

Protecting, Maintaining and Improving the Health of All Minnes ot ans

Electronically delivered July 22, 2021

Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

RE: CCN: 245414

Cycle Start Date: May 13, 2021

Dear Administrator:

On June 4, 2021, we notified you a remedy was imposed. On July 14, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 3, 2021.

As authorized by CMS the remedy of:

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

In our letter of June 4, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 4, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 3, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 22, 2021

Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

Re: Reinspection Results

Event ID: 532812

Dear Administrator:

On July 14, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 14, 2021. At this time these correction orders were found corrected.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 29, 2021

Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

RE: CCN: 245414

Cycle Start Date: May 13, 2021

Dear Administrator:

On June 4, 2021, we informed you of imposed enforcement remedies.

On June 10, 2021, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 4, 2021, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of June 4, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 4, 2021.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

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

Viewcrest Health Center June 29, 2021 Page 3

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 13, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Viewcrest Health Center June 29, 2021 Page 4

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Viewcrest Health Center June 29, 2021 Page 5 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

PRINTED: 07/01/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245414	B. WING		С
NAME OF F	PROVIDER OR SUPPLIER	245414		TREET ADDRESS, CITY, STATE, ZIP CODE	06/10/2021
VIEWCR	EST HEALTH CENTE	R		111 CHURCH STREET DULUTH, MN 55811	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENT	ΓS	F 000		
	abbreviated survey Your facility was NO with the requiremen	6/10/21, a standard was conducted at your facility. OT found to be in compliance at sof 42 CFR 483, Subpart B, ong Term Care Facilities.			
	SUBSTANTIATED:	plaint was found to be 8564). A deficiency was issued			
	as your allegation of Departments accept enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required the first page of the CMS-2567 ic submission of the POC will tion of compliance.			
F 697 SS=G	onsite revisit of you	acceptable electronic POC, an r facility may be conducted to intial compliance with the en attained.	F 697		7/3/21
	provided to residen consistent with prof the comprehensive and the residents' garding This REQUIREMENT by: Based on interview facility failed to effer	anagement. Issure that pain management is the who require such services, fessional standards of practice, person-centered care plan, goals and preferences. Note in the work of the work		It is the policy of Viewcrest Health (Center to ensure all residents have management provided that is consis	pain
LABORATORY	V DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE **Electronically Signed**

07/01/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		[`	(X3) DATE SURVEY COMPLETED	
		245414	B. WING			0 6/1	0/2021
NAME OF F	PROVIDER OR SUPPLIER	3		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3	111 CHURCH STREET		
VIEWCR	EST HEALTH CENTI	ER		D	OULUTH, MN 55811		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 697	Continued From p	age 1	F6	397			
		gical pain. This resulted in	_		with professional standards and pers	son	
		, when R1's narcotic pain			centered. R1 is no longer a resident		
		ot administered per orders			the care center. All residents with pa		
	resulting in unconf				have potential to be impacted by this		
		·			process. The Pain Management Pol	icy	
	Findings include:				was reviewed by the Director of Nurs	sing	
					(DON) and Administrator with no upon	dates	
		ecord printed on 6/10/21,			needed. The Missing/Unavailable		
		admitted on 6/4/21, with			Medications Policy was reviewed an	d	
		ncluded Atrioventricular			updated by the Administrator. The		
		n the heart chamber) block			Emergency Medication Kit policy was		
	pain, and muscle	weakness.			reviewed and updated by the DON.		
	D1's 40 Hour Boo	olina Cara Dlan initiated on			licensed nurses will be educated on		
		eline Care Plan initiated on R1's reason for admission was			Missing/Unavailable Medications Po		
		acemaker and Coronary Artery			E-Kit Policy and the Pain Manageme Policy by the DON and/or designee.		
		BG). R1 was to have assist of 1			Education will include process for pa		
		ambulation, toileting, bathing,			management when residents prescr		
		Pain interventions included ice,			pain medication is not available in-ho		
		action, massage, and			including contacting pharmacy and	Juoo,	
		s baseline care plan also			provider for orders to remove pain		
		a fall risk. R1's mental status			medication from e-kit or seek alterna	ative	
	was listed as alert	and orientated.			pain medication orders that are avai	lable	
					in e-kit, along with the list of pain		
		narge and facility admitting			medications available in the e-kit. W	ill also	
		21, included acetaminophen			educate on follow-up process for		
		5 milligrams (mg), take 1-2			assessing resident pain relief. All nu		
		every 6 hours as needed for			staff will be educated on ensuring ar		
		ol (Ultram, narcotic medication			resident reports of pain are reported		
		or use with moderate to			licensed nurse timely and any contin		
		e pain) 50 mg tablet every 6			reports of resident pain are reported		
		or pain. R1's hospital			timely to the licensed nurse until res		
		ork indicated R1 had last 000 mg dose at 9:50 a.m. and			by the DON and/or designee. Social Worker will be re-educated on proce		
		e at 8:12 a.m. prior to being			providing the pharmacy insurance ca		
	admitted to the fac				timely by the Administrator. All reside		
	admitted to the lat	onity.			will have their progress notes review		
	R1's PRN (as nee	ded medication) Report dated			going back 1 week from 7/1/21, to e		
	6/4/21 indicated t	, .			no unrelieved pain was exhibited by		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED C	
		245414	B. WING			10/2021	
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP COI 3111 CHURCH STREET DULUTH, MN 55811		10/2021	
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F 697	-6/4/21, at 4:53 p.m tablets by mouth werbalized pain. Th 9:43 p.m. as "unrel -6/4/21, at 9:47 p.m tablets by mouth acverbalized acute paa.m. the result was by medication6/4/21, at 10:16 p. administered to R1 level 10/10. The reas "unknown," as F medical advice (AN R1's Vital Sign recelectronic health reindicated R1's pain was 9/10 (on a scapain and 10 being 6 10/10, and at 10:16 On 6/10/21, at 12:0 and stated she had went home. R1 stated she did r prepared to take a stated she arrived a 11:00 a.m. and RN admission paperworks arrived, her pato see her. R1 states staff had stopped hake a copy of her	as administered to R1 for e result was documented at ieved" by medication. a. acetaminophen 325 mg, 2 dministered to R1 for ain at a level of 10/10. At 12:06 documented as "unrelieved" a. tramadol 50 mg tablet for verbalized acute pain at a sult was documented by RN-A R1 had left the facility against MA). ard reviewed from the cord (EHR) dated 6/4/21, level on 6/4/21, at 9:42 p.m. le of 1-10 with 1 being mild excruciating pain), at 9:47 p.m.	F 697	DON and/or designee. In add pain interview will be conductoresidents the week of 6/26/21 documentation of unrelieved prollowed-up on with the resideresident's provider by the Nurand/or designee. DON and/or will complete random pain aurone week, then 5x/week x 2 v weekly thereafter to ensure all complaint of pain is followed-care center policy starting 7/4 audits will be brought forward committee for review and furting recommendations.	ed on all . Any pain will be ent and se Manager designee dits daily x veeks, then ny resident up on per /21. All to the QAPI		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245414	B. WING				C 10/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 3111 CHURCH STREET DULUTH, MN 55811	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 697	needed another of because they lost R1 stated she corn her a photo of the email to RN-C with was asked if she I card, R1 stated the everything, including R1 stated she had vulnerable as she she did not see ar been brought to help placed her call light assistance with to R1 stated at one pfor over 90 minute female staff came asked her for her staff said she wou again. R1 stated the staff did come that time she was had told the staff in and she felt like sight time she called get her. R1 stated p.m. and around the tramadol pain memedications. R1 stated p.m. and around the tramadol pain memedications. R1 stated p.m. and around the tramadol pain memedications. R1 stated p.m. and around the tramadol pain memedications. R1 stated p.m. and around the tramadol pain memedications. R1 stated p.m. and around the tramadol pain memedications. R1 stated p.m. and around the tramadol pain memedications. R1 stated p.m. and around the tramadol pain memedications. R1 stated p.m. and around the tramadol pain memedications. R1 stated p.m. and around the tramadol pain memedications. R1 stated p.m. and around the tramadol pain memedications. R1 stated p.m. and around the tramadol pain memedications. R1 stated p.m. and around the tramadol pain memedications. R1 stated p.m. and around the tramadol pain memedications. R1 stated p.m. and around the tramadol pain memedications around the tramadol pain memedications. R1 stated p.m. and around the tramadol pain memedications around the tramadol pain memedications.	evening stating that the facility opy of her insurance card the first copy that was made. It is tacted her husband who sent card, and she forwarded an in the information. R1 stated she had more than one insurance ey had one insurance card for	F 6	97			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245414	B. WING				C 10/2021
	PROVIDER OR SUPPLIER EST HEALTH CENTE	R		311	REET ADDRESS, CITY, STATE, ZIP CODE 11 CHURCH STREET 11 LUTH, MN 55811	1 00/	10/2021
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F 697	delivered to the face medication was incincluded her tramace medication. Registe to have signed for the had been something to have signed for the had been something to have something	ility from the pharmacy. R1's luded in the delivery which dol (Ultram) 50 mg tablet pain ered nurse (RN)-A was noted he medication delivery. b.m. a progress note by the rindicated on 6/4/21, at 10:16 eived a phone call around -A had shown up to the facility R1 home. RN-A educated R1 erse benefit of leaving the still decided to leave the b.m. a progress note by RN-B, per RN-A, R1 was given 650 er request at 4:45 p.m. Staff 19:45 p.m. that R1 was having hyperventilating, and was a via telephone regarding R1 stated that she did not the left the hospital. R1 was er dose of Tylenol which R1 on returning to the cart to		97			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245414	B. WING				10/2021
	PROVIDER OR SUPPLIER	R		31	TREET ADDRESS, CITY, STATE, ZIP CODE 111 CHURCH STREET ULUTH, MN 55811	1 001	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 697	arrived at the facility R1 in his personal of go to the emergency in pain, or if she stafeel as though she on 6/10/21, at 9:30 and stated he compassessment on 6/4 day, R1 had been rated her pain at a offered Tylenol become delivered from RN-B stated R1 deaccept an ice pack, had available an stamedications which RN-B stated a pain showing nonverbal grimacing should haccess medications (Ekit). RN-B confirm tramadol pain medithat time, nor did her pain at 9/10 statemedication at 19/10 statemedi	y around 12:03 a.m. to pick up vehicle. R1 was encouraged to by room (ER) with any increase arted to feel worse or did not was improving. a.m. RN-B was interviewed bleted R1's admission /21. RN-B stated earlier that noted to be grimacing and 5/10. RN-B stated he had ause the tramadol had not in the pharmacy at that time. clined the Tylenol, but did RN-B confirmed the facility ock emergency(Ekit) supply of included a supply of tramadol. level of 5/10 in addition to signs of pain such as ave signaled a reason to so out of the emergency kit med he did not offer the cation to R1 from the Ekit at the reassess R1 for pain relief. I he felt if R1 had been rating ff should have accessed the	F6	697			

PRINTED: 07/01/2021 FORM APPROVED OMB NO. 0938-0391

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245414	B. WING				C 10/2021
	PROVIDER OR SUPPLIER			311	REET ADDRESS, CITY, STATE, ZIP CODE 11 CHURCH STREET JLUTH, MN 55811	1 00	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	RN-A stated she wand hyperventilating been discussion was a medication was a medications were RN-A stated her subut she had not see 9:45 p.m. On 6/10/21, at 10: interview the admired pain at a a nurse, she would medication effective administrator state or reached, she was the resident's physical administrator state or state	was alerted to R1 being anxious ng. RN-A stated there had with another nurse about getting rations from the Ekit, however, anade to wait until R1's delivered from the pharmacy. In the started around 7:00 p.m., when or assessed R1 until around ass	F6	97			
	copy of R1's insurant misplaced. RN-D scopy from R1 and stated this was so stated it was the rethe insurance cardadmission. RN-D scopy from R1's insurance cardadmission.	6 p.m. RN-D verified the first ance card had been lost or stated they needed another sent it to the pharmacy. RN-D me time after 4:00 p.m. RN-D esponsibility of SW-A to send it to the pharmacy at the time of stated it may or may not have a delivery of R1's medications.					
	unable to pull R1's	9 p.m. the DON stated she was call light logs to review. The					

Facility ID: 00602

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		(X3) DATE SURVEY COMPLETED C	
	245414	B. WING _			/10/2021
			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHURCH STREET DULUTH, MN 55811	, ,	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
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	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From pa 6/4/21, at 9:30 p.m been saved. The E been pulled autom would be no ability unfortunately." A facility document Against Medical Ac 6/4/21, at 10:32 p.m not have been adn to care for me. No care was provided someone." R1's fa RN-A both signed The facility administrator sher ordered pain in and had not. The a have contacted the additional medicat mediation available On 6/10/21, at 4:18 director (MD)-A sta be given timely and resident's pain. M or any medication he would expect the physician to get fur include obtaining a	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 6/4/21, at 9:30 p.m. with his concerns had not been saved. The DON stated, "Call logs had been pulled automatically on 6/9/21, so there would be no ability to review (R1's) call logs unfortunately." 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245414	B. WING			C / 10/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3111 CHURCH STREET DULUTH, MN 55811		10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 697	services that will re- resident's pain to si practicable level of pharmacological ar- interventions asses utilized to provide n scaled of 1-10 is us follows: 0 is No pain Moderate, 8-9 is Se pain. The Physicia on the Pain Evaluat Physician will also be	cognize and manage a support his or her highest wellbeing. Both and non-pharmacological sed as appropriate will be naximum pain relief. If a pain red, it will be interrupted as an, 1-4 Mild pain, 5-7 is evere and 10 is Excruciating in will be notified of pain levels are it in a suppropriate. The per notified when pain persists treatment or if suspected	F6	97		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 29, 2021

Administrator Viewcrest Health Center 3111 Church Street Duluth, MN 55811

Re: State Nursing Home Licensing Orders

Event ID: 532811

Dear Administrator:

The above facility was surveyed on June 9, 2021 through June 10, 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

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Viewcrest Health Center June 29, 2021 Page 2

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

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. DOILDING.			
		00602	B. WING			0/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VIEWCR	EST HEALTH CENTE	R	RCH STREE MN 55811	:T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTENTION*****					
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surve found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Deputermination of with the Minnesota Deputerments of the corrected requirements of the number and MN Ruwhen a rule contain comply with any of lack of compliance.	hether a violation has been compliance with all rule provided at the tagule number indicated below. It is several items, failure to the items will be considered Lack of compliance upon				
	result in the assess	any item of multi-part rule will sment of a fine even if the item uring the initial inspection was				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	was conducted at y the Minnesota Dep	6/10/21, a complaint survey rour facility by surveyors from artment of Health (MDH). Your IOT found to be in compliance				
	The following comp	plaint was found to be				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 07/01/21

TITLE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00602	B. WING		06/4	0/2021
			l		06/1	0/2021
NAME OF I	PROVIDER OR SUPPLIER		RCH STREE	STATE, ZIP CODE : T		
VIEWCR	EST HEALTH CENTE	R	MN 55811	••		
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2 000	SUBSTANTIATED: H5414090C (MN73 issued at 4658.052 Minnesota Departm the State Licensing Federal software. To assigned to Minnesota Nursing Homes. The appears in the far-letted Tag." The state state listed in the "Summer column and replace the correction order the findings which a statute after the state as evidence by." For are the Suggested Time Period for Coryou have agreed to receipt of State lice the Minnesota Department of Heatyou electronically. In infobulletins/ib14 orders are delineated Department of Heatyou electronically. Is necessary for State enter the word "CO available for text. You electronic State lice the Minnesota Department of Department of Heatyou electronic State lice the Minnesota Department of Department of Heatyou electronic State lice the Minnesota Department of Department of Heatyou electronic State lice the Minnesota Department of Heatyou electron	as 564) Licensing orders were 0 Subp 1 0830 Then the of Health is documenting Correction Orders using an any state statutes of the assigned tag number efficient of the assigned tag number efficiencies of the column entitled "ID Prefix attute out of compliance is the "To Comply" portion of the state of	2 000			
1	PLEASE DISREGA	ARD THE HEADING OF THE				

Minnesota Department of Health

STATE FORM 532811 If continuation sheet 2 of 11

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7.1. 20125.1.10.				
		00602	B. WING		06/1	0/2021	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
VIEWCR	EST HEALTH CENTE	K	RCH STREE MN 55811	T			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 2	2 000				
		N OF CORRECTION." THIS RAL DEFICIENCIES ONLY.					
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			7/4/21	
	receive nursing care custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.					
	by: Based on interview facility failed to effermanagement for 1 of for acute post surgicactual harm to R1,	of 1 residents (R1) reviewed cal pain. This resulted in when R1's narcotic pain administered per orders		Corrected			
	Findings include:						
	indicated she was a diagnoses which in	cord printed on 6/10/21, admitted on 6/4/21, with cluded Atrioventricular the heart chamber) block					

Minnesota Department of Health STATE FORM

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:		С	
	00602				06/1	0/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VIEWCREST HEALTH CENTER 3111 CHUI DULUTH,			RCH STREE MN 55811	T		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	6/4/21, indicated Rerelated to recent part Bypass Graft (CAB staff for toileting, and and bed mobility. Findications, distract conversation. R1's indicated R1 was a was listed as alert at R1's hospital discharders dated 6/4/21 (Tylenol) tablet 325 tablets by mouth expain, and tramadol called an opioid for moderately severe hours as needed for discharge paperwork received Tylenol 10 Ultram 50 mg dose admitted to the faci R1's PRN (as need 6/4/21, indicated the -6/4/21, at 4:53 p.m. tablets by mouth was verbalized pain. The 9:43 p.m. as "unreliced to the state of the state	eakness. ine Care Plan initiated on 1's reason for admission was cemaker and Coronary Artery G). R1 was to have assist of 1 inbulation, toileting, bathing, Pain interventions included ice, etion, massage, and baseline care plan also fall risk. R1's mental status and orientated. arge and facility admitting, included acetaminophen milligrams (mg), take 1-2 very 6 hours as needed for (Ultram, narcotic medication use with moderate to pain) 50 mg tablet every 6 r pain. R1's hospital rk indicated R1 had last 00 mg dose at 9:50 a.m. and at 8:12 a.m. prior to being lity. ed medication) Report dated e following: a. acetaminophen 325 mg, 2 as administered to R1 for e result was documented at eved" by medication. a. acetaminophen 325 mg, 2 liministered to R1 for in at a level of 10/10. At 12:06	2 830	DEFICIENCY)		
	a.m. the result was by medication.	documented as "unrelieved"				

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED	
00602 B. WING					C 10/2021	
VIEWCREST HEALTH CENTER 3111 CHU		DRESS, CITY, S RCH STREE MN 55811	STATE, ZIP CODE T			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	-6/4/21, at 10:16 p.I administered to R1 level 10/10. The res as "unknown," as R medical advice (AM R1's Vital Sign reco electronic health reindicated R1's pain was 9/10 (on a scal pain and 10 being e 10/10, and at 10:16 On 6/10/21, at 12:0 and stated she had went home. R1 stat the following mornin R1 stated she did n prepared to take a stated she arrived a 11:00 a.m. and RN-admission paperwo she arrived, her par to see her. R1 states staff had stopped h make a copy of her medications. R1 stated she conta her a photo of the cemail to RN-C with was asked if she had a card, R1 stated she had a vulnerable as she had a vulnera	m. tramadol 50 mg tablet for verbalized acute pain at a sult was documented by RN-A thad left the facility against IA). ord reviewed from the cord (EHR) dated 6/4/21, level on 6/4/21, at 9:42 p.m. e of 1-10 with 1 being mild excruciating pain), at 9:47 p.m. p.m. 10/10. 2 p.m. R1 was interviewed left the facility on 6/4/21, and ted she went to the hospital and and been readmitted. ot believe the facility had been patient post coronary care. R1 at the facility on 6/4/21, around B had completed the ork with her. R1 stated after rents and husband had come ed at the entrance, an office er husband and requested to insurance card for her ated RN-C had come to her vening stating that the facility by of her insurance card ne first copy that was made. acted her husband who sent eard, and she forwarded an the information. R1 stated she ad more than one insurance y had one insurance card for	2 830			

Minnesota Department of Health

STATE FORM 532811 If continuation sheet 5 of 11

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					С	
	00602		B. WING		06/1	0/2021
			STATE, ZIP CODE			
VIEWCREST HEALTH CENTER 3111 CHUR DULUTH, M			T			
(V4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 830	Continued From pa	ge 5	2 830			
2 830	been brought to her room, even though she had placed her call light on numerous times for assistance with toileting and pain management. R1 stated at one point, her call light had been on for over 90 minutes at which time an unidentified female staff came in, shut her call light off. R1 asked her for her pain medications. R1 stated the staff said she would check, but she never saw her again. R1 stated a little before 10:00 p.m. one of the staff did come and administer Tylenol, but by that time she was crying in pain. R1 stated she had told the staff no one had been to her room, and she felt like she was all alone. R1 stated at that time she called FM-A to tell him to come and get her. R1 stated FM-A arrived around 10:30 p.m. and around that time, RN-A brought her the tramadol pain medication with her other bedtime medications. R1 stated she had been in pain throughout her entire stay. R1 further stated when her call light was not being answered, she had called the other facility numbers she was given at the time of admission on the telephone, however, the staff had not answered any of those calls. A facility pharmacy delivery Packing Slip dated 6/4/21, indicated at 11:04 p.m. medications were delivered to the facility from the pharmacy. R1's medication was included in the delivery which included her tramadol (Ultram) 50 mg tablet pain medication. Registered nurse (RN)-A was noted		2 830			
	On 6/9/21, at 3:56 p facility administrato p.m. RN-A had rece 10:30 p.m. that FM- and wanted to take regarding the risk v	che medication delivery. c.m. a progress note by the r indicated on 6/4/21, at 10:16 eived a phone call around -A had shown up to the facility R1 home. RN-A educated R1 erse benefit of leaving the still decided to leave the				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

Minnesota Department of Health						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		00602	B. WING			0/2021
		00002			00/1	0/2021
NAME OF PROVIDER OR SUPPLIER STREET AN			DRESS, CITY, S	STATE, ZIP CODE		
3111 CHUE		RCH STREE	т			
VIEWCREST HEALTH CENTER DULUTH, N						
0(4) 15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		()(5)
(X4) ID PREFIX	_	/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
2 830	Continued From pa	ge 6	2 830			
2 000	Continued From pa	ge o	2 030			
	On 6/9/21, at 4:12 p	o.m. a progress note by RN-B				
	indicated on 6/4/21	, per RN-A, R1 was given 650				
	mg of Tylenol per h	er request at 4:45 p.m. Staff				
	mg of Tylenol per her request at 4:45 p.m. Staff reported to RN-A at 9:45 p.m. that R1 was having					
	a panic attack, was hyperventilating, and was					
	speaking with FM-A via telephone regarding					
	leaving the facility. R1 stated that she did not					
	think she should have left the hospital. R1 was					
	then offered another dose of Tylenol which R1					
		on returning to the cart to				
	prepare the Tylenol					
		st been delivered by the				
		time, RN-A reported she				
		ed tramadol and other bedtime				
		inistration. An ice pack was				
		. R1 continued to panic and				
		-A discussed with R1 the				
		MA, and encouraged R1 to				
		y to recover from her surgery.				
		d she had not been using her				
		not want to be a bother. Per				
		e was scared and she was too				
	,	acility, "This is all too much for				
		he facility administrator. FM-A				
		y around 12:03 a.m. to pick up				
		vehicle. R1 was encouraged to				
		cy room (ER) with any increase				
		arted to feel worse or did not				
	feel as though she	was improving.				
	0.0/40/04 40.00	DN Daniel Control				
		a.m. RN-B was interviewed				
		oleted R1's admission				
		/21. RN-B stated earlier that				
		noted to be grimacing and				
		5/10. RN-B stated he had				
		ause the tramadol had not				
		the pharmacy at that time.				
		clined the Tylenol, but did				
	accept an ice pack.	RN-B confirmed the facility				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
						С	
NAME OF DROVIDED OR SUPPLIED			B. WING		06/1	0/2021	
				STATE, ZIP CODE			
VIEWCREST HEALTH CENTER 3111 CHUF DULUTH, I				:I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 830	had available an stemedications which RN-B stated a pain showing nonverbal grimacing should haccess medications (Ekit). RN-B confinitramadol pain medithat time, nor did he RN-B further stated her pain at 9/10 statramadol from the form of 6/10/21, at 10:2 interviewed and states message detailing 6/4/21. The adminisinvestigation had not administrator stated light logs to verify if times. On 6/10/21, at 10:4 working the night RN-A stated she wand hyperventilating been discussion wir R1 her pain medicated the decision was medications were considered pain at a leanurse, she would medication effective medication eff	ock emergency(Ekit) supply of included a supply of tramadol. level of 5/10 in addition to signs of pain such as ave signaled a reason to sout of the emergency kit med he did not offer the cation to R1 from the Ekit at the reassess R1 for pain relief. If he felt if R1 had been rating off should have accessed the	2 830				

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STATE FORM 532811 If continuation sheet 8 of 11

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
						С	
		00602	B. WING		06/1	0/2021	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
VIEWCREST HEALTH CENTER DULUTH, I		RCH STREE MN 55811	ET .				
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 830	the resident's physical administrator stated cause anxiety and resident at risk. The her understanding included with the fir delivery because F wrong insurance can on 6/10/21, at 1:26 copy of R1's insural misplaced. RN-D scopy from R1 and stated this was son stated it was the rethe insurance card admission. RN-D scaffected the timely on 6/10/21, at 2:29 unable to pull R1's DON further stated 6/4/21, at 9:30 p.m been saved. The Dcap been pulled automa would be no ability unfortunately." A facility document Against Medical Adcaptage for me. No care was provided someone." R1's far RN-A both signed to the residence of the residenc	ould expect the staff to contact ician or pharmacy. The d uncontrolled pain could increase heart rate, and put a e administrator stated it was R1's medication had not been st pharmacy medication M-A had given the facility the	2 830				
	On 6/10/21, at 2:42	? p.m. during further follow up,					

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STATE FORM 532811 If continuation sheet 9 of 11

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE VIEWCREST HEALTH CENTER OULUTH, MN 55811 CAJ ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 9 The administrator stated R1 should have received her ordered pain medications to manage her pain and had not. The administrator stated staff should have contacted the on-call physician to obtain additional medication orders, and/or use mediation available in the facility Ekit. On 6/10/21, at 4:18 p.m. the facility medical director (MD)-A stated pain medications were to be given timely and as ordered to control resident's pain. MD-A stated if a pain medication or any medication was needed and not available, he would expect the facility to contact the on-call physician to get further instructions which may include obtaining an alternative medication or using the supply of medication from the facility Ekit. MD-A stated it was not acceptable to have a		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
NAME OF PROVIDER OR SUPPLIER 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 TAG CONTINUED FROM THE APPROPRIATE DATE 2 830 Continued From page 9 the administrator stated R1 should have received her ordered pain medications to manage her pain and had not. The administrator stated staff should have contacted the on-call physician to obtain additional medication orders, and/or use mediation available in the facility Ekit. On 6/10/21, at 4:18 p.m. the facility medical director (MD)-A stated pain medications were to be given timely and as ordered to control resident's pain. MD-A stated if a pain medication or any medication was needed and not available, he would expect the facility to contact the on-call physician to get further instructions which may include obtaining an alternative medication or using the supply of medication from the facility Ekit. MD-A stated it was not acceptable to have a						1		
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resident rate pain at 5/10, 9/10 or 10/10 and not seek alternative medications. The facility policy Pain Management Policy undated, directed the facility will provide care and services that will recognize and manage a resident's pain to support his or her highest practicable level of wellbeing. Both pharmacological and non-pharmacological interventions assessed as appropriate will be utilized to provide maximum pain relief. If a pain scaled of 1-10 is used, it will be interrupted as follows: 0 is No pain, 1-4 Mild pain, 5-7 is Moderate, 8-9 is Severe and 10 is Excruciating pain. The Physician will be notified of pain levels on the Pain Evaluation, as appropriate. The Physician will also be notified when pain persists or reoccurs despite treatment or if suspected adverse consequence are noted. The director of nursing (DON) or designee, could develop or revise policies/procedures to related to	2 830	the administrator sther ordered pain mand had not. The and have contacted the additional medication mediation available. On 6/10/21, at 4:18 director (MD)-A state be given timely and resident's pain. More any medication whe would expect the physician to get furninclude obtaining an using the supply of Ekit. MD-A stated is resident rate pain a seek alternative medicated, directed the services that will reresident's pain to suppracticable level of pharmacological arinterventions assessutilized to provide medicated of 1-10 is us follows: 0 is No pain Moderate, 8-9 is Sepain. The Physicia on the Pain Evaluated Physician will also for reoccurs despite adverse consequer.	rated R1 should have received edications to manage her pain dministrator stated staff should on-call physician to obtain on orders, and/or use in the facility Ekit. I. p.m. the facility medical ted pain medications were to as ordered to control O-A stated if a pain medication was needed and not available, a facility to contact the on-call ther instructions which may alternative medication or medication from the facility to was not acceptable to have a to 5/10, 9/10 or 10/10 and not edications. ain Management Policy he facility will provide care and cognize and manage a support his or her highest wellbeing. Both hid non-pharmacological used as appropriate will be naximum pain relief. If a pain sed, it will be interrupted as an, 1-4 Mild pain, 5-7 is evere and 10 is Excruciating an will be notified of pain levels tion, as appropriate. The per notified when pain persists a treatment or if suspected ance are noted.	2 830				

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Minnesota Department of Health
STATE FORM

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				С		
		00602	B. WING	G 06/10/2021		0/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VIEWCREST HEALTH CENTER 3111 CHUI DULUTH,		MN 55811	iT			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 10	2 830			
	The DON or design implementation of t	nee could train staff in he policies and plan of care. nee could perform audits to				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

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