform hand washing before and after direct care as well as after removing gloves and gowns. The policy further directed staff to complete handwashing prior to preparing or handing food and equipment. SUGGESTED METHOD OF CORRECTION: The DON or designee could train staff on hand hygeine and glove use as well as perform audits to ensure infection control techniques are being followed. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21375		