DEPARTMENT OF HEALTH

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

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.

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

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: 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 01/06/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 12/30/20, through 1/6/21, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 12/30/20, through 1/6/21, an abbreviated survey and a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The survey identified the facility was NOT in compliance. The following complaint was found to be SUBSTANTIATED: H5414074C, with a deficiencies cited at F677 and F684. 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	F 000		

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

Electronically 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.

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F 000	Continued From page 1 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 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to 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). Findings include: R2's Face Sheet dated 1/6/21, indicated R2's diagnoses included macular degeneration and chronic kidney disease. R2's annual Minimum Data Set (MDS) dated 11/30/20, indicated R2 had moderately impaired cognition. The MDS further indicated R2 had 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	F 677	It is the policy of Viewcrest Health Care Center to ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain good grooming personal care and oral hygiene. The facility policy titled Nail Care was reviewed by the Director of Nursing and remains current. Resident R2's nails were inspected on 1/6/2021 and noted to be short with a small amount of old nail polish noted on her nail beds, activity staff was noted to remove the old polish and paint her nails per her request. All residents who require assistance with grooming including nail care have the potential to be affected by this practice. Nursing staff will be re-educated by 1/27/20 on the need to ensure that nail care is completed weekly during the resident's bath per facility policy by the Director of Nursing or designee. Nurse	1/27/21

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F 677	Continued From page 2 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. On 1/5/20, at 10:56 a.m. an interview was conducted with family member (F)-A. F-A stated they preferred R2's fingernails to be short so they did not get dirty. On 1/5/20, at 1:13 p.m. an interview was conducted with F-B. F-B stated R2 preferred for her fingernails to be short, and longer fingernails "bugged" her. On 1/6/20, at 9:45 a.m. R2's fingernails were observed and remained long, with brown debris underneath the nail. At this time, an interview was conducted with nursing assistant (NA)-A. NA-A stated nail care was completed on resident bath days. NA-A stated she was floated to the unit and did not normally work with R2. NA-A confirmed R2's nails were long, and brown debris was under the nails. NA-A informed R2 staff would help with her nails in a little while, and R2 agreed. On 1/6/20, at 9:54 a.m. an interview was conducted with the administrator and director of nursing (DON). The administrator stated staff were expected to do nail care on bath days. The 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,	F 677	Managers will audit all resident's nails, who are dependent on staff for nail care, on their units to ensure that nail care has been performed and that nails are the length in which the resident prefers. All resident refusals to perform nail care will be documented in the resident's medical record. Facility activity staff will continue to assist with nails during their weekly scheduled nail time. The Director of Nursing (DON) or designee will complete random audits of nail care a minimum of three times per week for four weeks, then four times per month x 3 months, beginning 1/20/21 until compliance is achieved. Results of all audits will be reviewed by the facility Quality Assurance Performance Improvement committee.	

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F 677	Continued From page 3 but not provided by the facility.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to permit hospice staff into the facility to provide care for 8 of 8 residents (R1, R2, R3, R5, R6, R7, R8, and R9) reviewed for hospice. Findings include: Centers for Medicare and Medicaid Services (CMS) QSO-20-39-NH memo dated 9/17/20, indicated, "Health care workers who are not employees of the facility but provide direct care to the facility's residents, such as hospice workers, Emergency Medical Services (EMS) personnel, dialysis technicians, laboratory technicians, radiology technicians, social workers, clergy etc., must be permitted to come into the facility as long as they are not subject to a work exclusion due to an exposure to COVID-19 or show signs or symptoms of COVID-19 after being screened." R1's Face Sheet dated 1/6/21, indicated R1's diagnoses included Alzheimer's disease, and chronic kidney disease.	F 684	It is the policy of Viewcrest Health Care Center to ensure all residents receive treatment and care in accordance with professional standards of practice based on the comprehensive person centered care plan and the resident's choices. The facility policy on Coronavirus Prevention, screening, and identification was reviewed 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. Social services will contact all hospice companies that provide services at VHC to inform their main representative of VHC care center policy for in-person hospice services. Social services will inquire with the hospice companies' main representative on their company policy for in-person services. Social services will	1/27/21

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F 684	Continued From page 4 R1's progress notes dated 12/21/20, at 3:35 p.m. indicated a hospice referral was ordered due to a severe recent decline related to late Alzheimer's disease. R1's progress notes dated 12/23/20, at 12:08 p.m. indicated R1 was transferred from the facility to a hospice house. R2's annual Minimum Data Set (MDS) dated 11/30/20, indicated R2 received hospice care. R2's care plan dated 3/31/20, indicated R2 received hospice care. The care plan further indicated hospice would assess R2's pain, during each visit, and monitor effectiveness of R2's pain control regimen. R3's significant change MDS dated 12/9/20, indicated R3 received hospice care. R5's significant change MDS dated 10/26/20, indicated R5 received hospice care. R6's quarterly MDS dated 12/7/20, indicated R6 received hospice care. R7's admission MDS dated 12/8/20, indicated R7 received hospice care. R8's quarterly MDS dated 11/2/20, indicated R8 received hospice care. R9's quarterly MDS dated 11/16/20, indicated R9 received hospice care On 1/4/21, at 2:29 p.m. an interview was conducted with R1's family member (FM)-C.	F 684	request that the hospice representative contact the care center social services, administrator or director of nursing with any changes to their policies related to in-person services. VHC will continue to follow CDC, CMS and MDH guidelines for healthcare workers in relation to hospice services. DON and/or designee will perform random audits, interviewing residents/resident representative who is on hospice, to inquire if services are being provided in-person by hospice and if they have any concerns related to hospice care, 3x/week x 4 weeks and 1x/week thereafter beginning 1/20/21, until compliance is achieved. Results of all audits will be reviewed by the facility Quality Assurance Performance Improvement committee.	

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F 684	Continued From page 5	F 684		

FM-C stated R1 resided at the facility, and progressively became less interactive and non-verbal. FM-C stated on 12/18/20, she had a virtual visit with R1. FM-C stated it appeared like R1 was dying. FM-C stated she notified registered nurse (RN)-A, and was informed the facility was administering intravenous fluids to R1. FM-C stated she had an in-person visit with R1 on 12/19/20, and R1 was not responsive. FM-C stated R1's labs were going in the wrong direction, and the medical practitioner recommended hospice care. FM-C stated the medical practitioner informed her the facility did not allow in-person hospice visits, and hospice care would be provided virtually. FM-C stated hospice care was not a Zoom (virtual meeting) service, nor was hospice the facility's specialty. FM-C stated facility administration was arbitrarily enforcing policies, and lacked compassion and understanding for individuals who needed specialized end-of-life care. FM-C stated it was a violation of resident rights by not allowing in-person hospice services, and hospice care should never be denied to a human being. FM-C stated she elected to have R1 transferred to a hospice house, as R1's end-of-life needs would not be met by the facility.

On 1/5/21, at 10:56 a.m., an interview was 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

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F 684	Continued From page 6	F 684		

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.

On 1/5/21, at 1:13 p.m. an interview was conducted with FM-B. FM-B stated R2 received hospice care at the facility. FM-B stated she did not know if hospice staff was allowed to enter the facility.

On 1/5/21, at 1:37 p.m. an interview was conducted with RN-A. RN-A stated hospice aides and workers were not allowed into the facility since April or May. RN-A stated beginning this week, hospice aides were again allowed to enter the facility. RN-A stated he believed it was a corporate policy which restricted hospice workers from entering the facility. RN-A stated R1 had a decline in condition on 12/14/20. RN-A stated he updated the nurse practitioner and R1's family. RN-A stated labs and intravenous fluids were ordered, however, R1 did not respond to treatment, and the nurse practitioner recommended hospice care. RN-A stated he informed FM-C that hospice workers were restricted from the facility. RN-A confirmed FM-C wanted hospice care for R1, and since hospice staff were not allowed into the facility, FM-C elected to have R1 transferred to a hospice house.

On 1/6/21, at approximately 8:45 a.m. an 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

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F 684	Continued From page 7	F 684		

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 conducted with the administrator and director of nursing (DON). The DON stated hospice workers were previously allowed to enter the facility only when a resident was admitted to hospice services. The DON stated subsequent hospice visits were conducted virtually. The DON stated within the past couple of weeks, the facility was again allowing hospice staff to come into the facility. The administrator stated hospice staff was also previously allowed to enter when a resident had a significant change in condition, or had died.

The facility policy Coronavirus Prevention, Screening, and Identification reviewed/revised 12/3/20, directed, "Health care workers: Other health care workers, such as hospice workers, EMS personnel, or dialysis technicians that provide care to residents will be permitted to come into the facility as long as they meet the CDC guidelines for health care workers."

DEPARTMENT OF HEALTH

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 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
	00602	A. BUILDING: _____ B. WING _____	C 01/06/2021

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

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2 000	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 12/30/20, through 1/6/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. 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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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5414074C. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to permit hospice staff into the facility to provide care for 8 of 8 residents (R1, R2, R3, R5, R6, R7, R8, and R9) reviewed for hospice. Findings include: Centers for Medicare and Medicaid Services (CMS) QSO-20-39-NH memo dated 9/17/20, indicated, "Health care workers who are not employees of the facility but provide direct care to	2 830	See federal plan of correction	1/27/21

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2 830	Continued From page 2	2 830		

the facility's residents, such as hospice workers, Emergency Medical Services (EMS) personnel, dialysis technicians, laboratory technicians, radiology technicians, social workers, clergy etc., must be permitted to come into the facility as long as they are not subject to a work exclusion due to an exposure to COVID-19 or show signs or symptoms of COVID-19 after being screened."

R1's Face Sheet dated 1/6/21, indicated R1's diagnoses included Alzheimer's disease, and chronic kidney disease.

R1's progress notes dated 12/21/20, at 3:35 p.m. indicated a hospice referral was ordered due to a severe recent decline related to late Alzheimer's disease.

R1's progress notes dated 12/23/20, at 12:08 p.m. indicated R1 was transferred from the facility to a hospice house.

R2's annual Minimum Data Set (MDS) dated 11/30/20, indicated R2 received hospice care.

R2's care plan dated 3/31/20, indicated R2 received hospice care. The care plan further indicated hospice would assess R2's pain, during each visit, and monitor effectiveness of R2's pain control regimen.

R3's significant change MDS dated 12/9/20, indicated R3 received hospice care.

R5's significant change MDS dated 10/26/20, indicated R5 received hospice care.

R6's quarterly MDS dated 12/7/20, indicated R6 received hospice care.

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2 830	Continued From page 3 R7's admission MDS dated 12/8/20, indicated R7 received hospice care. R8's quarterly MDS dated 11/2/20, indicated R8 received hospice care. R9's quarterly MDS dated 11/16/20, indicated R9 received hospice care On 1/4/21, at 2:29 p.m. an interview was conducted with R1's family member (FM)-C. FM-C stated R1 resided at the facility, and progressively became less interactive and non-verbal. FM-C stated on 12/18/20, she had a virtual visit with R1. FM-C stated it appeared like R1 was dying. FM-C stated she notified registered nurse (RN)-A, and was informed the facility was administering intravenous fluids to R1. FM-C stated she had an in-person visit with R1 on 12/19/20, and R1 was not responsive. FM-C stated R1's labs were going in the wrong direction, and the medical practitioner recommended hospice care. FM-C stated the medical practitioner informed her the facility did not allow in-person hospice visits, and hospice care would be provided virtually. FM-C stated hospice care was not a Zoom (virtual meeting) service, nor was hospice the facility's specialty. FM-C stated facility administration was arbitrarily enforcing policies, and lacked compassion and understanding for individuals who needed specialized end-of-life care. FM-C stated it was a violation of resident rights by not allowing in-person hospice services, and hospice care should never be denied to a human being. FM-C stated she elected to have R1 transferred to a hospice house, as R1's end-of-life needs would not be met by the facility. On 1/5/21, at 10:56 a.m., an interview was	2 830		

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2 830	Continued From page 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.

On 1/5/21, at 1:13 p.m. an interview was conducted with FM-B. FM-B stated R2 received hospice care at the facility. FM-B stated she did not know if hospice staff was allowed to enter the facility.

On 1/5/21, at 1:37 p.m. an interview was conducted with RN-A. RN-A stated hospice aides and workers were not allowed into the facility since April or May. RN-A stated beginning this week, hospice aides were again allowed to enter the facility. RN-A stated he believed it was a corporate policy which restricted hospice workers from entering the facility. RN-A stated R1 had a decline in condition on 12/14/20. RN-A stated he updated the nurse practitioner and R1's family. RN-A stated labs and intravenous fluids were ordered, however, R1 did not respond to treatment, and the nurse practitioner recommended hospice care. RN-A stated he informed FM-C that hospice workers were restricted from the facility. RN-A confirmed FM-C wanted hospice care for R1, and since hospice staff were not allowed into the facility, FM-C

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2 830	Continued From page 5 elected to have R1 transferred to a hospice house. On 1/6/21, at approximately 8:45 a.m. an 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 conducted with the administrator and director of nursing (DON). The DON stated hospice workers were previously allowed to enter the facility only when a resident was admitted to hospice services. The DON stated subsequent hospice visits were conducted virtually. The DON stated within the past couple of weeks, the facility was again allowing hospice staff to come into the facility. The administrator stated hospice staff was also previously allowed to enter when a resident had a significant change in condition, or had died. The facility policy Coronavirus Prevention, Screening, and Identification reviewed/revised 12/3/20, directed, "Health care workers: Other health care workers, such as hospice workers, EMS personnel, or dialysis technicians that provide care to residents will be permitted to come into the facility as long as they meet the CDC guidelines for health care workers." SUGGESTED METHOD OF CORRECTION:	2 830		

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2 830	Continued From page 6 The administrator, or designee, could review and/or revise policies and procedures related to non-employed healthcare workers visitation. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to 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). Findings include: R2's Face Sheet dated 1/6/21, indicated R2's diagnoses included macular degeneration and chronic kidney disease. R2's annual Minimum Data Set (MDS) dated 11/30/20, indicated R2 had moderately impaired cognition. The MDS further indicated R2 had	2 920	See federal plan of correction	1/27/21

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2 920	Continued From page 7 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. On 1/5/20, at 10:56 a.m. an interview was conducted with family member (F)-A. F-A stated they preferred R2's fingernails to be short so they did not get dirty. On 1/5/20, at 1:13 p.m. an interview was conducted with F-B. F-B stated R2 preferred for her fingernails to be short, and longer fingernails "bugged" her. On 1/6/20, at 9:45 a.m. R2's fingernails were observed and remained long, with brown debris underneath the nail. At this time, an interview was conducted with nursing assistant (NA)-A. NA-A stated nail care was completed on resident bath days. NA-A stated she was floated to the unit and did not normally work with R2. NA-A confirmed R2's nails were long, and brown debris was under the nails. NA-A informed R2 staff would help with her nails in a little while, and R2 agreed. On 1/6/20, at 9:54 a.m. an interview was conducted with the administrator and director of nursing (DON). The administrator stated staff were expected to do nail care on bath days. The	2 920		

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2 920	Continued From page 8 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and/or revise the current grooming and personal hygiene policies and procedures to ensure nail care and hygiene is completed and maintained. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		