

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.

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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

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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.

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Feel free to contact me if you have questions.

Sincerely,

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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 . 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		
		X		DUL	UTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	F 00	00			
	survey was comple- complaint investiga NOT to be in compl	h 2/18/21, an abbreviated ted at your facility to conduct tions. Your facility was found iance with 42 CFR Part 483, ong Term Care Facilities.					
	The following comp SUBSTANTIATED:	laint was found to be H5414075C					
		f correction (POC) will serve f compliance upon the ptance.					
	signature is not req						
F 692 SS=D	on-site revisit of you validate that substa regulations has bee your verification. Nutrition/Hydration		F 69	92			3/19/21
	(Includes naso-gas both percutaneous percutaneous endo enteral fluids). Bas	essment, the facility must					
		tains acceptable parameters such as usual body weight or					
	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	·	TITLE		(X6) DATE 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 & MEDICAID SERVICES				FORM	03/12/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245414	B. WING			(02 /1	; 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 PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 692	desirable body weig balance, unless the demonstrates that to preferences indicate §483.25(g)(2) Is off maintain proper hyd §483.25(g)(3) Is off there is a nutritional provider orders a the This REQUIREMEN by: Based on interview facility failed to com weight monitoring a 1 of 4 residents (R1 Findings include: R1's Face Sheet pr diagnoses of vascu and history of other circulatory system. R1's annual Minimu 12/15/20, identified impairment, and red with bed mobility, tr personal hygiene an identified R1 require was independent w identified R1 had no difficulty with swallo R1's care plan initial the potential for alter	 and electrolyte aresident's clinical condition aresident's clinical condition bis is not possible or resident e otherwise; ered sufficient fluid intake to dration and health; ered a therapeutic diet when l problem and the health care areapeutic diet. NT is not met as evidenced and document review, the aplete accurate and ongoing and nutritional assessment for reviewed for nutrition. inted 2/18/21, included lar dementia, thyroid disorder, anspecified disease of and Data Set (MDS) dated R1 had severe cognitive quired extensive assistance ansfers, dressing, toileting, and bathing. The MDS ad set up assist for meals, and ath eating tasks. The MDS b weight loss, and had no and liquids/solids. 	F	\$92	It is the policy of Viewcrest Health C Center to ensure that all residents maintain adequate nutritional status including sufficient fluid intake. R1 M discharged from the facility on 1/18/ All residents in the facility have the potential to be impacted by this prace All residents in the facility were weig the week of 2/16/21 to ensure an act baseline weight was recorded. All n staff will be tested for competency of weighing a resident by 3/19/21. The policy and procedure for recording weights was reviewed and updated include verification of weight by two members all nursing staff will be edu on this policy change. A new tracki tool was created for tracking of mea percentages. All nursing staff along any staff involved in the service of m will be educated on the new policy a procedure for recording intakes by 3/19/21. All residents will be weighte minimum of weekly or per physician	was 2021. tice. hed curate ursing n to staff ucated ng l with neals ind ed a	
	the potential for altered leaving 25% or more				3/19/21. All residents will be weighe	ight	

Facility ID: 00602

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

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES OME	B NO. 0938-0391	
	(X3) DATE SURVEY 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 TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL 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 intake with 25% snack average documented intake on 12/21/20. No additional snack intake 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

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PRINTED: 03/12/2021

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING NAME OF PROVIDER OR SUPPLIER 245414 B. WING VIEWCREST HEALTH CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 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 CROSS-REFERENCED TO THE APPROPT DEFICIENCY) F 692 Continued From page 5 12/12/20: 172 lbs. F 692 12/21/20: 171 lbs. F 692						FORM	APPROVED . 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 C
		245414	B. WING				0 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 CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETION DATE
	Continued From pa 12/12/20: 172 lbs. 12/21/20: 171 lbs. 12/28/20: 144 lbs. T and represented a days. On 2/17/21, at 1:58 director of nursing (administrator stated was identified, only unit were educated and documenting the included reviewing the management policy there was no knowl weights for R1. The scales were checked and no additional di that time. The administrator furthe speak with RN-A as On 2/17/21, at 2:45 was interviewed and loss was reviewed as interdisciplinary tea stated a weight loss 10% in 6 months way weight loss. DM-C s aware of R1's weigh around 30 lbs. DM- of 30 lbs in a week	ge 5 This was a 27 lb weight loss, 16% weight loss in seven p.m. the administrator and DON) were interviewed. The d at the time the weight loss those staff working on R1's on taking weights accurately, ne weights. The education also the facility weight . The administrator stated edge of alleged falsifying e administrator stated all ed and calibrated for accuracy, screpancies were identified at nistrator stated, "There's no e not weighing correctly, so we	-		DEFICIENCY)		
		ewed. RD-D stated she worked					

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PRINTED: 03/12/2021

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

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

Facility ID: 00602

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

If continuation sheet Page 9 of 10

PRINTED: 03/12/2021

		AND HUMAN SERVICES				FORM	: 03/12/2021 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 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 DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 692	cold affect the resid adequate nutrition a Weight Loss Plann be an important ind resident's health sta significant weight lo interdisciplinary tea causes of changed change in medicati fluid volume status monitored on a con should be assessed	dent's ability to maintain and hydration. Under K0300: ing for Care: Weight loss may licator of a change in the 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 OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		00602	B. WING		C 02/1	; 8/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	2	RCH STREE MN 55811	T		
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2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed

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ND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	ORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:			
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2 000 Co	ntinued From pa	ge 1	2 000			
you is r entitex Sta con con Min De the ind you dat Th SU Min the fec ass	a electronically. hecessary for State ter the word "corr t. You must then ate licensure pro- mpletion date, the rected prior to elect nesota Departm 2/16/21, through partment's staff, collowing correct icate in your elect have reviewed te when they will e following comp BSTANTIATED: nesota Departm e State Licensing leral software. Tate	h 2/18/21, surveyors of this visited the above provider and tion orders are issued. Please ctronic plan of correction that these orders, and identify the be completed.				
col sta "Su and col find aft evi are Tin	umn entitled "ID tute/rule out of c ummary Stateme d replaces the "T rection order. Th dings which are i er the statement dence by." Follow the Suggested ne period for Cor	umber appears in the far left Prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rection.				
FC		N WHICH STATES,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	СОМ (E SURVEY PLETED C
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2 000	Continued From pa	age 2	2 000			
	APPLIES TO FED	AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. AR ON EACH PAGE.				
	PLAN OF CORRE	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF FE STATUTES/RULES.				
2 965	MN Rule 4658.060 -Nutritional Status	0 Subp. 2 Dietary Service	2 965			3/19/21
	must ensure that a which supplies the determined by the assessment. Subs	onal status. The nursing home a resident is offered a diet caloric and nutrient needs as comprehensive resident stitutes of similar nutritive value residents who refuse food				
	by: Based on interview facility failed to cor weight monitoring	nent is not met as evidenced w, and document review, the nplete accurate and ongoing and nutritional assessment for 1) reviewed for nutrition.		See federal POC		
	Findings include:					
	diagnosis of vascu	rinted 2/18/21, included lar dementia, thyroid disorder, r unspecified disease of				
	12/15/20, identified	um Data Set (MDS) dated d R1 had severe cognitive equired extensive assistance				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURV COMPLETE 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 MN 55811			
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2 965	personal hygiene ar identified R1 require was independent wi identified R1 had no difficulty with swallo R1's care plan initia the potential for alte leaving 25% or mor The care plan indica keep R1's weight st and R1 would const The care plan furthe weekly weights, and as needed for weigh noted. R1's Physician Orde weekly weights 1 tin 8:00 a.m. Ensure no weight, and docume R1's Annual Nutritio 12/15/20, identified 172 lbs. The assess was stable, and was weight of 165-175 II indicated R1's nutrit weight were assess day. The assessment intake was down fro weight was stable a On 12/28/20, at 6:3 indicated registered with R1's family me	ansfers, dressing, toileting, nd bathing. The MDS ed set up assist for meals, and ith eating tasks. The MDS o weight loss, and had no wing liquids/solids. ted 1/14/20, identified R1 had eration in nutrition due to e of food uneaten at times. ated goals which included to table at 165-175 pounds (lbs), ume at 75% of most meals. er instructed staff to perform d for the dietician to evaluate ht gain/loss or other problems ers initiated 4/2/20, included me per day every Monday at ursing assistant (NA) obtains	2 965	DEFICIENC	xΥ)	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00602			Сом	E SURVEY PLETED C 18/2021
JAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S		· · · · · · · · · · · · · · · · · · ·	
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/IEWCR	EST HEALTH CENTE	R	I, MN 55811			
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2 965	Continued From pa	age 4	2 965			
2 303	R1's meal intake rehealth record (EHR weekly total combin (breakfast, lunch, a snack (morning, aff averages included: 9/1/20, through 9/7 intake with no snac 9/8/20, through 9/1 intake with no snac 9/15/20, through 9/ intake with no snac 9/23/20, through 9/ intake with no snac 9/30/20, through 10 intake with no snac 10/7/20, through 10 intake with no snac 10/14/20, through 1 intake with no snac 10/21/20, through 1 intake with no snac	ecords from the electronic (a) from 9/1/20, to 12/31/20, and hed three daily meal and dinner) and three daily ternoon, and bedtime)	E E			
	intake with no snac	/10/20, 46% combined meal k intake for all 7 days.				
	11/11/20, through 1	1/17/20, 22% combined meal				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:			
		00602	B. WING			C 18/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
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2 965	Continued From pa	age 5	2 965			
	intake with no snack intake for all 7 days.					
		11/24/20, 33% combined meal ck intake for all 7 days.				
		12/2/20, 13% combined meal ck intake for all 7 days.				
		2/9/20, 34% combined meal ck intake for all 7 days.				
	intake with 25% sn	12/21/20, 15% combined meal ack average documented . No additional snack intake				
		12/31/20, 22% combined meal ck intake for all 7 days				
	R1's weight record 12/28/20, indicated	from the EHR 9/7/20, to 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 TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00602		CONSTRUCTION	Сом	E SURVEY PLETED C 18/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	URCH STREET I, MN 55811	r		
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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, 16% weight loss in seven				
	director of nursing (administrator stated was identified, only unit were educated and documenting th included reviewing management policy there was no knowl weights for R1. The scales were checked and no additional d that time. The admin proof that staff were think he lost 30 lbs. administrator furthe	7. The administrator stated edge of alleged falsifying administrator stated all ed and calibrated for accuracy iscrepancies were identified at inistrator stated, "There's no e not weighing correctly, so we				
	was interviewed an loss was reviewed a interdisciplinary tea stated a weight loss	p.m. dietary manger (DM)-C d stated a resident's weight and discussed at the m (IDT) meetings. DM-C s greater that 5% monthly and as considered a significant				

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

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

Minnesota Department of Health STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	COM	E SURVEY PLETED
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2 965	re-weighed your Da (Ibs). We are follow staff that obviously weights. I am sorry he has been losing indicate stable weige email also indicated weight discrepancie neither her or FM-A email regarding R1 was put on hospice stated she would ha only identify R1's de also have had bette family members. On 2/18/21, at 12:3 (MD)-B stated she admission. MD-B s a severe sudden w stated both herself investigating, and it been a error. MD-B to have that much o occurred over a tim and certainly not in she relied on the fa accurate weights, a weight loss. The facility policy W dated 12/15/20, ide resident weight sho previous recorded y be informed of a sig the registered dietit	ad today. He weighs 147# ving with disciplinary action on did not weigh him and falsified about this. Not sure how long weight since all records ght. Between 169-175#." The d the DON was aware of the es as well. FM-B stated A received a follow-up call or 's weight loss. FM-B stated R1 e and has since passed. FM-B ave expected the facility to not ecline and weight loss, but to er communication with the 47 p.m. R1's primary physician had been seeing R1 since his tated she had been notified of eight loss by RN-A. MD-B and RN-A did some twas determined there had b stated in her opinion, for R1 of a weight loss, it would have the frame of 3 months or longer, a 7-day period. MD-B stated cility to provide her with and she used those to identify Veight Monitoring Program entified a newly recorded build be compared to the weight. The physician should gnificant change in weight, and ian or dietary manager should sist with interventions.	2 965			
anoasta D		edicare and Medicaid (CMS) acility Resident Assessment				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SUF COMPLET	
		00602	B. WING			18/2021
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2 965	Instrument (RAI) 3. 10/2018, identified Swallowing/Nutritio with an intent to ass cold affect the resid adequate nutrition a Weight Loss Plann be an important ind resident's health sta significant weight lo interdisciplinary tea causes of changed change in medicati fluid volume status, monitored on a corr should be assessed of detection and no assessment." SUGGESTED MET The administrator, and/or revise policie accurately taking w intake/meal percent could educate the a policies/procedures develop a monitorin compliance.	0 User's Manual dated Section K: nal Status to be completed sess the many conditions that dent's ability to maintain and hydration. Under K0300: ing for Care: Weight loss may licator of a change in the atus or environment. If	2 965		·	