

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered March 25, 2021

Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

RE: CCN: 245414 Cycle Start Date: February 18, 2021

Dear Administrator:

On March 25, 2021, the Minnesota Department(s) 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 March 5, 2021

Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

RE: CCN: 245414 Cycle Start Date: February 18, 2021

Dear Administrator:

On February 18, 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 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 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 March 5, 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), i.e., the plan of correction should be directed to:

Terri 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 Office: (218) 302-6151 Mobile: (218) 766-2720

## 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

Viewcrest Health Center March 5, 2021 Page 2

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 May 18, 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 August 18, 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 specified for compliance or the imposition of remedies.

Viewcrest Health Center March 5, 2021 Page 2

Feel free to contact me if you have questions.

Sincerely,

35) 6

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

|                          | -  | & MEDICAID SERVICES  |                     |      |   | -  | APPROVED<br>. 0938-0391    |
|--------------------------|--|--|---------------------|------|---|----|----------------------------|
|                          |  | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MLII T         |      | CONSTRUCTION  |    | E SURVEY                   |
|                          | F CORRECTION   | IDENTIFICATION NUMBER:   | A. BUILDI           |      |   |    | IPLETED                    |
|                          |  |  | -                   |      |   |    | С                          |
|                          |  | 245414   | B. WING             |      |   |    | 18/2021                    |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                     | STRE | EET ADDRESS, CITY, STATE, ZIP CODE  |    |                            |
| VIEWCR                   | EST HEALTH CENTE   | 2  |                     | 3111 | CHURCH STREET   |    |                            |
|                          |  | <b>X</b>   |                     | DUL  | UTH, MN 55811   |    |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | <    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE | (X5)<br>COMPLETION<br>DATE |
| F 000                    | INITIAL COMMENT  | S  | F 00                | 00   |   |    |                            |
|                          | survey was comple-<br>complaint investiga<br>NOT to be in compl  | h 2/18/21, an abbreviated<br>ted at your facility to conduct<br>tions. Your facility was found<br>iance with 42 CFR Part 483,<br>ong Term Care Facilities. |                     |      |   |    |                            |
|                          | The following comp SUBSTANTIATED:  | laint was found to be<br>H5414075C   |                     |      |   |    |                            |
|                          |  | f correction (POC) will serve<br>f compliance upon the<br>ptance.  |                     |      |   |    |                            |
|                          | signature is not req   |  |                     |      |   |    |                            |
| F 692<br>SS=D            | on-site revisit of you<br>validate that substa<br>regulations has bee<br>your verification.<br>Nutrition/Hydration |  | F 69                | 92   |   |    | 3/19/21                    |
|                          | (Includes naso-gas<br>both percutaneous<br>percutaneous endo<br>enteral fluids). Bas                               | essment, the facility must   |                     |      |   |    |                            |
|                          |  | tains acceptable parameters<br>such as usual body weight or  |                     |      |   |    |                            |
|                          | DIRECTOR'S OR PROVID   | ER/SUPPLIER REPRESENTATIVE'S SIGN  | NATURE              | ·    | TITLE   |    | (X6) DATE<br>03/11/2021    |

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.

DEDADTMENT OF LIEALTH AND LIUMAN CEDVICES

PRINTED: 03/12/2021

|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |  |                 |   | FORM  | 03/12/2021<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|--|-----------------|---|---|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |                 |   | (X3) DATE SURVEY<br>COMPLETED   |                                     |
|                          |   | 245414  | B. WING                                |                 |   | (<br><b>02</b> /1   | ;<br> 8/2021                        |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |  | S               | TREET ADDRESS, CITY, STATE, ZIP CODE  |   |                                     |
|                          |   |   |  | 3               | 111 CHURCH STREET   |   |                                     |
| VIEWCR                   | EST HEALTH CENTE  | R   |  | ULUTH, MN 55811 |   |   |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                     |                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  | ЗE  | (X5)<br>COMPLETION<br>DATE          |
| F 692                    | desirable body weig<br>balance, unless the<br>demonstrates that to<br>preferences indicate<br>§483.25(g)(2) Is off<br>maintain proper hyd<br>§483.25(g)(3) Is off<br>there is a nutritional<br>provider orders a the<br>This REQUIREMEN<br>by:<br>Based on interview<br>facility failed to com<br>weight monitoring a<br>1 of 4 residents (R1<br>Findings include:<br>R1's Face Sheet pr<br>diagnoses of vascu<br>and history of other<br>circulatory system.<br>R1's annual Minimu<br>12/15/20, identified<br>impairment, and red<br>with bed mobility, tr<br>personal hygiene an<br>identified R1 require<br>was independent w<br>identified R1 had no<br>difficulty with swallo<br>R1's care plan initial<br>the potential for alter | <ul> <li>and electrolyte</li> <li>aresident's clinical condition</li> <li>aresident's clinical condition</li> <li>bis is not possible or resident</li> <li>e otherwise;</li> <li>ered sufficient fluid intake to</li> <li>dration and health;</li> <li>ered a therapeutic diet when</li> <li>l problem and the health care</li> <li>areapeutic diet.</li> <li>NT is not met as evidenced</li> <li>and document review, the</li> <li>aplete accurate and ongoing</li> <li>and nutritional assessment for</li> <li>reviewed for nutrition.</li> </ul> inted 2/18/21, included lar dementia, thyroid disorder, <ul> <li>anspecified disease of</li> </ul> and Data Set (MDS) dated R1 had severe cognitive quired extensive assistance <ul> <li>ansfers, dressing, toileting,</li> <li>and bathing. The MDS</li> <li>ad set up assist for meals, and</li> <li>ath eating tasks. The MDS</li> <li>b weight loss, and had no</li> <li>and liquids/solids.</li> </ul> | F                                      | \$92            | It is the policy of Viewcrest Health C<br>Center to ensure that all residents<br>maintain adequate nutritional status<br>including sufficient fluid intake. R1 M<br>discharged from the facility on 1/18/<br>All residents in the facility have the<br>potential to be impacted by this prace<br>All residents in the facility were weig<br>the week of 2/16/21 to ensure an act<br>baseline weight was recorded. All n<br>staff will be tested for competency of<br>weighing a resident by 3/19/21. The<br>policy and procedure for recording<br>weights was reviewed and updated<br>include verification of weight by two<br>members all nursing staff will be edu<br>on this policy change. A new tracki<br>tool was created for tracking of mea<br>percentages. All nursing staff along<br>any staff involved in the service of m<br>will be educated on the new policy a<br>procedure for recording intakes by<br>3/19/21. All residents will be weighte<br>minimum of weekly or per physician | was<br>2021.<br>tice.<br>hed<br>curate<br>ursing<br>n<br>to<br>staff<br>ucated<br>ng<br>l<br>with<br>neals<br>ind<br>ed a |                                     |
|                          | the potential for altered leaving 25% or more   |   |  |                 | 3/19/21. All residents will be weighe   | ight  |                                     |

Facility ID: 00602

If continuation sheet Page 2 of 10

|                          |   | E & MEDICAID SERVICES  |                     |   |   | 0938-039                  |  |
|--------------------------|---|--|---------------------|---|---|---------------------------|--|
|                          | F OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | TIPLE CONSTRUCTION  |   | E SURVEY<br>PLETED        |  |
|                          |   | 245414   | B. WING _           |   |   | C<br>02/18/2021           |  |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, Z  |   | 10/2021                   |  |
| VIEWCR                   | EST HEALTH CENTE  | R  |                     | 3111 CHURCH STREET<br>DULUTH, MN 55811  |   |                           |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>( (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC  | TION SHOULD BE<br>THE APPROPRIATE   | (X5)<br>COMPLETIO<br>DATE |  |
| F 692                    | and R1 would cons<br>The care plan furth<br>weekly weights, an<br>as needed for weig<br>noted.<br>R1's Physician Orc<br>weekly weights 1 ti<br>8:00 a.m. Ensure r<br>weight, and docum<br>R1's Annual Nutriti<br>12/15/20, identified<br>172 lbs. The asses<br>was stable, and wa<br>weight of 165-175<br>indicated R1's nutr<br>weight were asses<br>day. The assessme<br>intake was down fr<br>weight was stable a<br>On 12/28/20, at 6:3<br>indicated registere<br>with R1's family me<br>concerned about F<br>FM-B had also inque<br>R1's meal intake re<br>health record (EHF<br>weekly total combi<br>(breakfast, lunch, a<br>snack (morning, af<br>averages included:<br>9/1/20, through 9/7 | stable at 165-175 pounds (lbs),<br>sume at 75% of most meals.<br>her instructed staff to perform<br>ad for the dietician to evaluate<br>ght gain/loss or other problems<br>ders initiated 4/2/20, included<br>ime per day every Monday at<br>hursing assistant (NA) obtains<br>hents.<br>on Assessment dated<br>d R1's weight was noted to be<br>ssment indicated R1's weight<br>as within desired healthy goal<br>lbs. The assessment further<br>itional needs for maintaining<br>sed at 1900-2000 calories per<br>ent also indicated R1's oral<br>form last quarter, however, R1's<br>and within goal range.<br>39 p.m. a progress note<br>d nurse (RN)-A had spoken<br>ember (FM)-B. FM-B was<br>R1's decline and weight loss.<br>uired about R1's intake.<br>ecords from the electronic<br>R) from 9/1/20, to 12/31/20, and<br>ned three daily meal<br>and dinner) and three daily<br>'ternoon, and bedtime) | F 69                | 92<br>along with the facility die<br>will update the Registeren<br>needed. The interdiscipt<br>continue to review reside<br>significant weight loss for<br>interventions. The Direct<br>(DON) or Designee will a<br>weekly to ensure complet<br>accuracy until compliance<br>addition the DON or des<br>meal percentages three<br>for a minimum of a mont<br>substantial compliance is<br>Results of all audits will the<br>facility quality assuration<br>improvement program. | ed Dietician as<br>linary team will<br>ents with<br>r appropriate<br>tor of Nursing<br>audit weights<br>etion as well as<br>ee as achieved. In<br>ignee will audit<br>times per week<br>th or until<br>s achieved.<br>per reviewed by |                           |  |

If continuation sheet Page 3 of 10

|                          |   | AND HUMAN SERVICES  |                   |            |  | FORM                          | 03/12/2021<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|-------------------|------------|--|-------------------------------|-------------------------------------|
| STATEMEN                 | T OF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | · /               |            | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |   | 245414  | B. WING           | . <u> </u> |  |                               | C<br>18/2021                        |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |                   | S          | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                                     |
| VIEWCR                   | EST HEALTH CENTE  | R   |                   | -          | 3111 CHURCH STREET<br>DULUTH, MN 55811   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| F 692                    | 9/8/20, through 9/14<br>intake with no snac<br>9/15/20, through 9/2<br>intake with no snac<br>9/23/20, through 9/2<br>intake with no snac<br>9/30/20, through 10<br>intake with no snac<br>10/7/20, through 10<br>intake with no snac<br>10/14/20, through 11<br>intake with no snac<br>10/28/20, through 11<br>intake with 33% sna<br>intake on 10/30/20.<br>documented.<br>11/4/20, through 11<br>intake with no snac<br>11/11/20, through 11<br>intake with no snac<br>11/11/20, through 11<br>intake with no snac<br>11/18/20, through 1<br>intake with no snac<br>11/18/20, through 1<br>intake with no snac | ge 3<br>4/20, 35% combined meal<br>k intake for all 7 days.<br>22/20, 37% combined meal<br>k intake for all 7 days.<br>29/20, 48% combined meal<br>k intake for all 7 days.<br>0/6/20, 47% combined meal<br>k intake for all 7 days.<br>0/13/20, 33% combined meal<br>k intake for all 7 days.<br>0/20/20, 54% combined meal<br>k intake for all 7 days.<br>0/27/20, 43% combined meal<br>k intake for all 7 days.<br>1/3/20, 34% combined meal<br>ack average documented<br>No additional snack intake<br>/10/20, 46% combined meal<br>k intake for all 7 days.<br>1/17/20, 22% combined meal<br>k intake for all 7 days.<br>1/17/20, 22% combined meal<br>k intake for all 7 days.<br>1/24/20, 33% combined meal<br>k intake for all 7 days.<br>2/2/20, 13% combined meal<br>k intake for all 7 days. | F                 | 692        |  |                               |                                     |

If continuation sheet Page 4 of 10

| CENTERS FOR MEDICARE & MEDICAID SERVICES OME   | B NO. 0938-0391               |  |
|--|-------------------------------|--|
|  | (X3) DATE SURVEY<br>COMPLETED |  |
| 245414 B. WING   | C                             |  |
| NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE   | 02/18/2021                    |  |
| VIEWCREST HEALTH CENTER 3111 CHURCH STREET   |                               |  |
| DULUTH, MN 55811   |                               |  |
| (X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECTION           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>TAG         PREFIX         (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAL<br>DEFICIENCY) |                               |  |
| F 692 Continued From page 4 F 692  |                               |  |
| intake with no snack intake for all 7 days.  |                               |  |
| 12/10/20, through 12/21/20, 15% combined meal<br>intake with 25% snack average documented<br>intake on 12/21/20. No additional snack intake<br>documented.   |                               |  |
| 12/22/20, through 12/31/20, 22% combined meal intake with no snack intake for all 7 days   |                               |  |
| R1's weight record from the EHR 9/7/20, to 12/28/20, indicated:  |                               |  |
| 9/7/20: 170 lbs.   |                               |  |
| 9/14/20: 170 lbs.  |                               |  |
| 9/24/20: 171 lbs.  |                               |  |
| 9/27/20: 170 lbs.  |                               |  |
| 10/5/20: 172 lbs.  |                               |  |
| 10/12/20: 170 lbs.   |                               |  |
| 10/19/20: 171 lbs.   |                               |  |
| 10/26/20: 169 lbs.   |                               |  |
| 11/1/20: 173 lbs.  |                               |  |
| 11/9/20: 173 lbs.  |                               |  |
| 11/16/20: 172 lbs.   |                               |  |
| 11/23/20: 171 lbs.   |                               |  |
| 11/30/20: 169 lbs.   |                               |  |

Facility ID: 00602

If continuation sheet Page 5 of 10

PRINTED: 03/12/2021

| DEPARTMENT OF HEALTH AND HUMAN SERVICES         CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING         NAME OF PROVIDER OR SUPPLIER       245414       B. WING         VIEWCREST HEALTH CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE<br>3111 CHURCH STREET<br>DULUTH, MN 55811         (X4) ID<br>PREFIX<br>TAG       SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       ID<br>PREFIX<br>TAG       PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPT<br>DEFICIENCY)         F 692       Continued From page 5<br>12/12/20: 172 lbs.       F 692         12/21/20: 171 lbs.       F 692 |   |  |          |     |  | FORM     | APPROVED<br>. 0938-0391    |
|---|---|--|----------|-----|--|----------|----------------------------|
| STATEMENT   | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MUL | TIP |  | (X3) DAT | E SURVEY                   |
| AND PLAN O  | F CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILD | ING | 3  |          | IPLETED<br>C               |
|   |   | 245414   | B. WING  |     |  |          | 0<br>18/2021               |
| NAME OF F   | PROVIDER OR SUPPLIER  |  |          |     |  | <u> </u> |                            |
| VIEWCR  | EST HEALTH CENTEI   | र  |          |     |  |          |                            |
| PRÉFIX  | (EACH DEFICIENCY  | MUST BE PRECEDED BY FULL   | PREFI    |     | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO | D BE     | (X5)<br>COMPLETION<br>DATE |
|   | Continued From pa<br>12/12/20: 172 lbs.<br>12/21/20: 171 lbs.<br>12/28/20: 144 lbs. T<br>and represented a<br>days.<br>On 2/17/21, at 1:58<br>director of nursing (<br>administrator stated<br>was identified, only<br>unit were educated<br>and documenting the<br>included reviewing the<br>management policy<br>there was no knowl<br>weights for R1. The<br>scales were checked<br>and no additional di<br>that time. The administrator furthe<br>speak with RN-A as<br>On 2/17/21, at 2:45<br>was interviewed and<br>loss was reviewed as<br>interdisciplinary tea<br>stated a weight loss<br>10% in 6 months way<br>weight loss. DM-C s<br>aware of R1's weigh<br>around 30 lbs. DM-<br>of 30 lbs in a week | ge 5<br>This was a 27 lb weight loss,<br>16% weight loss in seven<br>p.m. the administrator and<br>DON) were interviewed. The<br>d at the time the weight loss<br>those staff working on R1's<br>on taking weights accurately,<br>ne weights. The education also<br>the facility weight<br>. The administrator stated<br>edge of alleged falsifying<br>e administrator stated all<br>ed and calibrated for accuracy,<br>screpancies were identified at<br>nistrator stated, "There's no<br>e not weighing correctly, so we | -        |     | DEFICIENCY)  |          |                            |
|   |   | ewed. RD-D stated she worked   |          |     |  |          |                            |

If continuation sheet Page 6 of 10

PRINTED: 03/12/2021

| <b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>  |                     |                                       |                 | APPROVED<br>. 0938-0391    |
|--|---------------------|---------------------------------------|-----------------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | · /                 | TIPLE CONSTRUCTION                    | (X3) DAT<br>CON | E SURVEY<br>IPLETED        |
| 245414   | B. WING             |                                       |                 | C<br>18/2021               |
| NAME OF PROVIDER OR SUPPLIER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE | •               |                            |
| VIEWCREST HEALTH CENTER  |                     | 3111 CHURCH STREET                    |                 |                            |
|  |                     | DULUTH, MN 55811                      |                 |                            |
| (X4) ID         SUMMARY STATEMENT OF DEFICIENCIES           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG |                                       | LD BE           | (X5)<br>COMPLETION<br>DATE |
| <ul> <li>F 692 Continued From page 6</li> <li>closely with DM-C and nursing staff. RD-D stated<br/>in her opinion, a weigh loss of 30 lbs in a week<br/>would be impossible. RD-D stated she was made<br/>aware of R1's significant weight loss in<br/>December. RD-D stated RN-A had verified, to<br/>her, R1's weight was in fact 144 lbs. RD-D<br/>further stated accurate weights taken by staff<br/>were very important because this was how she<br/>would identify a resident's weight loss. RD-D<br/>stated if weights were not taken and recorded<br/>accurately, there would be no way for her to<br/>identify weight loss and put in the necessary<br/>nutritional interventions.</li> <li>On 2/18/21, at 6:50 a.m. the facility medical<br/>director (MD)-A was interviewed and stated he<br/>would not expect a resident to have such a<br/>significant weight loss in one week. MD-A stated<br/>a weight loss that great would happen over a<br/>period of time, greater than even a month. MD-A<br/>stated he would expect the facility was closely<br/>monitoring residents' weights. MD-A stated poor<br/>nutritional intake would be a contributing factor,<br/>and he would have expected resident's meal<br/>intakes were monitored, and the resident's<br/>primary physical should have been notified.</li> <li>On 2/18/21, at 7:44 a.m. DM-C stated the nursing<br/>assistants (NA) were responsible for recording<br/>the meal percentage after the resident shave<br/>eaten. DM-C stated NAs record the intake on the<br/>meal tickets. DM-C stated herself and RD-D<br/>reviewed resident's meal intakes and<br/>percentages. DM-C stated herself and RD-D<br/>reviewed resident's who have documented weigh<br/>loss. DM-C again stated she personally does not<br/>look at the percentage of meals residents have<br/>eaten. DM-C stated it was very important for<br/>weights to be accurate, otherwise they would not</li> </ul> | e<br>t              |                                       |                 |                            |

If continuation sheet Page 7 of 10

| DEPARTMENT OF HEALTH AND HUI<br>CENTERS FOR MEDICARE & MEDIC   |   |                    |     |  | FORM             | 03/12/2021<br>APPROVED<br>0938-0391 |
|--|---|--------------------|-----|--|------------------|-------------------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROV  | IDER/SUPPLIER/CLIA  | ` '                |     |  | (X3) DATE<br>COM | E SURVEY<br>PLETED                  |
|  | 245414  | B. WING            |     |  |                  | C<br>18/2021                        |
| NAME OF PROVIDER OR SUPPLIER   |   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   | <u> </u>         |                                     |
| VIEWCREST HEALTH CENTER  |   |                    |     | 111 CHURCH STREET<br>ULUTH, MN 55811   |                  |                                     |
| (X4) ID SUMMARY STATEMENT OF<br>PREFIX (EACH DEFICIENCY MUST BE P<br>TAG REGULATORY OR LSC IDENTIFY  | RECEDED BY FULL   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE               | (X5)<br>COMPLETION<br>DATE          |
| <ul> <li>F 692 Continued From page 7<br/>know if there was a weight lo<br/>stated documented weight lo<br/>discussed at facility IDT mee<br/>then allow for interventions to<br/>followed, with monitoring of the<br/>On 2/18/21, at 8:08 a.m. the<br/>week's meal tickets had beer<br/>personally by her, reviewed, i<br/>intake logs. The DON stated<br/>tickets were to be reviewed b<br/>RD-D. The DON stated the in<br/>reviewing the percentage on<br/>what percentage of meals the<br/>eating. The DON verified the<br/>accurate weigh and meal per<br/>identifying a change in conditi<br/>if there was not a documente<br/>IDT would not review the indi<br/>meal intake.</li> <li>On 2/18/21, at 10:09 a.m. FM<br/>FM-B stated R1's weight had<br/>around 170 lbs. FM-B stated<br/>notice a weight loss was ridio<br/>he and FM-A had come for a<br/>12/27/20, and immediately re<br/>significant weight loss. FM-E<br/>immediately called RN-A, and<br/>he would re-weigh R1. FM-E<br/>her back and verified R1 had<br/>amount of weight, and that hi<br/>144 lbs. FM-B stated she rea<br/>RN-A on 12/29/20. The emai<br/>re-weighed your Dad today. F<br/>(lbs). We are following with d<br/>staff that obviously did not we<br/>weights. I am sorry about this<br/>he has been losing weight sin</li> </ul> | ss would then be<br>tings which would<br>be added and<br>he residents' weight.<br>DON stated this<br>n picked up<br>and then put into the<br>previously meal<br>by the DM-C and<br>mportance of<br>meal tickets to see<br>e residents were<br>importance of<br>rcentage for<br>tion. The DON stated<br>ed weight loss, the<br>ividual resident's<br>A-B was interviewed.<br>always been stable<br>for the facility to not<br>culous. FM-B stated<br>window visit on<br>ecognized R1 had a<br>8 stated she<br>d RN-A stated to her<br>8 stated she<br>d Iost a significant<br>is current weight was<br>ceived an email from<br>I indicated: "I<br>He weighs 147#<br>lisciplinary action on<br>eigh him and falsified<br>s. Not sure how long | Fθ                 | 592 |  |                  |                                     |

Facility ID: 00602

If continuation sheet Page 8 of 10

|                          |   | AND HUMAN SERVICES  |                   |      |  |   | FORM                                  | APPROVED                   |
|--------------------------|---|---|-------------------|------|--|---|---------------------------------------|----------------------------|
|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MUI          | TIF  | PLE CONSTRUCTION                       | 01  | OMB NO. 0938-0391<br>(X3) DATE SURVEY |                            |
| AND PLAN C               | OF CORRECTION   | IDENTIFICATION NUMBER:  | A. BUILD          | DINC | G                                      | -   |                                       | PLETED                     |
|                          |   | 245414  | B. WING           | i    |  |   |                                       | C<br>18/2021               |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |                   |      | STREET ADDRESS, CITY, ST               | ATE, ZIP CODE   | -                                     |                            |
| VIEWCR                   | EST HEALTH CENTE  | R   |                   |      | 3111 CHURCH STREET<br>DULUTH, MN 55811 |   |                                       |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |      | (EACH CORRECTI)<br>CROSS-REFERENCE     | AN OF CORRECTION<br>/E ACTION SHOULD<br>ED TO THE APPROPP<br>ICIENCY) | BE                                    | (X5)<br>COMPLETION<br>DATE |
| F 692                    | indicate stable weig<br>email also indicated<br>weight discrepancie<br>neither her or FM-A<br>email regarding R1<br>was put on hospice<br>stated she would ha<br>only identify R1's de<br>also have had better<br>family members.<br>On 2/18/21, at 12:3<br>(MD)-B stated she f<br>admission. MD-B st<br>a severe sudden we<br>stated both herself<br>investigating, and it<br>been a error. MD-B<br>to have that much co<br>occurred over a tim<br>and certainly not in<br>she relied on the fa<br>accurate weights, a<br>weight loss.<br>The facility policy W<br>dated 12/15/20, ide<br>resident weight sho<br>previous recorded we<br>be informed of a sig<br>the registered dietit<br>be consulted to ass<br>The Centers for Me<br>Long-Term Care Fa<br>Instrument (RAI) 3.<br>10/2018, identified<br>Swallowing/Nutrition | ht. Between 169-175#." The<br>d the DON was aware of the<br>es as well. FM-B stated<br>a received a follow-up call or<br>'s weight loss. FM-B stated R1<br>and has since passed. FM-B<br>ave expected the facility to not<br>ecline and weight loss, but to<br>er communication with the<br>7 p.m. R1's primary physician<br>had been seeing R1 since his<br>tated she had been notified of<br>eight loss by RN-A. MD-B<br>and RN-A did some<br>was determined there had<br>stated in her opinion, for R1<br>of a weight loss, it would have<br>e frame of 3 months or longer,<br>a 7-day period. MD-B stated<br>cility to provide her with<br>and she used those to identify<br>//eight Monitoring Program<br>ntified a newly recorded<br>build be compared to the<br>weight. The physician should<br>gnificant change in weight, and<br>ian or dietary manager should<br>sist with interventions. | F                 | 692  | 2                                      |   |                                       |                            |

If continuation sheet Page 9 of 10

PRINTED: 03/12/2021

|                          |  | AND HUMAN SERVICES  |                   |     |  | FORM                               | : 03/12/2021<br>APPROVED<br>. 0938-0391 |
|--------------------------|--|---|-------------------|-----|--|------------------------------------|---|
|                          | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | · ·               |     | PLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED<br>C |   |
|                          |  | 245414  | B. WING           | i   |  |                                    | /18/2021                                |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                   |     | STREET ADDRESS, CITY, STATE, ZIP CODE  |                                    |   |
| VIEWCR                   | EST HEALTH CENTE   | R   |                   | -   | 3111 CHURCH STREET<br>DULUTH, MN 55811   |                                    |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                              | (X5)<br>COMPLETION<br>DATE              |
| F 692                    | cold affect the resid<br>adequate nutrition a<br>Weight Loss Plann<br>be an important ind<br>resident's health sta<br>significant weight lo<br>interdisciplinary tea<br>causes of changed<br>change in medicati<br>fluid volume status<br>monitored on a con<br>should be assessed | dent's ability to maintain<br>and hydration. Under K0300:<br>ing for Care: Weight loss may<br>licator of a change in the<br>atus or environment. If | F                 | 692 |  |                                    |   |

Facility ID: 00602

If continuation sheet Page 10 of 10



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 5, 2021

Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

#### Re: State Nursing Home Licensing Orders Event ID: VPSI11

Dear Administrator:

The above facility was surveyed on February 16, 2021 through February 18, 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.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF

Viewcrest Health Center March 5, 2021 Page 2 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:

Terri 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 Office: (218) 302-6151 Mobile: (218) 766-2720

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

| Minneso                  | ta Department of He  | alth   |                       |   | T OT WIT             |                          |
|--------------------------|--|--|-----------------------|---|----------------------|--------------------------|
|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                       | E CONSTRUCTION  | (X3) DATE S<br>COMPL |                          |
|                          |  | 00602  | B. WING               |   | C<br>02/1            | ;<br>8/2021              |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S        | STATE, ZIP CODE   |                      |                          |
| VIEWCR                   | EST HEALTH CENTE   | 2  | RCH STREE<br>MN 55811 | T   |                      |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE                 | (X5)<br>COMPLETE<br>DATE |
| 2 000                    | Initial Comments   |  | 2 000                 |   |                      |                          |
|                          | *****ATTEI   | NTION*****   |                       |   |                      |                          |
|                          | NH LICENSING   | CORRECTION ORDER   |                       |   |                      |                          |
|                          | 144A.10, this correct<br>pursuant to a surver<br>found that the defic<br>herein are not corrected shall<br>with a schedule of f<br>the Minnesota Depa<br>Determination of wh<br>corrected requires of<br>requirements of the<br>number and MN Ru<br>When a rule contain<br>comply with any of<br>lack of compliance.<br>re-inspection with a<br>result in the assess | nether a violation has been  |                       |   |                      |                          |
|                          | that may result from<br>orders provided tha<br>the Department with   | hearing on any assessments<br>n non-compliance with these<br>t a written request is made to<br>hin 15 days of receipt of a<br>nt for non-compliance.                       |                       |   |                      |                          |
|                          | receipt of State lice<br>the Minnesota Depa<br>Informational Bullet<br>http://www.health.st<br>obul.htm The State<br>delineated on the a   | participate in the electronic<br>nsure orders consistent with<br>artment of Health<br>in 14-01, available at<br>tate.mn.us/divs/fpc/profinfo/inf<br>e licensing orders are |                       |   |                      |                          |
| ABORATOR                 | epartment of Health<br>Y DIRECTOR'S OR PROVID  | ER/SUPPLIER REPRESENTATIVE'S SIG   | NATURE                | TITLE   |                      | (X6) DATE                |

Electronically Signed

6899

L

| ND PLAN OF C   |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           | CONSTRUCTION   |                 | E SURVEY<br>PLETED      |
|--|---|---|---------------------------|--|-----------------|-------------------------|
|  | ORRECTION   | IDENTIFICATION NUMBER.  | A. BUILDING:              |  |                 |                         |
|  |   | 00602   | B. WING                   |  | C<br>02/18/2021 |                         |
| AME OF PROV  | IDER OR SUPPLIER  | STREET AL   | DRESS, CITY, ST           | TATE, ZIP CODE   |                 |                         |
| IEWCREST   | HEALTH CENTE  | R   | JRCH STREET<br>, MN 55811 | r  |                 |                         |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | TION SHOULD BE  | (X5)<br>COMPLET<br>DATE |
| 2 000 Co   | ntinued From pa   | ge 1  | 2 000                     |  |                 |                         |
| you<br>is r<br>entitex<br>Sta<br>con<br>con<br>Min<br>De<br>the<br>ind<br>you<br>dat<br>Th<br>SU<br>Min<br>the<br>fec<br>ass | a electronically.<br>hecessary for State<br>ter the word "corr<br>t. You must then<br>ate licensure pro-<br>mpletion date, the<br>rected prior to elect<br>nesota Departm<br>2/16/21, through<br>partment's staff,<br>collowing correct<br>icate in your elect<br>have reviewed<br>te when they will<br>e following comp<br>BSTANTIATED:<br>nesota Departm<br>e State Licensing<br>leral software. Tate | h 2/18/21, surveyors of this<br>visited the above provider and<br>tion orders are issued. Please<br>ctronic plan of correction that<br>these orders, and identify the<br>be completed.  |                           |  |                 |                         |
| col<br>sta<br>"Su<br>and<br>col<br>find<br>aft<br>evi<br>are<br>Tin  | umn entitled "ID<br>tute/rule out of c<br>ummary Stateme<br>d replaces the "T<br>rection order. Th<br>dings which are i<br>er the statement<br>dence by." Follow<br>the Suggested<br>ne period for Cor  | umber appears in the far left<br>Prefix Tag." The state<br>compliance is listed in the<br>ent of Deficiencies" column<br>to Comply" portion of the<br>his column also includes the<br>n violation of the state statute<br>, "This Rule is not met as<br>wing the surveyors findings<br>Method of Correction and<br>rection. |                           |  |                 |                         |
| FC   |   | N WHICH STATES,   |                           |  |                 |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | A. BUILDING               | LE CONSTRUCTION   | СОМ (    | E SURVEY<br>PLETED<br>C             |
|--------------------------|---|--|---------------------------|---|----------|-------------------------------------|
|                          |   | 00602  | B. WING                   |   | 02/      | 18/2021                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                           | STATE, ZIP CODE   |          |                                     |
| /IEWCR                   | EST HEALTH CENTE  | R  | URCH STREE<br>I, MN 55811 | ĒT  |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLE <sup>-</sup><br>DATE |
| 2 000                    | Continued From pa   | age 2  | 2 000                     |   |          |                                     |
|                          | APPLIES TO FED  | AN OF CORRECTION." THIS<br>ERAL DEFICIENCIES ONLY.<br>AR ON EACH PAGE.   |                           |   |          |                                     |
|                          | PLAN OF CORRE   | QUIREMENT TO SUBMIT A<br>CTION FOR VIOLATIONS OF<br>FE STATUTES/RULES.   |                           |   |          |                                     |
| 2 965                    | MN Rule 4658.060<br>-Nutritional Status   | 0 Subp. 2 Dietary Service  | 2 965                     |   |          | 3/19/21                             |
|                          | must ensure that a<br>which supplies the<br>determined by the<br>assessment. Subs | onal status. The nursing home<br>a resident is offered a diet<br>caloric and nutrient needs as<br>comprehensive resident<br>stitutes of similar nutritive value<br>residents who refuse food |                           |   |          |                                     |
|                          | by:<br>Based on interview<br>facility failed to cor<br>weight monitoring          | nent is not met as evidenced<br>w, and document review, the<br>nplete accurate and ongoing<br>and nutritional assessment for<br>1) reviewed for nutrition.                                   |                           | See federal POC   |          |                                     |
|                          | Findings include:   |  |                           |   |          |                                     |
|                          | diagnosis of vascu  | rinted 2/18/21, included<br>lar dementia, thyroid disorder,<br>r unspecified disease of  |                           |   |          |                                     |
|                          | 12/15/20, identified  | um Data Set (MDS) dated<br>d R1 had severe cognitive<br>equired extensive assistance   |                           |   |          |                                     |

|                          | ota Department of He<br>NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | A. BUILDING:           | CONSTRUCTION   | (X3) DATE SURV<br>COMPLETE<br>C  |                         |
|--------------------------|--|--|------------------------|--|----------------------------------|-------------------------|
|                          |  | 00602  | B. WING                |  | 02/                              | 18/2021                 |
| NAME OF                  | PROVIDER OR SUPPLIER   |  | DRESS, CITY, ST        | ATE, ZIP CODE  |                                  |                         |
| VIEWCR                   | EST HEALTH CENTER  | 2  | RCH STREET<br>MN 55811 |  |                                  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 965                    | personal hygiene ar<br>identified R1 require<br>was independent wi<br>identified R1 had no<br>difficulty with swallo<br>R1's care plan initia<br>the potential for alte<br>leaving 25% or mor<br>The care plan indica<br>keep R1's weight st<br>and R1 would const<br>The care plan furthe<br>weekly weights, and<br>as needed for weigh<br>noted.<br>R1's Physician Orde<br>weekly weights 1 tin<br>8:00 a.m. Ensure no<br>weight, and docume<br>R1's Annual Nutritio<br>12/15/20, identified<br>172 lbs. The assess<br>was stable, and was<br>weight of 165-175 II<br>indicated R1's nutrit<br>weight were assess<br>day. The assessment<br>intake was down fro<br>weight was stable a<br>On 12/28/20, at 6:3<br>indicated registered<br>with R1's family me | ansfers, dressing, toileting,<br>nd bathing. The MDS<br>ed set up assist for meals, and<br>ith eating tasks. The MDS<br>o weight loss, and had no<br>wing liquids/solids.<br>ted 1/14/20, identified R1 had<br>eration in nutrition due to<br>e of food uneaten at times.<br>ated goals which included to<br>table at 165-175 pounds (lbs),<br>ume at 75% of most meals.<br>er instructed staff to perform<br>d for the dietician to evaluate<br>ht gain/loss or other problems<br>ers initiated 4/2/20, included<br>me per day every Monday at<br>ursing assistant (NA) obtains | 2 965                  | DEFICIENC  | xΥ)                              |                         |

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br>00602  |                     |   | Сом                                   | E SURVEY<br>PLETED<br>C<br>18/2021 |
|--------------------------|---|---|---------------------|---|---------------------------------------|------------------------------------|
| JAME OF F                | PROVIDER OR SUPPLIER  |   | DDRESS, CITY, S     |   | · · · · · · · · · · · · · · · · · · · |                                    |
|                          |   | 3111 CH   |                     |   |                                       |                                    |
| /IEWCR                   | EST HEALTH CENTE  | R   | I, MN 55811         |   |                                       |                                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE        | (X5)<br>COMPLE<br>DATE             |
| 2 965                    | Continued From pa   | age 4   | 2 965               |   |                                       |                                    |
| 2 303                    | R1's meal intake rehealth record (EHR<br>weekly total combin<br>(breakfast, lunch, a<br>snack (morning, aff<br>averages included:<br>9/1/20, through 9/7<br>intake with no snac<br>9/8/20, through 9/1<br>intake with no snac<br>9/15/20, through 9/<br>intake with no snac<br>9/23/20, through 9/<br>intake with no snac<br>9/30/20, through 10<br>intake with no snac<br>10/7/20, through 10<br>intake with no snac<br>10/14/20, through 1<br>intake with no snac<br>10/21/20, through 1<br>intake with no snac | ecords from the electronic<br>(a) from 9/1/20, to 12/31/20, and<br>hed three daily meal<br>and dinner) and three daily<br>ternoon, and bedtime) | E E                 |   |                                       |                                    |
|                          | intake with no snac   | /10/20, 46% combined meal<br>k intake for all 7 days.   |                     |   |                                       |                                    |
|                          | 11/11/20, through 1   | 1/17/20, 22% combined meal  |                     |   |                                       |                                    |

|               | IT OF DEFICIENCIES<br>OF CORRECTION         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                 |
|---------------|---|---|---|--|-------------------------------|-----------------|
| AND PLAN      | OF CORRECTION                               | IDENTIFICATION NUMBER.  | A. BUILDING:                            |  |                               |                 |
|               |   | 00602   | B. WING                                 |  |                               | C<br>18/2021    |
| NAME OF I     | PROVIDER OR SUPPLIER                        | STREET A  | DDRESS, CITY, ST                        | TATE, ZIP CODE                             |                               |                 |
| VIEWCR        | EST HEALTH CENTE                            | R   | URCH STREET<br>I, MN 55811              | ſ  |                               |                 |
| (X4) ID       |   | ATEMENT OF DEFICIENCIES   | ID                                      | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT |                               | (X5)<br>COMPLET |
| PREFIX<br>TAG |   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                             | PREFIX<br>TAG                           | CROSS-REFERENCED TO T<br>DEFICIENC         | THE APPROPRIATE               | DATE            |
| 2 965         | Continued From pa                           | age 5   | 2 965                                   |  |                               |                 |
|               | intake with no snack intake for all 7 days. |   |   |  |                               |                 |
|               |   | 11/24/20, 33% combined meal<br>ck intake for all 7 days.                              |   |  |                               |                 |
|               |   | 12/2/20, 13% combined meal<br>ck intake for all 7 days.                               |   |  |                               |                 |
|               |   | 2/9/20, 34% combined meal<br>ck intake for all 7 days.                                |   |  |                               |                 |
|               | intake with 25% sn                          | 12/21/20, 15% combined meal<br>ack average documented<br>. No additional snack intake |   |  |                               |                 |
|               |   | 12/31/20, 22% combined meal<br>ck intake for all 7 days                               |   |  |                               |                 |
|               | R1's weight record 12/28/20, indicated      | from the EHR 9/7/20, to<br>I:   |   |  |                               |                 |
|               | 9/7/20: 170 lbs.                            |   |   |  |                               |                 |
|               | 9/14/20: 170 lbs.                           |   |   |  |                               |                 |
|               | 9/24/20: 171 lbs.                           |   |   |  |                               |                 |
|               | 9/27/20: 170 lbs.                           |   |   |  |                               |                 |
|               | 10/5/20: 172 lbs.                           |   |   |  |                               |                 |
|               | 10/12/20: 170 lbs.                          |   |   |  |                               |                 |
|               | 10/19/20: 171 lbs.                          |   |   |  |                               |                 |
|               | 10/26/20: 169 lbs.                          |   |   |  |                               |                 |
|               | 11/1/20: 173 lbs.                           |   |   |  |                               |                 |

| STATEMEN                 | ta Department of He<br>TOF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br>00602  |                            | CONSTRUCTION   | Сом                              | E SURVEY<br>PLETED<br>C<br>18/2021 |
|--------------------------|---|---|----------------------------|--|----------------------------------|------------------------------------|
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, ST           | TATE, ZIP CODE   |                                  |                                    |
| VIEWCR                   | EST HEALTH CENTE  | R   | URCH STREET<br>I, MN 55811 | r  |                                  |                                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE            |
| 2 965                    | Continued From pa   | ge 6  | 2 965                      |  |                                  |                                    |
|                          | 11/9/20: 173 lbs.   |   |                            |  |                                  |                                    |
|                          | 11/16/20: 172 lbs.  |   |                            |  |                                  |                                    |
|                          | 11/23/20: 171 lbs.  |   |                            |  |                                  |                                    |
|                          | 11/30/20: 169 lbs.  |   |                            |  |                                  |                                    |
|                          | 12/12/20: 172 lbs.  |   |                            |  |                                  |                                    |
|                          | 12/21/20: 171 lbs.  |   |                            |  |                                  |                                    |
|                          |   | This was a 27 lb weight loss,<br>16% weight loss in seven   |                            |  |                                  |                                    |
|                          | director of nursing (<br>administrator stated<br>was identified, only<br>unit were educated<br>and documenting th<br>included reviewing<br>management policy<br>there was no knowl<br>weights for R1. The<br>scales were checked<br>and no additional d<br>that time. The admin<br>proof that staff were<br>think he lost 30 lbs.<br>administrator furthe | 7. The administrator stated<br>edge of alleged falsifying<br>administrator stated all<br>ed and calibrated for accuracy<br>iscrepancies were identified at<br>inistrator stated, "There's no<br>e not weighing correctly, so we |                            |  |                                  |                                    |
|                          | was interviewed an<br>loss was reviewed a<br>interdisciplinary tea<br>stated a weight loss  | p.m. dietary manger (DM)-C<br>d stated a resident's weight<br>and discussed at the<br>m (IDT) meetings. DM-C<br>s greater that 5% monthly and<br>as considered a significant  |                            |  |                                  |                                    |

|                          | ta Department of He<br>TOF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING |  | (X3) DATE SURVEY<br>COMPLETED<br>C |                         |
|--------------------------|---|---|---|--|------------------------------------|-------------------------|
|                          |   | 00602   |   |  | 02/                                | 18/2021                 |
| NAME OF I                | PROVIDER OR SUPPLIER  |   | DRESS, CITY, ST<br>JRCH STREET                  |  |                                    |                         |
| VIEWCR                   | EST HEALTH CENTE  | R   | MN 55811  |  |                                    |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                             | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | FION SHOULD BE<br>THE APPROPRIATE  | (X5)<br>COMPLET<br>DATE |
| 2 965                    | Continued From pa   | ige 7   | 2 965   |  |                                    |                         |
|                          | aware of R1's weig<br>around 30 lbs. DM<br>of 30 lbs in a week<br>On 2/17/21, at 3:00<br>(RD)-D was intervie<br>closely with DM-C a<br>in her opinion, a we<br>would be impossibl<br>aware of R1's signi<br>December. RD-D s<br>her, R1's weight wa<br>further stated accur<br>were very importan<br>would identify a res<br>stated if weights we<br>accurately, there we | stated RN-A had made her<br>ht loss, and the loss was<br>-C further stated a weight loss<br>would be impossible.<br>9 p.m. registered dietician<br>ewed. RD-D stated she worked<br>and nursing staff. RD-D stated<br>eigh loss of 30 lbs in a week<br>e. RD-D stated she was made<br>ficant weight loss in<br>tated RN-A had verified, to<br>as in fact 144 lbs. RD-D<br>rate weights taken by staff<br>t because this was how she<br>ident's weight loss. RD-D<br>ere not taken and recorded<br>ould be no way for her to<br>and put in the necessary<br>ions. |   |  |                                    |                         |
|                          | director (MD)-A was<br>would not expect a<br>significant weight los<br>a weight loss that g<br>period of time, grea<br>stated he would exp<br>monitoring resident<br>nutritional intake wo<br>and he would have<br>intakes were monitor<br>primary physical sh<br>On 2/18/21, at 7:44<br>assistants (NA) were<br>the meal percentag<br>eaten. DM-C stated                 | a.m. the facility medical<br>s interviewed and stated he<br>resident to have such a<br>bass in one week. MD-A stated<br>great would happen over a<br>atter than even a month. MD-A<br>pect the facility was closely<br>s' weights. MD-A stated poor<br>build be a contributing factor,<br>expected resident's meal<br>ored, and the resident's<br>nould have been notified.<br>a.m. DM-C stated the nursing<br>re responsible for recording<br>ge after the residents have<br>to NAs record the intake on the<br>C stated she personally does                   |   |  |                                    |                         |

| Innesota Department of H<br>TATEMENT OF DEFICIENCIES<br>ND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE (<br>A. BUILDING:<br>B. WING | CONSTRUCTION  | COM                               | E SURVEY<br>PLETED      |
|--|--|--|---|-----------------------------------|-------------------------|
|  | 00602  | B. WING                                    |   | 02/                               | 18/2021                 |
| IAME OF PROVIDER OR SUPPLIER   |  | DDRESS, CITY, STA                          | ATE, ZIP CODE   |                                   |                         |
| VIEWCREST HEALTH CENT  | R  | URCH STREET                                |   |                                   |                         |
| PREFIX (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| reviewed residents<br>loss. DM-C again<br>look at the percen<br>eaten. DM-C state<br>weights to be accu<br>know if there was<br>stated documente<br>discussed at facilit<br>then allow for inter<br>followed, with mor<br>On 2/18/21, at 8:0<br>week's meal ticket<br>personally by her,<br>intake logs. The D<br>tickets were to be<br>RD-D. The DON s<br>reviewing the perc<br>what percentage of<br>eating. The DON s<br>reviewing the perc<br>what percentage of<br>eating. The DON s<br>accurate weigh an<br>identifying a chang<br>if there was not a of<br>IDT would not revi<br>meal intake.<br>On 2/18/21, at 10:<br>FM-B stated R1's<br>around 170 lbs. F<br>notice a weight los<br>he and FM-A had<br>12/27/20, and imm<br>significant weight l<br>immediately called<br>he would re-weigh<br>her back and verif<br>amount of weight, | age 8<br>C stated herself and RD-D<br>s who have documented weight<br>stated she personally does not<br>tage of meals residents have<br>d it was very important for<br>irrate, otherwise they would not<br>a weight loss. DM-C further<br>d weight loss would then be<br>y IDT meetings which would<br>ventions to be added and<br>itoring of the residents' weight.<br>8 a.m. the DON stated this<br>s had been picked up<br>reviewed, and then put into the<br>ON stated previously meal<br>reviewed by the DM-C and<br>tated the importance of<br>entage on meal tickets to see<br>if meals the residents were<br>verified the importance of<br>d meal percentage for<br>ge in condition. The DON stated<br>documented weight loss, the<br>ew the individual resident's<br>09 a.m. FM-B was interviewed.<br>weight had always been stable<br>M-B stated for the facility to not<br>s was ridiculous. FM-B stated<br>come for a window visit on<br>nediately recognized R1 had a<br>oss. FM-B stated she<br>I RN-A, and RN-A stated to her<br>R1. FM-B stated RN-A called<br>ed R1 had lost a significant<br>and that his current weight was<br>ted she received an email from |  |   |                                   |                         |

Minnesota Department of Health STATE FORM

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE<br>A. BUILDING: | CONSTRUCTION  | COM                            | E SURVEY<br>PLETED       |
|--------------------------|--|--|-------------------------------|---|--------------------------------|--------------------------|
|                          |  | 00602  | B. WING                       |   |                                | C<br>18/2021             |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, ST               | TATE, ZIP CODE  |                                |                          |
| IEWCR                    | EST HEALTH CENTE   | R  | IRCH STREET<br>MN 55811       | ſ   |                                |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETI<br>DATE |
| 2 965                    | re-weighed your Da<br>(Ibs). We are follow<br>staff that obviously<br>weights. I am sorry<br>he has been losing<br>indicate stable weige<br>email also indicated<br>weight discrepancie<br>neither her or FM-A<br>email regarding R1<br>was put on hospice<br>stated she would ha<br>only identify R1's de<br>also have had bette<br>family members.<br>On 2/18/21, at 12:3<br>(MD)-B stated she<br>admission. MD-B s<br>a severe sudden w<br>stated both herself<br>investigating, and it<br>been a error. MD-B<br>to have that much o<br>occurred over a tim<br>and certainly not in<br>she relied on the fa<br>accurate weights, a<br>weight loss.<br>The facility policy W<br>dated 12/15/20, ide<br>resident weight sho<br>previous recorded y<br>be informed of a sig<br>the registered dietit | ad today. He weighs 147#<br>ving with disciplinary action on<br>did not weigh him and falsified<br>about this. Not sure how long<br>weight since all records<br>ght. Between 169-175#." The<br>d the DON was aware of the<br>es as well. FM-B stated<br>A received a follow-up call or<br>'s weight loss. FM-B stated R1<br>e and has since passed. FM-B<br>ave expected the facility to not<br>ecline and weight loss, but to<br>er communication with the<br>47 p.m. R1's primary physician<br>had been seeing R1 since his<br>tated she had been notified of<br>eight loss by RN-A. MD-B<br>and RN-A did some<br>twas determined there had<br>b stated in her opinion, for R1<br>of a weight loss, it would have<br>the frame of 3 months or longer,<br>a 7-day period. MD-B stated<br>cility to provide her with<br>and she used those to identify<br>Veight Monitoring Program<br>entified a newly recorded<br>build be compared to the<br>weight. The physician should<br>gnificant change in weight, and<br>ian or dietary manager should<br>sist with interventions. | 2 965                         |   |                                |                          |
| anoasta D                |  | edicare and Medicaid (CMS)<br>acility Resident Assessment  |                               |   |                                |                          |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE<br>A. BUILDING: _ | CONSTRUCTION  | (X3) DATE SUF<br>COMPLET       |                         |
|--------------------------|---|---|---------------------------------|---|--------------------------------|-------------------------|
|                          |   | 00602   | B. WING                         |   |                                | 18/2021                 |
| IAME OF                  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, ST                 | TATE, ZIP CODE  |                                |                         |
| IEWCR                    | EST HEALTH CENTE  | R   | IRCH STREET<br>MN 55811         | T   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 965                    | Instrument (RAI) 3.<br>10/2018, identified<br>Swallowing/Nutritio<br>with an intent to ass<br>cold affect the resid<br>adequate nutrition a<br>Weight Loss Plann<br>be an important ind<br>resident's health sta<br>significant weight lo<br>interdisciplinary tea<br>causes of changed<br>change in medicati<br>fluid volume status,<br>monitored on a corr<br>should be assessed<br>of detection and no<br>assessment."<br>SUGGESTED MET<br>The administrator,<br>and/or revise policie<br>accurately taking w<br>intake/meal percent<br>could educate the a<br>policies/procedures<br>develop a monitorin<br>compliance. | 0 User's Manual dated<br>Section K:<br>nal Status to be completed<br>sess the many conditions that<br>dent's ability to maintain<br>and hydration. Under K0300:<br>ing for Care: Weight loss may<br>licator of a change in the<br>atus or environment. If | 2 965                           |   | ·                              |                         |