DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 12, 2022

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

RE: CCN: 245414
Cycle Start Date: March 31, 2022

Dear Administrator:

On April 11, 2022, we notified you a remedy was imposed. On May 9, 2022 the Minnesota Department of Health 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 April 29, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 11, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 11, 2022, 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 May 11, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 29, 2022, 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 Therefore, the NATCEP prohibition is rescinded.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, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 12, 2022

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

Re: Reinspection Results
Event ID: 9HC712

Dear Administrator:

On May 9, 2022 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 May 9, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
April 11, 2022

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

RE: CCN: 245414
Cycle Start Date: March 31, 2022

Dear Administrator:

On March 31, 2022, a survey was completed at your facility by the Minnesota Department of Health 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 delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 11, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 11, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 11, 2022.

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.

This Department is also recommending that CMS impose:

• 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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 11, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Viewcrest Health Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 11, 2022.. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. 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.

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 September 30, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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:

Tamika.Brown@cms.hhs.gov

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 (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division

P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	C 03/31/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS From 3/30/22, to 3/31/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5414100C (MN 00080222), with deficiencies cited at F580, and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		4/29/22

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

Electronically Signed | 04/21/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 580	It is the policy of Viewcrest Health Care	

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F 580	Continued From page 2 failed to notify family of a urinary tract infection (UTI) and antibiotic use for 1 of 3 residents (R1) reviewed for notification of change. Findings included: R1's face sheet printed 3/31/22, indicated diagnoses that included unspecified dementia with behavioral disturbances, benign prostatic hyperplasia (BPH) with lower urinary tract symptoms and other retention of urine. R1's quarterly Minimum Data Set (MDS) from 12/29/21, indicated indwelling foley catheter due to benign prostatic hyperplasia (BPH) and retention of urine. R1's physician orders indicated on 12/17/21, orders for a metabolic panel and start Bactrim DS 800-160mg per peg tube 2 times daily for UTI. Notify provider if culture returns sensitivity. A concern from FM-A dated 1/14/22, indicated FM-A approached facility staff and asked if R1 had a urinary tract infection (UTI) because of not feeling well. Staff told FM-A that R-1 did not have a UTI. FM-A's concern indicated FM-A spoke with the nurse manager later that day and was informed R1 did have a UTI and had been treated for UTI with antibiotics a few days already. FM-A's concerns indicated they were not made aware prior to this. R1's medical record lacked indication R1's family/health care agent was notified of the UTI, symptoms or antibiotic use. On 3/31/22, at 10:02 a.m., registered nurse (RN)-A reviewed R1's medical record and stated	F 580	Center to ensure that resident representatives are notified of all changes in condition along with the resident's physician. The facility policy on Change in Condition was reviewed and remains appropriate. R1 is no longer a resident in the facility. All other residents in the building may be impacted by this practice. All licensed nursing staff will be re-educated on the change in condition policy and procedure. The Director of Nursing (DON) or designee will audit resident records to ensure notifications have occurred per the policy. Audits will be conducted a minimum of twice weekly for four weeks then weekly for three months. Results of all audits will be reviewed by the facility Quality Assurance Performance Improvement Committee	

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F 580	Continued From page 3 there were no notes indicating R1's family had been notified of the UTI, symptoms or antibiotic usage. On 3/31/22, at 11:19 a.m., the administrator reviewed R1's medical record and stated that there was no documentation showing R1's family was notified of the UTI, symptoms or antibiotics. The administrator stated there was an expectation that staff notify family members when the is a resident change of condition such as UTI or antibiotic use. The facility policy Notification of Significant changes dated 9/29/17, and reviewed/revised on 1/17/19, defined a significant change as a change to resident's status, a need to alter treatment, an accident that resulted in injury, or a decision to transfer or discharge the individual receiving services from the care center. The policy indicated the charge nurse would immediately inform the resident, consult with the physician, and notify the resident's representative for significant change situations including a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment.	F 580		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		4/29/22

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F 880	Continued From page 4 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 5 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper perineal care and hand hygiene and glove use were followed/maintained for 1 of 1 resident (R2) observed during personal cares. In addition, the facility failed to ensure proper eye protection was worn by staff working in resident care areas. Findings include: R2's Face Sheet printed 3/31/22, identified diagnoses that included spastic quadriplegic (severe form of cerebral palsy) cerebral palsy (a congenital disorder of movement, muscle tone, or posture), depressive disorder, anxiety disorder, muscle weakness, and abnormal posture. R2's quarterly Minimum Data Set (MDS) dated 3/8/22, indicated R2 was cognitively intact, and required extensive assistance with activities of	F 880	It is the policy of Viewcrest Health Care Center to ensure that residents are provided with a safe, sanitary comfortable environment that helps prevent the transmission of communicable diseases and infections. The following policies were reviewed and remain current; Infection control and prevention program, hand hygiene, perineal cares and Coronavirus prevention screening and detection. R2 remains in the building in good health with no noted infection or skin impairment. All residents in the facility may be impacted by this practice. All facility staff will be re-educated on the use of eye protection per current recommendations. All facility staff will be tested on hand washing competency through return demonstration. In addition all nursing staff who provide direct	

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F 880	Continued From page 6 daily living (ADLs). R2's MDS indicated she was frequently incontinent of bladder and always incontinent of bowel. R2's care plan dated 8/10/21, indicated R2 was dependent on staff to provide all grooming/hygiene tasks. R2's care plan further indicated R2 was at risk for bladder and bowel incontinence. R2's care card (nursing assistant care guide) dated 3/24/22, indicated R2 would call and needed toileting upon waking to void and defecate. On 3/30/22, at 10:03 a.m. until 10:40 a.m. R2 was continuously observed. R2 rang her call light, nursing assistant (NA)-A entered the room, she was not wearing eye protection and placed R2 on a bed pan. R2 was given the call light and the head of the bed was raised, NA-A left to give R2 privacy. On 3/30/22, at 10:14 a.m. R2 called again, said she couldn't go. NA-A put gloves on and removed the bed pan. There was a small amount of soft brown stool in R2's rectal area, none in the bedpan. NA-A changed her gloves and wiped R2's perineal area from the front, there stool was on the wash cloth; NA-A folded the wash cloth and wiped the front of R2's perineal area again. NA-A then left to get more assistance. On 3/30/22, at 10:19 a.m. NA-A returned with NA-B, NA-B was not wearing eye protection. NA-A and NA-B rolled R2 on her left side and NA-A took a new wash cloth and wiped R2's rectal area five times with the same wash cloth, NA-A kept folding the wash cloth over and	F 880	personal cares will be competency tested on providing perineal care with proper infection control practices. Per the directed plan of correction the facility will conduct a root cause analysis via the Quality Assurance Performance Improvement Committee (QAPI) on 4/25/22. The facilities Infection Preventionist will review all aspects of the facility infection control program with the facility medical director. All staff will be educated on this plan along with education for residents and their families. The DON or designee will conduct infection control audits to include proper hand hygiene and use of ppe including eye protection every day for one week on all shifts until compliance is met. Frequency will be decreased to four times per week on all shifts, then twice weekly for one week once compliance is met. Audits will continue until 100% compliance is met. The results of all audits will be reviewed by the facility QAPI committee. The DON or designee will also audit perineal cares a minimum of five times per week for four weeks then, weekly for one month until compliance with infection control in relation to personal cares is achieved. Returning with attached documents.	

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	245414	A. BUILDING _____ B. WING _____	C 03/31/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 7	F 880		

re-using the wash cloth in the rectal area to clean stool. NA-A dried R2's perineal area with a towel. NA-A and NA-B removed their gloves, did not perform hand hygiene and dressed R2. Next they put R2's foot braces on, lifted her from her bed to her wheelchair using a mechanical lift, NA-B then left the room. When NA-A had completed cares, she removed her gloves; no hand hygiene was performed.

On 3/30/31, at 2:00 p.m. NA-A verified she re-used a wash cloth with stool on it to wipe R2's perineal area several times and stated it was not a good practice to keep using the same wash cloth with stool on it. NA-A verified she did not perform hand hygiene after each glove change. NA-A verified she had not been wearing eye protection while she provided care for R2. NA-A stated she was unclear about when she needed to wear eye protection. NA-A stated sometimes there were notices up in the break room about eye protection (she was unclear about what these signs directed staff to do regarding eye protection). NA-A stated there were not any current notices posted. NA-A stated no one at the facility had told her she needed to wear eye protection.

On 3/30/22, at 9:47 a.m. housekeeper (H)-A was observed cleaning resident rooms, he was wearing eye glasses, no eye protection. H-A stated he was told when he started that his eye glasses were sufficient protection.

On 3/30/22, at 9:52 a.m. NA-B was observed in a patient care area wearing eye glasses, no eye protection. NA-B stated she had been told she needed to wear eye protection and said they were in her locker and she needed to go get them.

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F 880	Continued From page 8 On 3/30/22, at 10:01 a.m. dietary aide (DA)-A was observed in a resident care area. DA-A was not wearing any eye protection. DA-A stated he did not need to wear any eye protection because he didn't work with residents. On 3/30/21, at 1:53 p.m. NA-A was not wearing eye protection and was in a resident care area. On 3/30/22, at 4:10 p.m. the administrator verified she expected staff to wear eye protection when they were in resident care areas. On 3/31/22, at 10:14 a.m. registered nurse (RN)-B verified he would expect staff to get a new wash cloth to use if there was stool on the wash cloth to prevent a urinary tract infection when providing perineal care and wiping front to back. RN-B verified he would expect staff to wash their hands with soap and water after glove removal following perineal cares that involved stool. RN-B verified staff are expected to wear eye protection when they are in resident care areas. On 3/31/22, at 10:41 a.m. the assistant director of nursing (ADON) verified she would expect staff to use a new wash cloth anytime the wash cloth had stool on it. The ADON also verified she would expect all staff to wear eye protection when they were in resident care areas. The facility policy titled Perineal Care dated 7/2015, directed staff to clean the perineal area from front to back to prevent contamination from rectal area to urethra. Repeat as needed using a clean part of washcloth each time or a new washcloth if it becomes soiled. The policy further directed staff to wash hands at the end of the	F 880		

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F 880	Continued From page 9 procedure. The facility policy titled Hand Hygiene dated 5/8/17, directed staff to wash hands after glove removal. The facility policy titled Coronavirus Prevention, Screening, and Identification revision date 2/11/22, directed staff to wear a mask and eye protection (sides on eye glasses is not acceptable) in all resident areas during working hours.	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 11, 2022

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

Re: State Nursing Home Licensing Orders
Event ID: 9HC711

Dear Administrator:

The above facility was surveyed on March 29, 2022 through March 31, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: _____ B. WING _____	C 03/31/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: From 3/30/22, to 3/31/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5414100C (MN00080222) with licensing order issued at 0265. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		4/29/22

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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to notify family of a urinary tract infection (UTI) and antibiotic use for 1 of 3 residents (R1) reviewed for notification of change. Findings included: R1's face sheet printed 3/31/22, indicated diagnoses that included unspecified dementia with behavioral disturbances, benign prostatic hyperplasia (BPH) with lower urinary tract symptoms and other retention of urine. R1's quarterly Minimum Data Set (MDS) from 12/29/21, indicated indwelling foley catheter due to benign prostatic hyperplasia (BPH) and retention of urine. R1's physician orders indicated on 12/17/21, orders for a metabolic panel and start Bactrim DS 800-160mg per peg tube 2 times daily for UTI. Notify provider if culture returns sensitivity. A concern from FM-A dated 1/14/22, indicated FM-A approached facility staff and asked if R1 had a urinary tract infection (UTI) because of not feeling well. Staff told FM-A that R-1 did not have a UTI. FM-A's concern indicated FM-A spoke with the nurse manager later that day and was informed R1 did have a UTI and had been treated for UTI with antibiotics a few days already. FM-A's concerns indicated they were not made aware prior to this.	2 265	Corrected	

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2 265	Continued From page 4 R1's medical record lacked indication R1's family/health care agent was notified of the UTI, symptoms or antibiotic use. On 3/31/22, at 10:02 a.m., registered nurse (RN)-A reviewed R1's medical record and stated there were no notes indicating R1's family had been notified of the UTI, symptoms or antibiotic usage. On 3/31/22, at 11:19 a.m., the administrator reviewed R1's medical record and stated that there was no documentation showing R1's family was notified of the UTI, symptoms or antibiotics. The administrator stated there was an expectation that staff notify family members when the is a resident change of condition such as UTI or antibiotic use. The facility policy Notification of Significant changes dated 9/29/17, and reviewed/revised on 1/17/19, defined a significant change as a change to resident's status, a need to alter treatment, an accident that resulted in injury, or a decision to transfer or discharge the individual receiving services from the care center. The policy indicated the charge nurse would immediately inform the resident, consult with the physician, and notify the resident's representative for significant change situations including a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop, review, and/or revise policies and procedures to ensure residents/family representatives/physicians are notified of a change in condition or treatment, educate all	2 265		

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2 265	Continued From page 5 appropriate staff on the policies and procedures, and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		