

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered February 3, 2021

Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

RE: CCN: 245414 Cycle Start Date: February 6, 2021

Dear Administrator:

On February 2, 2021, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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 January 12, 2021

Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

RE: CCN: 245414 Cycle Start Date: January 6, 2021

Dear Administrator:

On January 6, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

Viewcrest Health Center January 12, 2021 Page 2

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor Duluth 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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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

Viewcrest Health Center January 12, 2021 Page 3

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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 6, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 6, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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

Viewcrest Health Center January 12, 2021 Page 4 specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

6 35

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	IMENT 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:			ISTRUCTION		`́сом	E SURVEY PLETED
		245414	B. WING					C 06/2021
NAME OF F	PROVIDER OR SUPPLIER	I		STREE	TADDRESS, CITY, STATE, ZIF	P CODE	• • • •	
VIEWCR	EST HEALTH CENTE	R			HURCH STREET TH, 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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00				
	was conducted on your facility by the N Health to determine	sed Infection Control survey 12/30/20, through 1/6/21, at Minnesota Department of compliance with Emergency lations §483.73(b)(6). The ompliance						
		nrolled in ePOC, your uired at the bottom of the first 567 form.						
F 000			F 0	00				
	survey and a COVI Control survey was the Minnesota Dep if your facility was in requirements of 42 Requirements for L	igh 1/6/21, an abbreviated D-19 Focused Infection conducted at your facility by artment of Health to determine n compliance with CFR Part 483, Subpart B, and ong Term Care Facilities. The e facility was NOT in						
		plaint was found to be H5414074C, with a t F677 and F684.						
		f correction (POC) will serve of compliance upon the ptance.						
	signature is not req page of the CMS-2	nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic						
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE			(X6) DATE
	ically Signed							01/20/2021

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: 01/21/2021

		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		E SURVEY PLETED
		245414	B. WING			C
	PROVIDER OR SUPPLIER	245414	D. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	01/	06/2021
	ROVIDER OR SUFFLIER			3111 CHURCH STREET		
VIEWCR	EST HEALTH CENTE	R		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) COMPLETIO DATE
F 000	Continued From pa	ae 1	F 00	0		
1 000	submission of the F	-	F 00			
	verification of comp					
		acceptable electronic POC, an				
		ur facility may be conducted to				
		ntial compliance with the en attained in accordance with				
	your verification.					
F 677		for Dependent Residents	F 67	7		1/27/21
	CFR(s): 483.24(a)(
	out activities of dail services to maintain personal and oral h					
		NT is not met as evidenced				
	by: Based on observat	tion, interview, and document		It is the policy of Viewcrest Health	Care	
		ailed to ensure nail care		Center to ensure residents who are		
	assistance was pro	vided for 1 of 3 residents (R2),		unable to carry out activities of dail	y living	
		t upon staff for assistance, es of daily living (ADLs).		receive the necessary services to maintain good grooming personal of and oral hygiene. The facility polic		
	Findings include:			Nail Care was reviewed by the Dire Nursing and remains current. Res	ector of	
	R2's Face Sheet da	ated 1/6/21, indicated R2's		R2's nails were inspected on 1/6/2	021	
	diagnoses included chronic kidney dise	macular degeneration and ase.		and noted to be short with a small of old nail polish noted on her nail	oeds,	
	R2's annual Minimu	ım Data Set (MDS) dated		activity staff was noted to remove t polish and paint her nails per her re		
		R2 had moderately impaired		All residents who require assistance		
	cognition. The MDS	6 further indicated R2 had		grooming including nail care have t	the	
		not refuse care, and required		potential to be affected by this prac		
	extensive assistance	e with personal hygiene.		Nursing staff will be re-educated by 1/27/20 on the need to ensure that		
	R2's group sheet (r	nursing assistant cares sheet)		care is completed weekly during th		
	printed 12/31/20, in	dicated R2 needed assistance		resident's bath per facility policy by	the	
	of two staff with dre	ssing and grooming. The		Director of Nursing or designee. N	urse	

Facility ID: 00602

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TATEMENT OF DEFICIEN	CIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245414	B. WING	G		C
NAME OF PROVIDER OR	SUPPI IFR	240414		STREET ADDRESS, CITY, STATE, ZIP		06/2021
		R		3111 CHURCH STREET DULUTH, MN 55811		
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
fingernails On 1/5/20 in bed. R2 and had b not intervi On 1/5/20 conducted they prefe did not ge On 1/5/20 conducted her fingern "bugged" On 1/6/20 observed underneal was condu NA-A state bath days and did no confirmed was unde would hell agreed. On 1/6/20 ocnducted nursing (I were expe administra scheduled residents	et directe after me , at 10:00 's fingerr rown deb ewable. , at 10:56 l with fan rred R2's t dirty. , at 1:13 l with F-E nails to b ner. , at 9:45 and rema h the nail ucted with ed nail ca NA-A st to normal R2's nai the nails b with hel o with hel o with the con). The coted to d with their	a staff to clean under R2's eals. a.m. R2 was observed laying nails were noted to be long, oris underneath them. R2 was a.m. an interview was nily member (F)-A. F-A stated fingernails to be short so they p.m. an interview was F-B stated R2 preferred for e short, and longer fingernails a.m. R2's fingernails were ained long, with brown debris I. At this time, an interview n nursing assistant (NA)-A. are was completed on resident ated she was floated to the unit ly work with R2. NA-A ls were long, and brown debris s. NA-A informed R2 staff r nails in a little while, and R2 a.m. an interview was administrator and director of e administrator stated staff lo nail care on bath days. The stated if an extra nurse was build go around and help	F 67	7 Managers will audit all resid who are dependent on staf on their units to ensure tha been performed and that n length in which the residen resident refusals to perform be documented in the resid record. Facility activity stat to assist with nails during th scheduled nail time. The D Nursing (DON) or designed random audits of nail care three times per week for fo four times per month x 3 m beginning 1/20/21 until con achieved. Results of all au reviewed by the facility Qua Performance Improvement	f for nail care, t nail care has ails are the t prefers. All n nail care will dent's medical f will continue heir weekly Director of e will complete a minimum of ur weeks, then onths, npliance is dits will be ality Assurance	

If continuation sheet Page 3 of 8

		AND HUMAN SERVICES			FO	RM AI)1/21/2021 PPROVED 938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			COMPL	SURVEY ETED
		245414	B. WING	;		C 01/06	6/2021
NAME OF F	PROVIDER OR SUPPLIER				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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	((X5) COMPLETION DATE
F 677		-	F	677			
	but not provided by Quality of Care CFR(s): 483.25	the facility.	F	684		1	/27/21
	applies to all treatm facility residents. Ba assessment of a re- that residents recei- accordance with pri- practice, the compri- care plan, and their This REQUIREMEN by: Based on interview facility failed to pern to provide care for a R5, R6, R7, R8, an Findings include: Centers for Medica (CMS) QSO-20-39- indicated, "Health of employees of the fa- the facility's resider Emergency Medica dialysis technicians radiology technicians radiology technicians radiology technicians must be permitted to as they are not sub an exposure to CO symptoms of COVI R1's Face Sheet da	fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered residents' choices. NT is not met as evidenced v and document review, the mit hospice staff into the facility 8 of 8 residents (R1, R2, R3, d R9) reviewed for hospice. re and Medicaid Services -NH memo dated 9/17/20, care workers who are not acility but provide direct care to nts, such as hospice workers, al Services (EMS) personnel, back, a workers, clergy etc., to come into the facility as long ject to a work exclusion due to VID-19 or show signs or D-19 after being screened."			It is the policy of Viewcrest Health Care Center to ensure all residents receive treatment and care in accordance with professional standards of practice base on the comprehensive person centered care plan and the resident's choices. T facility policy on Coronavirus Preventior screening, and identification was review and remains current. Resident R1 was discharged from the facility on 12/23/2020, resident R1 didn't receive hospice services. R8 expired on 1/7/2021. All residents who receive hospice services have potential to be impacted by this deficient practice. Soc services will contact all hospice companies that provide services at VH0 to inform their main representative of V care center policy for in-person hospice services. Social services will inquire wit the hospice companies' main representative on their company policy in-person services. Social services will	d he i, ved al C HC	

Facility ID: 00602

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/21/2021 APPROVED 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245414	B. WING				C 06/2021
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
VIEWCRE	ST HEALTH CENTER	R			111 CHURCH STREET ULUTH, MN 55811		
						.1	
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684 (Continued From pa	ge 4	Fe	684			
	R1's progress notes indicated a hospice severe recent declin disease. R1's progress notes p.m. indicated R1 w to a hospice house. R2's annual Minimu 11/30/20, indicated R2's care plan date received hospice ca indicated hospice w each visit, and mon control regimen. R3's significant cha indicated R3 receive R5's significant cha indicated R5 receive R6's quarterly MDS received hospice ca R8's quarterly MDS received hospice ca R8's quarterly MDS received hospice ca R8's quarterly MDS received hospice ca R9's quarterly MDS received hospice ca R9's quarterly MDS received hospice ca R9's quarterly MDS	s dated 12/21/20, at 3:35 p.m. referral was ordered due to a he related to late Alzheimer's s dated 12/23/20, at 12:08 vas transferred from the facility im Data Set (MDS) dated R2 received hospice care. d 3/31/20, indicated R2 are. The care plan further vould assess R2's pain, during itor effectiveness of R2's pain nge MDS dated 12/9/20, ed hospice care. nge MDS dated 10/26/20, ed hospice care. dated 12/7/20, indicated R6 are. S dated 12/8/20, indicated R7 are. dated 11/2/20, indicated R8 are.			request that the hospice representa contact the care center social servi administrator or director of nursing any changes to their policies related in-person services. VHC will contine follow CDC, CMS and MDH guideli healthcare workers in relation to ho services. DON and/or designee will perform random audits, interviewing residents/resident representative w on hospice, to inquire if services are provided in-person by hospice and have any concerns related to hospic care, 3x/week x 4 weeks and 1x/we thereafter beginning 1/20/21, until compliance is achieved. Results of audits will be reviewed by the facilit Quality Assurance Performance Improvement committee.	ces, with d to ue to nes for ospice g ho is e being if they ce eek all	

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		AND HUMAN SERVICES				FORM	01/21/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE COM	E SURVEY IPLETED
		245414	B. WING	i			C 06/2021
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
VIEWCR	EST HEALTH CENTE	R		-	111 CHURCH STREET DULUTH, MN 55811		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION DATE
F 684	Continued From pa	ace 5	Ff	584			
	FM-C stated R1 res	sided at the facility, and					
		me less interactive and					
		stated on 12/18/20, she had a . FM-C stated it appeared like					
	R1 was dying. FM-0	C stated she notified					
		RN)-A, and was informed the					
		stering intravenous fluids to R1. ad an in-person visit with R1					
	on 12/19/20, and R	1 was not responsive. FM-C					
		ere going in the wrong					
	direction, and the m	pice care. FM-C stated the					
		r informed her the facility did					
		hospice visits, and hospice					
		ided virtually. FM-C stated not a Zoom (virtual meeting)					
		ospice the facility's specialty.					
	FM-C stated facility	administration was arbitrarily					
		and lacked compassion and ndividuals who needed					
		life care. FM-C stated it was a					
	violation of resident	t rights by not allowing					
		services, and hospice care					
		nied to a human being. FM-C to have R1 transferred to a					
	hospice house, as I	R1's end-of-life needs would					
	not be met by the fa	acility.					
	On 1/5/21, at 10:56	a.m., an interview was					
	conducted with FM-	-A. FM-A stated R2 received					
		the facility. FM-A stated she					
		om hospice regularly, ink the facility allowed					
	in-person hospice v						
		′ p.m. an interview was					
		ospice RN, RN-F. RN-F					
		hospice care for R2. RN-F kers were not allowed to enter					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/21/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245414	B. WING	i			C 06/2021
NAME OF F	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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	believed hospice vis last April. RN-F stat with the facility's nu services. On 1/5/21, at 1:13 p conducted with FM- hospice care at the not know if hospice facility. On 1/5/21, at 1:37 p conducted with RN- and workers were r since April or May. I week, hospice aide the facility. RN-A stat corporate policy wh from entering the fa decline in condition updated the nurse p RN-A stated labs ar ordered, however, F treatment, and the r recommended hosp informed FM-C that restricted from the f wanted hospice car staff were not allow elected to have R1 house. On 1/6/21, at appro interview was condu- (SW)-A. SW-A conf- only allowed to enter admission assessm	 this week. RN-F stated he sits were restricted sometime red he conducted Zoom visits rse managers to provide o.m. an interview was B. FM-B stated R2 received facility. FM-B stated she did staff was allowed to enter the o.m. an interview was A. RN-A stated hospice aides not allowed into the facility RN-A stated beginning this s were again allowed to enter ated he believed it was a ich restricted hospice workers acility. RN-A stated R1 had a on 12/14/20. RN-A stated he practitioner and R1's family. Ind intravenous fluids were R1 did not respond to 	F	584			

Facility ID: 00602

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		AND HUMAN SERVICES				FORM	01/21/2021 APPROVED 0938-0391
STATEMEN	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED C
		245414	B. WING				_ 06/2021
NAME OF	PROVIDER OR SUPPLIER				TREET 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 (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 684	virtually via Zoom c in-person hospice v now. SW-A stated s requested R1 to be house, and had arr stated some other r discharged to the h On 1/6/30, at 9:54 a conducted with the nursing (DON). The were previously allo when a resident wa services. The DON visits were conduct within the past coup again allowing hosp facility. The adminis also previously allo had a significant ch The facility policy C Screening, and Ide 12/3/20, directed, "I health care workers EMS personnel, or provide care to resi come into the facility	alls. SW-A stated she believed visits were allowed more often she was informed FM-C transferred to a hospice anged for transportation. W-A residents were also	F	\$84			

Facility ID: 00602

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 12, 2021

Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

Re: State Nursing Home Licensing Orders Event ID: 22VK11

Dear Administrator:

The above facility was surveyed on December 30, 2020 through January 6, 2021 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 <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. 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.

Viewcrest Health Center January 12, 2021 Page 2

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

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00602	B. WING		01/0	; 6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	RCH STREE MN 55811	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON 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 result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	survey was conduct with State Licensurvey NOT in compliance Please indicate in y correction that you and identify the date	TS: gh 1/6/21, an abbreviated ted to determine compliance e. Your facility was found to be with the MN State Licensure. our electronic plan of have reviewed these orders, e when they will be completed.				
	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED
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2 000	Continued From pa	age 1	2 000			
	The following com	plaint was found to be : H5414074C.				
		led in ePOC and therefore a quired at the bottom of the first				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			1/27/21
	receive nursing can custodial care, and individual needs ar the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from	a general. A resident must re and treatment, personal and I supervision based on ad preferences as identified in e resident assessment and scribed in parts 4658.0400 and sing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.				
	by: Based on interview facility failed to per to provide care for	ent is not met as evidenced and document review, the mit hospice staff into the facility 8 of 8 residents (R1, R2, R3, ad R9) reviewed for hospice.	/	See federal plan of correction		
	Findings include: Centers for Medica	are and Medicaid Services				
	(CMS) QSO-20-39 indicated, "Health of	-NH memo dated 9/17/20, care workers who are not acility but provide direct care to				

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	Сом	E SURVEY PLETED C
		00602	B. WING	· · · · · · · · · · · · · · · · · · ·		06/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
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2 830	Emergency Medica dialysis technicians radiology technicians radiology technicians must be permitted t as they are not sub an exposure to CO' symptoms of COVII R1's Face Sheet da diagnoses included chronic kidney dise R1's progress notes indicated a hospice severe recent declin disease. R1's progress notes p.m. indicated R1 w to a hospice house. R2's annual Minimu 11/30/20, indicated R2's care plan date received hospice ca indicated hospice w each visit, and mon control regimen. R3's significant cha indicated R3 receiv	tts, such as hospice workers, I Services (EMS) personnel, , laboratory technicians, ns, social workers, clergy etc., to come into the facility as long ject to a work exclusion due to VID-19 or show signs or D-19 after being screened." ated 1/6/21, indicated R1's Alzheimer's disease, and ase. s dated 12/21/20, at 3:35 p.m. referral was ordered due to a ne related to late Alzheimer's s dated 12/23/20, at 12:08 vas transferred from the facility um Data Set (MDS) dated R2 received hospice care. d 3/31/20, indicated R2 are. The care plan further <i>v</i> ould assess R2's pain, during itor effectiveness of R2's pain unge MDS dated 12/9/20, ed hospice care.				
	R6's quarterly MDS received hospice ca	dated 12/7/20, indicated R6 are.				

VIEWCREST (X4) ID PREFIX TAG 2 830 Col R7' rec R8' rec R9' rec On cor FM	(EACH DEFICIENCY REGULATORY OR L ontinued From pa ''s admission MD ceived hospice ca S's quarterly MDS ceived hospice ca	R 3111 CHU DULUTH, TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 3 S dated 12/8/20, indicated R7 are. dated 11/2/20, indicated R8 are.	B. WING DRESS, CITY, ST RCH STREET MN 55811 PREFIX TAG 2 830		ION JLD BE	(X5) COMPLETE DATE
VIEWCREST (X4) ID PREFIX TAG 2 830 Col R7' rec R8' rec R9' rec On cor FM	THEALTH CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ontinued From pa 7's admission MD ceived hospice ca 8's quarterly MDS ceived hospice ca	R 3111 CHU DULUTH, TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 3 S dated 12/8/20, indicated R7 are. dated 11/2/20, indicated R8 are.	RCH STREET MN 55811 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO	JLD BE	COMPLET
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PRÉFIX TAG 2 830 Col R7' rec R8' rec R9' rec On cor FM	(EACH DEFICIENCY REGULATORY OR L ontinued From pa "s admission MD ceived hospice ca 3's quarterly MDS ceived hospice ca	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) uge 3 VS dated 12/8/20, indicated R7 are. 6 dated 11/2/20, indicated R8 are.	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	COMPLET
R7 rec R8 rec R9 rec On cor FM	"s admission MD ceived hospice ca 3's quarterly MDS ceived hospice ca 9's quarterly MDS	PS dated 12/8/20, indicated R7 are. 6 dated 11/2/20, indicated R8 are.	2 830			
rec R8 rec R9 rec On cor FM	ceived hospice ca 3's quarterly MDS ceived hospice ca 9's quarterly MDS	are. 6 dated 11/2/20, indicated R8 are.				
rec R9 rec On cor FM	ceived hospice ca o's quarterly MDS	are.				
rec On cor FM						
cor FM	•	dated 11/16/20, indicated R9 are				
virt R1 reg fac FM on sta dire rec me not car hos ser FM enf und spe viol in-p sho sta	nducted with R1 ¹ A-C stated R1 responsively becau n-verbal. FM-C s tual visit with R1. was dying. FM-C gistered nurse (R cility was adminis A-C stated she ha 12/19/20, and R ated R1's labs we rection, and the m commended hos edical practitioner t allow in-person re would be prov spice care was n rvice, nor was ho A-C stated facility forcing policies, a derstanding for in ecialized end-of-lo plation of resident person hospice s ould never be de ated she elected facility	b.m. an interview was s family member (FM)-C. sided at the facility, and me less interactive and tated on 12/18/20, she had a FM-C stated it appeared like C stated she notified N)-A, and was informed the tering intravenous fluids to R1. ad an in-person visit with R1 1 was not responsive. FM-C ere going in the wrong nedical practitioner pice care. FM-C stated the r informed her the facility did hospice visits, and hospice ided virtually. FM-C stated tot a Zoom (virtual meeting) espice the facility's specialty. administration was arbitrarily and lacked compassion and ndividuals who needed life care. FM-C stated it was a t rights by not allowing services, and hospice care nied to a human being. FM-C to have R1 transferred to a R1's end-of-life needs would acility.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
		00602	B. WING		01/	06/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
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2 830	Continued From pa	ge 4	2 830			
	conducted with FM-A. FM-A stated R2 received hospice services at the facility. FM-A stated she received updates from hospice regularly, however, did not think the facility allowed in-person hospice visits.					
	On 1/5/21, at 12:07 p.m. an interview was conducted with a hospice RN, RN-F. RN-F stated he provided hospice care for R2. RN-F stated hospice workers were not allowed to enter the facility, until just this week. RN-F stated he believed hospice visits were restricted sometime last April. RN-F stated he conducted Zoom visits with the facility's nurse managers to provide services.					
	conducted with FM hospice care at the	o.m. an interview was -B. FM-B stated R2 received facility. FM-B stated she did staff was allowed to enter the				
	conducted with RNA and workers were r since April or May. week, hospice aide the facility. RN-A st corporate policy wh from entering the fa decline in condition updated the nurse r RN-A stated labs an ordered, however, I treatment, and the recommended hos informed FM-C that restricted from the	b.m. an interview was A. RN-A stated hospice aides not allowed into the facility RN-A stated beginning this s were again allowed to enter ated he believed it was a nich restricted hospice workers acility. RN-A stated R1 had a on 12/14/20. RN-A stated he practitioner and R1's family. nd intravenous fluids were R1 did not respond to nurse practitioner pice care. RN-A stated he t hospice workers were facility. RN-A confirmed FM-C re for R1, and since hospice				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00602				Сом	E SURVEY PLETED C 06/2021	
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2 830	Continued From pa	ge 5	2 830			
	elected to have R1 transferred to a hospice house.					
	interview was conducted with social worker (SW)-A. SW-A confirmed hospice providers were only allowed to enter the facility to complete an admission assessment. SW-A stated after admission, hospice services were facilitated virtually via Zoom calls. SW-A stated she believed in-person hospice visits were allowed more often now. SW-A stated she was informed FM-C requested R1 to be transferred to a hospice house, and had arranged for transportation. W-A stated some other residents were also discharged to the hospice house. On 1/6/30, at 9:54 a.m. an interview was		1			
	conducted with the nursing (DON). The were previously allow when a resident was services. The DON visits were conduct within the past coup again allowing hosp facility. The administ also previously allow	administrator and director of e DON stated hospice workers by be do enter the facility only is admitted to hospice stated subsequent hospice ed virtually. The DON stated ble of weeks, the facility was bice staff to come into the strator stated hospice staff was wed to enter when a resident ange in condition, or had died.	5			
	Screening, and Ide 12/3/20, directed, "I health care workers EMS personnel, or provide care to resi come into the facilit	Foronavirus Prevention, ntification reviewed/revised Health care workers: Other s, such as hospice workers, dialysis technicians that dents will be permitted to ty as long as they meet the health care workers."				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			3) DATE SURVEY COMPLETED	
			A. DOILDING.			С	
		00602	B. WING			06/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	RECTION SHOULD BE APPROPRIATE		
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(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	, MN 55811	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
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2 830	Continued From pa	ge 6	2 830				
	and/or revise policient non-employed heal DON or designee of staff on the policiest designee could deve ensure ongoing cor	or designee, could review es and procedures related to thcare workers visitation. The ould educate the appropriate /procedures. The DON or relop a monitoring system to mpliance. R CORRECTION: Twenty-one					
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			1/27/21	
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,					
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nail care assistance was provided for 1 of 3 residents (R2), who was dependent upon staff for assistance, reviewed for activities of daily living (ADLs).		,	See federal plan of correction	on		
	Findings include:						
		ated 1/6/21, indicated R2's macular degeneration and ase.					
	11/30/20, indicated	um Data Set (MDS) dated R2 had moderately impaired S further indicated R2 had					

Minnesc	ta Department of He	alth				APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
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	EST HEALIN CENTER	DULUTH,	MN 55811			
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2 920	Continued From pa	ge 7	2 920			
	impaired vision, did not refuse care, and required extensive assistance with personal hygiene.					
	R2's group sheet (nursing assistant cares sheet) printed 12/31/20, indicated R2 needed assistance of two staff with dressing and grooming. The group sheet directed staff to clean under R2's fingernails after meals.					
	On 1/5/20, at 10:00 a.m. R2 was observed laying in bed. R2's fingernails were noted to be long, and had brown debris underneath them. R2 was not interviewable.					
	conducted with fam	a.m. an interview was ily member (F)-A. F-A stated fingernails to be short so they				
	conducted with F-B	o.m. an interview was . F-B stated R2 preferred for e short, and longer fingernails				
	observed and rema underneath the nail was conducted with NA-A stated nail ca bath days. NA-A sta and did not normall confirmed R2's nail was under the nails	a.m. R2's fingernails were ined long, with brown debris . At this time, an interview nursing assistant (NA)-A. re was completed on resident ated she was floated to the unit y work with R2. NA-A s were long, and brown debris . NA-A informed R2 staff nails in a little while, and R2				
nnosota D	conducted with the nursing (DON). The	a.m. an interview was administrator and director of administrator stated staff o nail care on bath days. The				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
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2 920	Continued From page 8		2 920			
	administrator also stated if an extra nurse was scheduled, they would go around and help residents with their nails.					
	A facility policy regarding nail care was requested, but not provided by the facility.		,			
	The director of nurs review and/or revis personal hygiene p ensure nail care an maintained. The D the appropriate sta The DON or design	THOD OF CORRECTION: sing (DON), or designee, could e the current grooming and olicies and procedures to id hygiene is completed and ON or designee could educate ff on the policies/procedures. nee could develop a monitoring ngoing compliance.	,			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				