Electronically delivered September 3, 2020

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

RE: CCN: 245414
Cycle Start Date: August 13, 2020

Dear Administrator:

On August 13, 2020, 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 actual harm that was not immediate jeopardy (Level G), 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 September 18, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 18, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 18, 2020.

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 $11,160; 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 September 18, 2020, 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 September 18, 2020. 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" tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor

Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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 February 13, 2021 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.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	C 08/13/2020

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

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F 000	INITIAL COMMENTS On 8/10/20, through 8/13/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5414066C and H5414067C. The following complaints were found to be unsubstantiated: H5414068C and H5414069C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate	F 622		9/18/20

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

Electronically Signed | 09/11/2020

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F 622	Continued From page 1	F 622		

because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's

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F 622	Continued From page 2 medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to communicate a resident's current	F 622	It is the policy of Viewcrest Health Care Center to ensure that all residents are	

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F 622	Continued From page 3 status on discharge to the receiving facility for 1 of 4 residents (R200) reviewed for admission, transfer, and discharge. Findings include: R200's Face Sheet printed 8/13/20, indicated R200 was admitted to the facility on 7/1/20, and diagnoses included squamous cell carcinoma of skin of scalp and neck, edema (swelling caused by excess fluid trapped in your body's tissues), diabetes, and anemia. R200's General Nurse's Observation (GNO) dated 7/7/20, indicated R200 was at low risk for skin breakdown, developed redness on the spine after lying for 5 hours, and on the coccyx (tailbone) after 3 hours of sitting. R200 areas of dry, flaky skin with areas of thin skin, and had areas of bruising and a cancerous lesion on his head. In addition, R200 had edema of both lower extremities with compression stockings. R200's GNO notes did not document any open lesions on R200's right shin. R200's care plan dated 7/16/20, indicated R200 was at risk for skin breakdown related to decreased mobility, and had an impaired skin integrity with an open area, lacked identification of location of skin impairment. R200's Skin Condition Report With Images dated 7/1/20, indicated R200 had bruises on arms, legs and head, and a cancerous lesion on his head. R200's Skin Condition Report With Images dated 7/8/20, indicated R200 had a cancerous lesion on his head. R200's skin report lacked any indication of skin concerns on R200's right shin.	F 622	discharged with the appropriate documentation as well as ensuring the receiving facility or agency receives appropriate documentation of the discharge plan of care. Resident R200 was discharged from the facility on 7/30/2020. All residents who discharge from the facility have the potential to be impacted. The facility discharge planning policy as well as the discharge plan of care document were reviewed and remain appropriate. The facility RN Manager who discharged R200 was provided re-education on the need to complete all sections of the discharge plan of care including the skin assessment prior to discharge on 9/11/2020. All RN managers were given education on the discharge planning process, including completing a skin assessment prior to discharge and documenting the skin condition upon discharge. The Director of Nursing or designee will audit all discharge transfer records for one month, then 50% of discharges for three months to ensure compliance discharge documentation of skin condition. Results of all audits will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI).	

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F 622	Continued From page 4 R200's Skin Condition Report With Images dated 7/10/20, lacked lacked any indication of skin concerns on R200's right shin. R200's Skin Condition Report With Images dated 7/21/20, indicated R200 continued with a cancerous lesion on his head, but lacked any indication of skin concerns on R200's right shin. A complaint filed with the State Agency (SA) indicated R200 arrived at the receiving facility on 7/30/20, with an open area on the right shin measuring 2.5 inches by 1.5 inches, with a necrotic area, and yellow, draining tissue. In addition, R200 had edema of both his legs, and did not have compression stockings on (stockings used to decrease edema). R200's initial care conference note dated 7/15/20, indicated R200 would be discharged to an assisted living facility which had an opening in one to two weeks. R200's care conference note indicated R200 had a few bruises, a cancerous lesion on his head, along with compression stockings or Tubigrips to his legs. R200's progress notes dated 7/23/20, indicated R200 was to be discharged to an assisted living on 7/30/20. R200's progress notes from 7/23/20, through 7/30/20, lacked documentation of any skin assessments or skin conditions. R200's GNO started 7/29/20, indicated R200's body check for skin conditions was not completed.	F 622		

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F 622	Continued From page 5	F 622		

R200's Post Discharge Plan of Care signed by registered nurse (RN)-B and dated 7/30/20, lacked documentation of R200's current skin condition.

R200's nurse practitioner signed Resident Transfer Sheet dated 7/29/20, with data for the seven days prior to 7/28/20, indicated R200 had bruises on his arms and on his left thigh, with a cancerous lesion on the scalp, though did not indicate the date of the skin observations. R200's Resident Transfer Sheet further indicated R200 had compression stocking to lower extremities to be put on in the a.m. and off in the p.m., and an ointment for wound care.

The skin documentation received by the assisted living facility on 7/30/20, indicated R200's right shin open area was not documented, and not communicated to the assisted living.

The photos of R200's right shin dated 7/30/20, the date of his discharge from the facility and admission to the assisted living facility, indicated R200 had a large ulceration on the right shin with some depth, irregular edges, and moist tissue with a possible darker area near the upper edge, yellow draining tissue on the lower edge, with light erythema (redness) on the lateral edge. R200 had swollen lower legs with dry, scaly skin. R200 further had a dark linear dark area between the open area and knee.

On 8/13/20, at 12:54 p.m. R200's resident representative (RR)-C was interviewed by phone. RR-C stated R200 was treated well at the facility, but when he transferred to the assisted living, he was found to have an ulcer on his right shin that was draining. RR-C stated the information

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regarding R200's ulcer was not included on the transfer form, and she had not been notified of the area.

On 8/13/20, at 1:27 p.m. nursing assistant (NA)-C stated she had worked with R200, and was not aware of any sores, other than on his head.

On 8/13/20, at 2:22 p.m. RN-A stated she had not been notified of an ulceration of R200's skin. RN-A stated they had been called by the assisted living facility about the wound on his leg the day of discharge, had reviewed R200's documentation, and did not find any documentation of a wound on R200's shin. RN-A verified R200's skin status and documentation should be noted on the post discharge plan of care and was not. RN-A verified R200's head wound should have been documented on the form, and was not. RN-A further stated a skin assessment should have been done prior to discharge.

On 8/13/20, at 2:45 p.m. RN-B stated she had been filling in for the RN manager on R200's unit that day, and did not know the resident. RN-B verified she did not do a skin assessment, and did not know if R200 had any wounds, other than the wound on his head. RN-B stated she did not fill out the discharge plan of care, and she just signed it. RN-B stated she should have put the status of the skin on the form, even if it was clear. RN-B stated the assisted living facility had called about a wound, so she checked documentation, and asked staff. Staff did not remember a wound on R200's shin when they got him dressed.

On 8/13/20, at 3:03 p.m. the director of nursing (DON) verified skin status should be included on

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F 622	Continued From page 7 the post discharge plan of care, and verified it was not documented on R200's form. The DON stated skin should be checked before discharge. On 8/14/20, at 9:50 am. assisted living facility director (ALD) stated she was very concerned about R200's skin condition on his shin when he arrived at their facility. ALD stated the nurse looked at him right when he got there, and found a "Stage 3 diabetic ulcer" on his shin with yellow, draining tissue, and necrosis in the center. ALD stated RR-C was an RN, and was very upset by it, stating it was neglect. ALD stated R200's skin status was not communicated to the facility. ALD stated R200 was being seen by wound care, and was healing well. ALD stated R200 did not have compression stockings on either, and his legs were very swollen. The facility policy Discharge Planning reviewed/amended 1/17, directed nursing to complete a discharge plan of care with a final summary of the resident 's status at the time of discharge, with an assessment of the resident, and provided to the facility receiving services.	F 622		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		9/18/20

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F 686	Continued From page 8 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement identified pressure relieving intervention of repositioning for 1 of 3 (R201) residents who was at risk for developing pressure ulcers. Findings include: R201's Face Sheet printed 8/13/20, indicated R201's diagnoses included Parkinson's disease (progressive nervous system disorder that affects movement), diabetes mellitus type 2, and low back pain. R201's quarterly Minimum Data Set (MDS) dated 7/17/20, indicated R201 was cognitively intact and had no rejection of cares during the assessment period. The MDS further identified R201 required one person assist for bed mobility, toileting, and two assist for transfers. The MDS indicated R201 was at risk for pressure ulcers, had no current pressure ulcers, or other identified skin concerns . The MDS indicated R201 had pressure relief devices in chair and mattress, and was treated with topical medications. R201's care plan revised 8/12/20, identified R201 was at risk for skin breakdown and was incontinent of urine. R201's care plan revealed R201 required physical assistance of two staff for turning and repositioning, and required every two hour toileting R201's care plan directed staff to re-approach R201 if he refused toileting or	F 686	It is the policy of Viewcrest Health Care Center to ensure that all residents receive the necessary care and services prevent and treat pressure ulcers. The facility Skin Ulcer Protocol was reviewed and remains appropriate. Resident R201 is a current resident in the facility. On 8/11/20 at 105pm the facility wound care nurse conducted a skin assessment after completing cares and the resident was noted to have blancahable redness to her coccyx, no sign of skin impairment was noted. The resident's skin remains intact with no noted pressure ulcers. A new Tissue Tolerance Assessment and comprehensive skin risk assessment will be completed to ensure the appropriate turning and repositioning program is in place. The resident is also noted to refuse toileting and repositioning at times, facility will review a risk versus benefit with the R201. The nursing assistant that worked with R201 on 8/11/20 has been out of work on an LOA, she will be re-educated upon her return. All residents who are at risk for pressure ulcers and require assistance with turning and repositioning could be impacted by this practice. All at risk residents will be identified and reviewed for any necessary changes to their current repositioning program. All nursing staff will be provided with education on the need to reposition	

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F 686	Continued From page 9 repositioning. R201's nursing assistant care sheet printed 8/10/20, directed staff to turn and reposition R201 every two hours, and toilet R201 at 8:00 a.m. to void, 8 p.m. for BM and every two hours. R201's Tissue Tolerance (TT, an assessment of how long of an interval the resident can tolerate for lying or sitting) dated 2/28/20, indicated R201's coccyx developed a non-blanchable reddened area after 2 hours of lying, and sitting. On 8/11/20, at 9:47 a.m. nursing assistant (NA)-A exited R201's room with a bag of soiled linens and garbage and verbalized to NA-B, R201 was repositioned, changed and washed up for the morning and planned to get her up soon in her recliner chair. -9:51 a.m. NA-A entered R201's room and delivered a fresh cup of ice water and exited the room. R201 was not offered toileting or repositioning, and remained in her bed lying on her back. -10:34 a.m. the director of nursing (DON) entered R102's room, talked with R201 for a few minutes and exited the room. R201 was not offered toileting or repositioning, and remained in her bed lying on her back. -11:37 a.m. staff entered R201's room and delivered meal tray and apologized for lunch being late, set up meal tray and exited the room. R201 was not offered toileting or repositioning, and remained in her bed lying on her back. -11:42 a.m. NA-A entered R201's room and delivered a piece of cake, set up chips and salsa per R201's request and exited the room. R201 was not offered toileting or repositioning, and remained in her bed lying on her back.	F 686	and toilet residents per their plan of care. The Director of Nursing (DON) or designee will audit repositioning schedules for all residents with pressure ulcers and a minimum of four at risk residents weekly x4 weeks then monthly x3 months to ensure compliance. Results of all audits will be reviewed by the facility Quality Assurance Performance Improvement Committee (QAPI).	

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-12:20 p.m. the activities director (AD) entered R201 room and talked about a beautician appointment, scheduling time to see R201's significant other, and exited the room. R201 was not offered toileting or repositioning, and remained in her bed lying on her back.
-12:30 p.m. the AD entered R201's room and notified R201 they were arranging a video chat with her significant other and exited the room. R201 was not offered toileting or repositioning, and remained in her bed lying on her back
-12:40 p.m. the AD entered R201's room and set up the IPad for a video chat with R201's significant other and exited the room. R201 was not offered toileting or repositioning, and remained in her bed lying on her back.
-1:00 p.m. the AD entered R20's room and waited for R201 to finish her video chat and exited the room. R201 was not offered toileting or repositioning, and remained in her bed lying on her back.
-1:05 p.m. the assistant director of nursing (ADON) and DON entered R201's room to reposition and assess R201's skin per surveyors request. R2 was remained lying on her back.

R201 was not offered toileting or repositioning, and remained in her bed lying on her back from 9:47 a.m. to 1:07 p.m.

On 8/11/20, at 12:28 p.m. NA-A stated she repositioned and changed R201 at 9:20 a.m. NA-A viewed her nursing assistant care sheet that she kept in her pocket and stated R201 was to be turned and repositioned every two hours, and toileted at 8 a.m. to void and 8 p.m. for BM, and every two hours. NA-A stated she was late on repositioning R201 because it had been a busy morning and planned to get R201 up soon in

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her recliner chair. NA-A proceeded to go into another resident's room with the mechanical lift and did not provide repositioning to R201 following the interview.

On 8/11/20, at 12:37 p.m. NA-B stated residents toileting times were documented on the toileting log kept at the nursing desk. NA-B stated according the toileting log, it was documented R201 was last toileted at 9:20 a.m.

On 8/11/20, at 12:53 a.m. assistant director of nursing (ADON) was notified surveyor had completed continuous observations of R201, R201 had not been repositioned since 9:20 a.m., and R201's skin needed to be assessed by a RN. RN went to find staff to assist with repositioning R201 so she could check her skin.

On 8/11/20, at 1:05 a.m. upon entrance, R201 was observed lying on her back on her IPAD. R201's lunch tray remained in room. The ADON and director of nursing (DON) entered R201's room and explained they needed to reposition her and check her skin. R201 stated she "had a mess in her pants" and needed to be changed. At 1:07 p.m., the ADON and DON proceeded and changed R201's incontinent brief which was observed to be soiled of urine and stool. R201's peri area appeared to be dry, pink in color. R201's skin to coccyx was observed to be intact with redness noted to coccyx. After the DON provided incontinent cares, The ADON assessed R201's buttocks, coccyx, and back and confirmed there were no opened areas and stated R201's coccyx skin color was "pink and blanchable." The DON applied a standard barrier cream to R201's periarea and buttocks, and a clean incontinent brief. R201 remained lying on back and head of

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F 686	Continued From page 12 bed was elevated and talked with ADON about giving R201's chair in room to her significant other. On 8/11/20, at 1:17 p.m. ADON stated R201 was at risk for pressure ulcer development and required every two hour repositioning. RN-A stated she would have expected staff to provide timely repositioning as directed on R201's care plan. On 8/13/20, at 4:06 p.m. the DON confirmed R201's had blanchable redness to her coccyx after not being turned or repositioned for over 3 hours. The DON stated it was her expectation of staff to follow the resident's plan of care for pressure ulcer prevention. The DON verified R201's care plan and nursing assistant care sheet directed staff to turn and reposition R201 every two hours to prevent skin breakdown. The facility policy Skin Ulcer Protocol undated, indicated tissue tolerance test determines an individual's turning and reposition schedule. The facility policy Urinary Incontinence Program undated, directed nursing assistant care sheets will be utilized and kept updated, to ensure the nursing assistants are aware of the resident's current toileting needs, including the use of incontinence products, and plans to prevent complications of urinary incontinence.	F 686		
F 740 SS=G	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and	F 740		9/18/20

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F 740	Continued From page 13 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure development of a comprehensive care plan, and implement interventions to address suicidal ideation that included behavioral health services, provision of a safe environment, and meaningful activities and social interactions to promote psychosocial well-being and prevent a suicide attempt for 1 of 1 residents (R201) reviewed for suicidal ideations and suicide attempt. This resulted in actual psychosocial and physical harm for R201 when she attempted suicide by strangulation. Findings include: R201's Face Sheet printed 8/13/20, indicated R201's diagnoses included suicide attempt, avoidant personality disorder, somatoform disorder (a group of psychological disorders that cause unexplained physical symptoms), anxiety, major depression, and Parkinson's disease (progressive nervous system disorder that affects movement). R201's quarterly Minimum Data Set (MDS) dated 7/17/20, identified R201's was cognitively intact, and was mildly depressed. R201's care plan dated 7/21/20, identified R201	F 740	It is the policy of Viewcrest Health Care Center to ensure that all residents receive the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. The facility policy and procedure on behavioral health care was reviewed and updated along with the facility policy on psychosocial wellbeing assessment. The facility social workers were provided with education on the behavioral health care policy as well which assessments are required when a resident returns from the hospital on 9/10/20 by the administrator. Resident R201 is a current resident in the facility. Resident R201 was hospitalized for suicidal ideation on 6/8/20, at the time of this incident the resident was not noted to have lost consciousness and had no signs or symptoms of physical harm from the incident. R201 is followed by her primary care physician and nurse practitioner for her mental health needs. R201 has declined outside behavioral health care services in the past. The resident's care plan and care card were updated to include suicidal ideation along with interventions for staff to use when the	

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F 740	Continued From page 14 was at risk for alteration in psychosocial well-being related to restriction on visitation due to COVID-19. The care plan dated further indicated R201 preferred activities in her room, and directed activity staff/volunteers to visit during daily rounds to provide socialization. R201's care plan lacked identification of suicidal ideation. R201's nursing assistant care sheet printed 8/10/20, lacked identification of R201's suicidal ideation, and lacked staff direction on what to do when R201 expressed thoughts of self-harm. R201's Quarterly assessment completed by the social service director (SS)-A dated 4/27/20, indicated R201 was cognitively intact, Patient Health Questionnaire (PHQ-9, a screening for the presence and severity of depression) indicated R201's mood was normal and further indicated R201 stated during the past week she felt more depressed due to her family being unable to visit. The assessment identification of R201's recent suicidal ideation. On 6/8/20, an Incident Details report revealed R201 was in her room when she attempted to strangle herself with a stretch band (Theraband) that was attached to the mobility bar on her bed. The report indicated the Theraband was removed from R201's neck, and R201 was taken to the hospital by ambulance. The incident report revealed R201 was placed on 15 minute checks. On 6/18/20, a hospital Behavioral Health Discharge Summary indicated R201 was seen in the emergency room after being found with a Theraband around her neck in attempt to kill herself. The summary further indicated nursing home staff noted R201 had been making suicidal	F 740	resident expresses self-harm. R201 also completed a No Self-Harm Contract on 8/18/20 that identifies resources that can be used if the resident is having a Behavioral Health Crisis. The facility SW completed a psychosocial wellbeing assessment on R201 on 8/21/20 as well as updating the resident care plan. There is a potential for all residents who are experiencing isolation to exhibit signs of depression and or suicidal ideation. All residents were reviewed for risk factors on 8/10/20 by the interdisciplinary team. Resident's that scored above a nine on the PHQ9 assessment will be followed a minimum of weekly by the facility social workers. Any resident that expresses suicidal ideation will have a safety contract put into place and their physician will be notified. The facility Administrator or designee will audit all PHQ9 assessments completed for one month, then 50% for three months to ensure compliance. Results of all audits will be reviewed by the facility Quality Assurance Performance Improvement Committee (QAPI). Corrected by 9/18/20.	

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statements two weeks prior to her attempt, and felt they could not keep R201 safe after being found with the Theraband around her neck. R201 was admitted to a mental health unit for stabilization, medication management, and assessment. The hospital Discharge Summary indicated at the time of discharge, R201's condition had improved and was stable and discharge to nursing home and instructed to follow up with primary care provider within 5 days.

On 6/24/20, a provider note indicated R201 had a physician visit via Zoom visit. The note indicated R201 was tearful through much of the visit, and expressed a lot of sadness. R201 expressed she was being quarantined, and would rather be back in her old familiar room. R201 stated, "I've missed so much, everything is gone." R201 expressed a friend of hers health had deteriorated, and he was in a nursing home, and she was unable to communicate with him. The note further indicated R201's distress reached a point earlier in the month that lead to an attempt of self-harm with a Theraband around her neck, and lead to an inpatient stay on the psychiatry unit from June 11-19, 20. During that stay, R201 received psychotherapy, and had medication adjustments. The note indicated R201 was emotionally distressed, and she struggled to compose herself, but was able to carry on a conversation. R201's physician discussed with the director of nursing (DON), and the facility's plan was R201 would return to her room after quarantine period ended, and R201 would have outdoor visits with her family.

On 8/10/20, at 3:52 p.m. family member (FM)-A was interviewed and stated R201 was having a difficult time being isolated to her room, and the

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lack of contact from the outside also was difficult for her. FM-A stated R201 had a history of depression for many years, and had experienced several losses including the death of immediate family members, and the most recent loss was her home and not being able to see or communicate with her significant other. FM-A expressed concern of R201's mental health, and stated R201 recently attempted suicide by trying to strangle herself with an exercise stretch band. FM-A stated R201 started making comments of suicidal ideation about six weeks prior to her attempt. FM-A stated the facility removed dangerous items from R201's room and placed R201 on 15 minute checks when R201 expressed self-harm. FM-A stated the nurse practitioner (NP) made medication changes, and the facility talked about setting up an appointment with a mental health provider for R201, but it never happened. FM-A stated R201 refused to go out to appointments, and feared R201 would have to go to a different room to quarantine for 14 days. FM-A stated R201 had to quarantine after her last hospitalization which was a difficult time for R201 mentally. R201 was unable to see family during this quarantine, and was not surrounded by her personal items. FM-A was unaware if the facility attempted to arrange a video visit for mental health services. FM-A stated she thought if R201 would attempt to commit suicide it would have been when R201 lived in the community, and FM-A never thought it would be at her age in a nursing home. FM-A stated she felt R201 would attempt to end her life again.

On 8/11/20, at 3:47 p.m. R201 was interviewed and stated she had been awake from 1:00 a.m. until 4:00 a.m., and thought she was having a

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heart attack. R201 stated the doctor was called, and was told R201 was having an anxiety attack. R201 stated it was upsetting that she had not been able to see her significant other since he was admitted to a nursing home. R201 stated staff were going to try and arrange an outside visit with R201's significant other sometime next week. R201 expressed feeling lonely and isolated since no one could leave their rooms, and all activities had stopped. R201 stated she was very close with her family, and talked with her daughter daily. R201 stated she video chatted with her daughter a couple of times, and they had two outdoor visits. R201 became teary eyed, and stated she felt like she had missed so much, and the summer was gone. R201 stated she struggled with depression for many years, and now she had so much time on her hands to think and stare at the four walls within her room. R201 stated no one came to her room to visit anymore, staff walked in, did what they had to do and walked out. R201 stated she had Parkinson's disease and could no longer crochet or knit, but could still make snowflakes from paper. R201 stated she was unable to make the snowflakes because staff took her scissors away. R201 further explained she had tried to strangle herself with the exercise band she received from therapy a couple of months ago. R201 stated she told staff she was going to kill herself, but would not tell them how. R201 stated staff took her scissors away and removed her cordless phone base, because of the cords. R201 further stated if she wanted to strangle herself she would use the cords from the desk phone staff gave her, and proceeded to point at the desk phone on the side table between her recliner chair and bed. R201 stated she was currently not seeing a mental health provider, and she would not leave

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the facility in fear she would have to go to the isolation unit and quarantine for 14 days. R201 stated she could not handle that. R201 stated she had a psychiatric appointment scheduled for September, and she was told since she was in a private room with a private bath, she would not have to go to the isolation unit. R201 stated she visited with the NP via video chat, and expressed her concern of feeling anxious, depressed and lonely. R201 stated she was told a meeting was going to be scheduled to see if she could have her personal items returned, and stated the meeting had not been scheduled as of date. R201 stated the day she attempted to strangle herself she was feeling very alone and isolated, and stated staff bought in her lunch that day around 11:00 a.m. and did not come in her room again until the nursing assistant (NA) found her with the Theraband around her neck at 4:00 p.m. R201 stated her family bought her an IPad after hospitalization to stay connected, play Scrabble, and go on the internet, otherwise she had nothing to occupy her time.

Review of R201's progress notes from 4/19/20, to 7/29/20, revealed the following:

- 4/19/20, R201 verbalized she was suicidal and had a plan, but would not elaborate further and stated, "You'll take it away from me." The NP was notified, clonazepam (tranquilizer) was increased for a one time dose, and R201 was placed on 15 minute checks. The note further indicated R201's family was updated, and R201 safety checks were decreased to 30 minute checks for the rest of the shift.

-4/20/20, SS-A spoke with R201's daughter regarding a room change. The note lacked

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indication SS-A had a conversation with R201's daughter regarding R201's suicidal thoughts or her current state of mental health.

- 4/21/20, SS-A spoke with R201 and followed up on room change. The note lacked any indication SS-A had a conversation with R201 regarding suicidal thoughts, or her current state of mental health.

- 4/30/20, R201 expressed to the nurse of feeling sad all of the time. The note further indicated the NP was contacted to address R201 blood sugars and her non-compliance with dietary choices. The note lacked indication R201's mood was addressed.

- 5/27/20, R201 was "very depressed" that morning due to hearing her house was cleared out and was being sold, and her boyfriend moved to an assisted living facility. R201 expressed to registered nurse (RN)-C she felt hopeless, and did not want to live anymore. RN-C asked R201 if she had a plan to hurt herself, and R201 stated she had nothing to hurt herself, with otherwise she may do it. R201 was put on 15 minute safety checks and R201's daughter was updated. R201's daughter planned a window visit for that afternoon.

- 5/28/20, SS-A met with R201 and discussed recent days of feeling down. R201 denied any suicidal thoughts at that time and stated she "cannot live like this." R201 expressed increased anxiety of not being able to see her significant other. SS-A discussed arranging a Zoom visit with R201's significant other.

-5/28/20, R201 was taken off of 15 minute safety

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checks, had spoken with family, and had a Zoom visit with the NP which addressed blood sugars, and her depression. The note lacked any indication if R201's NP changed any medications, addressed any suicidal ideations, or added any new interventions.

- 6/8/20, R201 was found by a NA with a stretch band around her neck which was attached to the mobility bar. R201 was pulling the stretch band tightly trying to strangle herself. The note further indicated the stretch band was removed, R201 had a reddened mark all around her neck, and R201 stated she was trying to kill herself. Potential harmful items were removed from R201's room, family was notified, and the NP ordered R201 to be sent to emergency department. R201 was placed on 15 minute checks until the ambulance arrived.

- 6/9/20, SS-A spoke with R201's daughter regarding R201's recent suicidal attempt, and having her bed held. The note indicated R201's daughter stated she talked to R201 daily, and felt R201 had been in a better mood, and R201 had not made any recent comments about wanting to hurt herself.

- 6/9/20, the hospital social worker stated R201 still had thoughts of harming herself, and the hospital was looking for in-house placement.

-6/19/20, R201 was readmitted to the nursing home. R201 stated the two new medications were helping with her depression, she denied thoughts of self-harm, and stated did not plan on going down that road again.

-6/25/20, R201's progress notes lacked any follow

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up from SS-A upon return to the facility from the hospital, until six days later.

- 6/25/20, Interdisciplinary Team (IDT) reviewed R201's medications and blood glucose levels, weight, non-compliance with dietary choices and indicated no MDS concerns. The IDT lacked any information on R201's mental health.

-7/4/20, R201 was crying and stated she was sick of being alone in her room. The note further indicated R201 requested the nurse to sit and talk with her for a while. The nurse sat with R201 and talked until R201 felt better.

-7/7/20, R201 stated the new medications she was taking were making her fell more depressed, more tired than usual, and gave her a loss of appetite. The note further indicated the nurse explained R201 was not on any new medications, but had an increase dosages and she would update the physician.

-7/10/20, IDT reviewed and discussed R201's pain medications. The IDT did not address R201's mental health.

-7/10/20, a progress note indicated FM-A called the facility and left a voice mail message for the nurse manager. FM-A stated R201 called and stated her anxiety medications were not effective. The note further indicated the NP changed R201's medications two weeks prior, and wanted to give the medications a chance to work.

-7/15/20, R201 had been crying all day, and told staff she needed a mental health doctor. The note further indicated R201 stated she did not want to live anymore, then denied that statement

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to the nurse manager and assistant director of nursing (ADON). R201's bed remote was removed due to it having a cord and R201 having suicidal ideations. The NP was notified and requested R201 to be seen by her that next day.

-7/16/20, NP ordered to continue to monitor and document R201's behaviors and sleep patterns for 14 days, and ordered Zofran for nausea.

-7/27/20, the Spiritual Director (SP) visited with R201.

-7/29/20, R201's quarterly care conference with IDT and FM-A via phone included a review of medications, diet, activities, and R201 recently received a new IPad.

On 7/7/20, R201's Psychotropic medication review indicated on 4/3/20, R201's had a onetime dose increase in a medication (unnamed) related to suicidal thoughts. Review further indicated R201 was noted to be crying and depressed on 7/4, 7/7, 7/10, 7/15, and 7/16.

R201's medical record lacked evidence of mental health service, suicide prevention evaluation and assessments, and documentation of supporting activity interactions and participation.

On 8/12/20, at 10:17 a.m. activities aide (AA)-A stated the only in-house activity for residents was Bingo. Bingo consisted of activities staff going from room to room marking the Bingo cards on the resident's door. AA-A verified activity staff were not interacting with the residents during Bingo except to let the residents know if they won something. AA-A stated activity staff were not allowed to go into the resident's rooms for

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activities due to COVID-19. AA-A stated the first month activities stopped was terrible, the residents were very upset and had a hard time without activities, and now they do not say anything. AA-A stated activity staff were busy screening staff and visitors at the front door, and bringing residents on outside visits. AA-A stated staff were being hired to do the screening at the front door which would allow more time for activities with residents.

On 8/12/20, at 10:19 a.m. registered nurse (RN)-D stated she was aware of R201's depression and attempt to end her life. RN-D further stated R201 had never made suicidal comments to her. RN-D stated R201 safety interventions included removal of unsafe items with cords from R201's room. RN-D then placed R201's desk phone down to the floor, out of R201's reach.

On 8/12/20, at 10:46 p.m. the DON stated R201 she was unsure how R201 got the desk phone. The DON stated there was no formal assessment to determine when it would be appropriate to return items that had been removed for safety, and stated R201 was doing better. The DON stated R201 had not been making comments about harming herself, and staff were able to recognize when R201 felt depressed and teary-eyed. The DON stated staff visited with R201 frequently, provided one-on-one activities, and R201 had Zoom and outdoor visits. The DON stated staff visits were documented on the room visit logs outside of the resident's doors. The DON stated anytime anyone enters a resident's room, they were to sign in and out. The DON stated R201 didn't start complaining about not being able to make snowflakes until her scissors

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were taken away.

On 8/12/20, at 11:19 a.m. the DON stated R201's phone was put out of R201's reach, and maintenance did not give R201 the desk phone. The DON further started the NP did a Zoom visit with R201 recently, and the NP stated R201 could have all of her items returned to her. The DON further stated she could try plastic scissors or rounded scissors for R201, if making snowflakes was important to her. The DON stated an assessment had not been completed to determine R201's mental health status or risks of self-harm.

On 8/12/20, at 12:06 p.m. SS-A stated she was aware R201's history of depression and suicidal ideation. SS-A stated she met with R201 frequently, but did not chart her visits or conversations in R201's medical record. SS-A stated she did not conduct any formal assessment to assess R201's suicide risk level, or complete a depression assessment after R201 verbalized suicidal ideations. SS-A was unsure if R201 was receiving any outside mental health services, and stated she did not make any mental health referrals.

On 8/13/20, at 9:54 a.m. activities director (AD)-A stated it had been very frustrating for staff and residents since COVID-19 restrictions of stopping group activities, and residents being restricted to their rooms. AD-A stated activity staff had taken on additional responsibilities like delivering mail and packages to residents, and screening staff and visitors at the front door. AD-A stated all group activities had stopped since COVID-19, and there were no hallway activities occurring. AD-A stated resident activities included delivering

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packages to resident rooms, putting items away, dropping off puzzles, books, crossword puzzles, and crafts the residents could do independently in their rooms. AD-A stated activity staff were not allowed to go into resident rooms until recently. AD-A stated Zoom visits and outdoor visits were the main focus for activities due to the high requests from families. AD-A stated the activity department currently had two IPads for Zoom visits, and more were on order. AD stated residents had complained about not having activities like they were used to, and staff tried to accommodate residents, but it was difficult due to the restrictions set by the facility. AD-A stated R201 used to play dice, paint, attend Bingo, and had expressed frustrations of not being able to have regular Bingo or see her significant other. AD-A stated activity staff could visit with R201 more if requested. AD-A stated activity staff could provide one-on-one visits doing crafts or just talking if that would help with R201's feelings of depression and isolation. AD-A stated more staff were being hired, which would allow more time and opportunities for resident activities. AD-A stated activity staff don't chart or keep records on resident's participation in an activity. AD-A stated R201 has had window visits, two or three outdoor visits, and Zoom visits with family.

On 8/12/20, at 4:02 p.m. RN-D was interviewed again. RN-D stated she noticed a decline in R201's ambulatory status and being weepier since COVID-19. RN-D stated R201 used to see her family every day, and now she only talked with them daily, but recently started outdoor visits which seemed to help with R201's mood.

On 8/13/20, at 10:44 p.m. housekeeper (H)-A stated R201 had made comments to her about

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wanting to die, which she reported to nursing. H-A stated when R201 made those comments, H-A would talk with R201 about positive things like her family, which seemed to help. H-A stated R201 stated she missed going to Bingo, socializing with other residents, and was going stir crazy.

On 8/13/20, at 1:48 p.m. the spiritual coordinator (SC)-A stated she worked 3 days a week, not full days, and visited with residents. SP-A stated she recently had a leave. SP-A stated she tried to check on R201 at least once a week, but had not seen her for a while because she had been on leave. SP-A stated she did not always chart her visits with the residents because a lot of the time she was just stopping by to say "hi." SP-A stated she had seen more depression in the residents since COVID-19. SP-A stated the focus was on nursing for the residents, and more focus needed to be on the mental health of the residents, and taking a holistic approach. SP-A further stated she tried to help out the activity department as much as she could, the activities department were shorthanded, and had additional responsibilities added to their day that did not involve activities with the residents. SP-A stated there were a few residents that really struggled with depression, and identified R201 as being one of them. SP-A stated she wanted to get those residents together wearing masks, and social distancing for their mental health. SP-A further stated groups of any kind were not permitted in the facility.

On 8/13/20, at 4:06 p.m. the ADON stated she was working the day R201 attempted to strangle herself. The ADON stated staff stayed with R201 until the ambulance arrived, family was notified, and R201 was transported to the hospital. The

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ADON stated she was aware of R201's previous suicidal ideation, but R201 had no plan. The ADON stated residents were to stay in their rooms and all hallway activities were canceled per corporate office policy. The ADON stated staff rotated and took a few residents outside for activities. The ADON stated isolation could impact a resident's depression, and it was difficult to balance keeping the residents safe from COVID-19 and socialization. The ADON stated residents that went out to appointments were put on contact precautions due to the risk of exposure outside of the facility.

On 8/13/20, at 4:40 p.m. another interview was conducted with the DON. The DON stated she was notified immediately by the ADON of R201's suicidal attempt. The DON stated she instructed staff to call 911, notified R201's medical provider and family, and placed R201 on 15 minute checks until R201 left the building. The DON stated the plan when R201 returned to the facility was to remove potentially harmful items from R201's room, and replace the call light with a call box without cords. The DON stated she would expect a comprehensive assessment to be completed within a week of R201's hospital return. The DON verified R201 was not seen by SS-A until 6/25/20, nor had a comprehensive assessment completed to determine R201's new baseline after readmission. The DON stated R201's nurse manager visited with her every day, and SS-A saw R201 frequently after R201's hospital return, although documentation in R201's electronic medical record (EMR) did not support that. The DON stated back in April 2020, R201 verbalized wanting to harm herself. The DON stated R201's medical provider was notified, and R201's care plan directed staff to watch for signs

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and symptoms of depression, and to allow R201 to talk. The DON further stated R201 did not have a plan to end her life, and no updates were made to R201's care plan at that time. The DON stated R201's care plan should have been updated in April after R201 expressed suicidal ideation. The DON stated updating R201's care plan and nursing assistant care sheets were important so staff knew what was going on with R201, and to ensure R201's safety. The DON verified R201's care plan was not updated following her suicide attempt, and stated it should have been updated. The DON stated upon R201's return from the hospital, staff were informally educated on R201 suicide attempt by memo and meetings. The DON stated R201 had not been seen by a mental health provider since R201 returned from the mental health unit, and further stated R201 had an appointment scheduled in September (three months after R201's suicide attempt). The DON stated group and hallway activities were canceled, and further stated resident's received socialization by activity staff delivering packages to resident rooms, offering snacks, and Zoom and outside visits. The DON stated R201's activities included one-on-one visits, outdoor and Zoom visits with family, and R201 recently received her own IPad. The DON verified IDT notes from 6/25/20, did not address R201's suicidal ideation, depression, or overall mental health status. The DON stated the facility did not have an assessment to determine resident's suicidal ideation risks, and recently found a suicide contract on-line.

On 8/13/20, at 5:48 p.m. the administrator stated if a resident verbalized wanting to harm themselves, she would expect the nurse to talk with the resident, and find out if the resident had

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a plan. The administer further stated an assessment would be completed to determine the level of seriousness, safety checks would be initiated, harmful objects would be removed from the room, and the medical provider and family would be notified. The administrator stated safety checks would be removed after the nurse or SS-A talked with the resident to determine if there was a need to continue, or if the resident needed to be sent to the hospital. The administrator stated SS-A could have completed a depression assessment to identify if there were other areas of concern after R201 expressed suicidal ideation. The administrator stated she would expect a comprehensive assessment to be completed upon R201's return from the hospital right away, within a day, by SS-A to create a new baseline and identify any concerns. The administrator stated she expected care plans to be updated with any resident changes, and verified R201's care plan should have been updated after R201 verbalized suicidal thoughts back in April 2020. The administrator stated they had never experienced a resident attempt to commit suicide, and did not have any formal assessment or tools to assess a resident's risk level that expressed suicidal ideation. The administrator stated staff were not formally educated on what to do if a resident verbalized suicidal ideation. The administrator stated staff were informed on reporting the smaller things like watching a resident's mood closely with medication changes. The administrator stated R201 had been offered mental health services in the past, and R201 declined. The administrator was unable to provide documentation to support the facility made referrals for mental health services for R201. The administrator verified R201 was not receiving mental health services at

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that time, and had an appointment scheduled for September. The administrator stated there was a mental health practitioner who made in-house visits for another resident, and the facility could have requested R201 to be seen. The administrator stated the facility was in the process of hiring more staff so the activity staff had more time for resident activities instead of using activities for screening staff and visitors. The administrator stated activity staff were allowed in resident rooms for one-on-one activities, and activity staff passed out mail, art projects, and books to the residents. The administrator stated the focus for the activities department had been on Zoom meetings and outdoor visits. The administrator stated residents were allowed out of their rooms as long as they wore a mask, and were social distancing. The administrator further stated staff had been used to keeping residents in their rooms, and need to be re-educated.

The facility provided the following on education provided to staff for residents that expressed suicidal ideation: Memo From The Desk Of The Administrator dated 6/22/20, and 6/29/20, reminded staff after an incident with a resident, exercise bands would no longer be stored in the residents rooms. The memo also reminded staff if a resident had a medication change to watch for adverse side effects including but not limited to changes in sleep/eating habits, depression, anxiety, mania, panic attacks, restlessness, or suicidal thoughts/ideation to notify the nurse.

The facility policy Suicide Precaution Policy revised date 4/17, directed:
1. Residents observed attempting suicide call 911
2. Any employee hearing or observing any

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suicidal talk or behavior of a resident must report such to the nurse in charge immediately.
3. Employee to remain with the resident until the charge nurse assess. Determine if resident has a plan, remove all equipment that could be used and/cause harm, i.e. sharps, cords, belts, etc., and begin 15 minute visual checks on resident.
4. Charge nurse to contact resident's Physician, Administrator, Director of Nursing, Social Services, and Clergy (if appropriate).
5. Nursing personnel will be informed of the suicide threat and to report changes in the resident's behavior immediately.
6. Resident's may be temporarily secluded if there is a potential of danger to him/herself or others.
7. An assessment of the resident's behavior will be made by the interdisciplinary care plan team within 24-48 hours of such incident to determine interventions that may be necessary to prevent the recurrence of such threats. Revised care plans will be developed to reflect such interventions.
8. Document all the above and update the care plan.

The facility policy Comprehensive Care Planning Process undated, was to ensure each resident's status is properly assessed and that the highest practicable functional status can be attained and maintained. The policy directed the following:
-Nursing Department will be responsible for modifying, adding, updating the following focuses: Additional Vulnerability Areas (if applicable), Behavior, and Safety.
-Activity Department in collaboration with Social Service will be responsible for modifying, updating the following focus: Psycho-Social/Activities.

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F 740	Continued From page 32 -Nursing, Dietary, Social Service, Activity Departments will schedule new interventions or link interventions previously scheduled to improve resident's functioning or minimize decline as needed on the care plan. The Director of Social Services Job description undated, indicated the responsibilities and standard of the DSS for resident services were to provide individual, family, and group services designed to improve social functioning and reduce the psychosocial problems of residents. The facility policy on Behavioral Health Services and Activities were requested and not provided by the facility.	F 740		

Electronically delivered
September 3, 2020

Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

Re: State Nursing Home Licensing Orders
Event ID: IIUP11

Dear Administrator:

The above facility was surveyed on August 10, 2020 through August 13, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Teresa Ament, Unit Supervisor
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00602	A. BUILDING: _____ B. WING _____	C 08/13/2020

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
On 8/10/20, through 8/13/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be not in compliance with the MN State Licensure.

The following complaints were found to be SUBSTANTIATED: H5414066C and H5414067C

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2 000	Continued From page 1 with licensing orders issued. The following complaints were found to be UNSUBSTANTIATED: H5414068C and H5414069C. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Please indicate your electronic plan of correction that you have reviewed these orders, and identify the date when they will be corrected.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement identified pressure relieving intervention of repositioning for	2 900	Corrected in federal deficiencies.	9/18/20

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2 900	Continued From page 2 1 of 3 (R201) residents who was at risk for developing pressure ulcers. Findings include: R201's Face Sheet printed 8/13/20, indicated R201's diagnoses included Parkinson's disease (progressive nervous system disorder that affects movement), diabetes mellitus type 2, and low back pain. R201's quarterly Minimum Data Set (MDS) dated 7/17/20, indicated R201 was cognitively intact and had no rejection of cares during the assessment period. The MDS further identified R201 required one person assist for bed mobility, toileting, and two assist for transfers. The MDS indicated R201 was at risk for pressure ulcers, had no current pressure ulcers, or other identified skin concerns . The MDS indicated R201 had pressure relief devices in chair and mattress, and was treated with topical medications. R201's care plan revised 8/12/20, identified R201 was at risk for skin breakdown and was incontinent of urine. R201's care plan revealed R201 required physical assistance of two staff for turning and repositioning, and required every two hour toileting R201's care plan directed staff to re-approach R201 if he refused toileting or repositioning. R201's nursing assistant care sheet printed 8/10/20, directed staff to turn and reposition R201 every two hours, and toilet R201 at 8:00 a.m. to void, 8 p.m. for BM and every two hours. R201's Tissue Tolerance (TT, an assessment of how long of an interval the resident can tolerate for lying or sitting) dated 2/28/20, indicated	2 900		

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2 900	Continued From page 3 R201's coccyx developed a non-blanchable reddened area after 2 hours of lying, and sitting. On 8/11/20, at 9:47 a.m. nursing assistant (NA)-A exited R201's room with a bag of soiled linens and garbage and verbalized to NA-B, R201 was repositioned, changed and washed up for the morning and planned to get her up soon in her recliner chair. -9:51 a.m. NA-A entered R201's room and delivered a fresh cup of ice water and exited the room. R201 was not offered toileting or repositioning, and remained in her bed lying on her back. -10:34 a.m. the director of nursing (DON) entered R102's room, talked with R201 for a few minutes and exited the room. R201 was not offered toileting or repositioning, and remained in her bed lying on her back. -11:37 a.m. staff entered R201's room and delivered meal tray and apologized for lunch being late, set up meal tray and exited the room. R201 was not offered toileting or repositioning, and remained in her bed lying on her back. -11:42 a.m. NA-A entered R201's room and delivered a piece of cake, set up chips and salsa per R201's request and exited the room. R201 was not offered toileting or repositioning, and remained in her bed lying on her back. -12:20 p.m. the activities director (AD) entered R201 room and talked about a beautician appointment, scheduling time to see R201's significant other, and exited the room. R201 was not offered toileting or repositioning, and remained in her bed lying on her back. -12:30 p.m. the AD entered R201's room and notified R201 they were arranging a video chat with her significant other and exited the room. R201 was not offered toileting or repositioning, and remained in her bed lying on her back	2 900		

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2 900	Continued From page 4 -12:40 p.m. the AD entered R201's room and set up the IPad for a video chat with R201's significant other and exited the room. R201 was not offered toileting or repositioning, and remained in her bed lying on her back. -1:00 p.m. the AD entered R20's room and waited for R201 to finish her video chat and exited the room. R201 was not offered toileting or repositioning, and remained in her bed lying on her back. -1:05 p.m. the assistant director of nursing (ADON) and DON entered R201's room to reposition and assess R201's skin per surveyors request. R2 was remained lying on her back. R201 was not offered toileting or repositioning, and remained in her bed lying on her back from 9:47 a.m. to 1:07 p.m. On 8/11/20, at 12:28 p.m. NA-A stated she repositioned and changed R201 at 9:20 a.m. NA-A viewed her nursing assistant care sheet that she kept in her pocket and stated R201 was to be turned and repositioned every two hours, and toileted at 8 a.m. to void and 8 p.m. for BM, and every two hours. NA-A stated she was late on repositioning R201 because it had been a busy morning and planned to get R201 up soon in her recliner chair. NA-A proceeded to go into another resident's room with the mechanical lift and did not provide repositioning to R201 following the interview. On 8/11/20, at 12:37 p.m. NA-B stated residents toileting times were documented on the toileting log kept at the nursing desk. NA-B stated according the toileting log, it was documented R201 was last toileted at 9:20 a.m. On 8/11/20, at 12:53 a.m. assistant director of	2 900		

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2 900	Continued From page 5	2 900		

nursing (ADON) was notified surveyor had completed continuous observations of R201, R201 had not been repositioned since 9:20 a.m., and R201's skin needed to be assessed by a RN. RN went to find staff to assist with repositioning R201 so she could check her skin.

On 8/11/20, at 1:05 a.m. upon entrance, R201 was observed lying on her back on her IPAD. R201's lunch tray remained in room. The ADON and director of nursing (DON) entered R201's room and explained they needed to reposition her and check her skin. R201 stated she "had a mess in her pants" and needed to be changed. At 1:07 p.m., the ADON and DON proceeded and changed R201's incontinent brief which was observed to be soiled of urine and stool. R201's peri area appeared to be dry, pink in color. R201's skin to coccyx was observed to be intact with redness noted to coccyx. After the DON provided incontinent cares, The ADON assessed R201's buttocks, coccyx, and back and confirmed there were no opened areas and stated R201's coccyx skin color was "pink and blanchable." The DON applied a standard barrier cream to R201's periarea and buttocks, and a clean incontinent brief. R201 remained lying on back and head of bed was elevated and talked with ADON about giving R201's chair in room to her significant other.

On 8/11/20, at 1:17 p.m. ADON stated R201 was at risk for pressure ulcer development and required every two hour repositioning. RN-A stated she would have expected staff to provide timely repositioning as directed on R201's care plan.

On 8/13/20, at 4:06 p.m. the DON confirmed R201's had blanchable redness to her coccyx

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2 900	Continued From page 6 after not being turned or repositioned for over 3 hours. The DON stated it was her expectation of staff to follow the resident's plan of care for pressure ulcer prevention. The DON verified R201's care plan and nursing assistant care sheet directed staff to turn and reposition R201 every two hours to prevent skin breakdown. The facility policy Skin Ulcer Protocol undated, indicated tissue tolerance test determines an individual's turning and reposition schedule. The facility policy Urinary Incontinence Program undated, directed nursing assistant care sheets will be utilized and kept updated, to ensure the nursing assistants are aware of the resident's current toileting needs, including the use of incontinence products, and plans to prevent complications of urinary incontinence. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure necessary care and services are provided according to the care plan to prevent development or worsening of pressure ulcers. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21475	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements	21475		9/18/20

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21475	Continued From page 7 Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to communicate a resident's current status on discharge to the receiving facility for 1 of 4 residents (R200) reviewed for admission, transfer, and discharge. Findings include: R200's Face Sheet printed 8/13/20, indicated R200 was admitted to the facility on 7/1/20, and diagnoses included squamous cell carcinoma of skin of scalp and neck, edema (swelling caused by excess fluid trapped in your body's tissues), diabetes, and anemia. R200's General Nurse's Observation (GNO) dated 7/7/20, indicated R200 was at low risk for skin breakdown, developed redness on the spine after lying for 5 hours, and on the coccyx (tailbone) after 3 hours of sitting. R200 areas of dry, flaky skin with areas of thin skin, and had areas of bruising and a cancerous lesion on his head. In addition, R200 had edema of both lower extremities with compression stockings. R200's GNO notes did not document any open lesions on R200's right shin.	21475	Corrected in federal deficiencies.	

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21475	Continued From page 8	21475		

R200's care plan dated 7/16/20, indicated R200 was at risk for skin breakdown related to decreased mobility, and had an impaired skin integrity with an open area, lacked identification of location of skin impairment.

R200's Skin Condition Report With Images dated 7/1/20, indicated R200 had bruises on arms, legs and head, and a cancerous lesion on his head.

R200's Skin Condition Report With Images dated 7/8/20, indicated R200 had a cancerous lesion on his head. R200's skin report lacked any indication of skin concerns on R200's right shin.

R200's Skin Condition Report With Images dated 7/10/20, lacked lacked any indication of skin concerns on R200's right shin.

R200's Skin Condition Report With Images dated 7/21/20, indicated R200 continued with a cancerous lesion on his head, but lacked any indication of skin concerns on R200's right shin.

A complaint filed with the State Agency (SA) indicated R200 arrived at the receiving facility on 7/30/20, with an open area on the right shin measuring 2.5 inches by 1.5 inches, with a necrotic area, and yellow, draining tissue. In addition, R200 had edema of both his legs, and did not have compression stockings on (stockings used to decrease edema).

R200's initial care conference note dated 7/15/20, indicated R200 would be discharged to an assisted living facility which had an opening in one to two weeks. R200's care conference note indicated R200 had a few bruises, a cancerous lesion on his head, along with compression stockings or Tubigrips to his legs.

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21475	Continued From page 9 R200's progress notes dated 7/23/20, indicated R200 was to be discharged to an assisted living on 7/30/20. R200's progress notes from 7/23/20, through 7/30/20, lacked documentation of any skin assessments or skin conditions. R200's GNO started 7/29/20, indicated R200's body check for skin conditions was not completed. R200's Post Discharge Plan of Care signed by registered nurse (RN)-B and dated 7/30/20, lacked documentation of R200's current skin condition. R200's nurse practitioner signed Resident Transfer Sheet dated 7/29/20, with data for the seven days prior to 7/28/20, indicated R200 had bruises on his arms and on his left thigh, with a cancerous lesion on the scalp, though did not indicate the date of the skin observations. R200's Resident Transfer Sheet further indicated R200 had compression stocking to lower extremities to be put on in the a.m. and off in the p.m., and an ointment for wound care. The skin documentation received by the assisted living facility on 7/30/20, indicated R200's right shin open area was not documented, and not communicated to the assisted living. The photos of R200's right shin dated 7/30/20, the date of his discharge from the facility and admission to the assisted living facility, indicated R200 had a large ulceration on the right shin with some depth, irregular edges, and moist tissue with a possible darker area near the upper edge,	21475		

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21475	Continued From page 10	21475		

yellow draining tissue on the lower edge, with light erythema (redness) on the lateral edge. R200 had swollen lower legs with dry, scaly skin. R200 further had a dark linear dark area between the open area and knee.

On 8/13/20, at 12:54 p.m. R200's resident representative (RR)-C was interviewed by phone. RR-C stated R200 was treated well at the facility, but when he transferred to the assisted living, he was found to have an ulcer on his right shin that was draining. RR-C stated the information regarding R200's ulcer was not included on the transfer form, and she had not been notified of the area.

On 8/13/20, at 1:27 p.m. nursing assistant (NA)-C stated she had worked with R200, and was not aware of any sores, other than on his head.

On 8/13/20, at 2:22 p.m. RN-A stated she had not been notified of an ulceration of R200's skin. RN-A stated they had been called by the assisted living facility about the wound on his leg the day of discharge, had reviewed R200's documentation, and did not find any documentation of a wound on R200's shin. RN-A verified R200's skin status and documentation should be noted on the post discharge plan of care and was not. RN-A verified R200's head wound should have been documented on the form, and was not. RN-A further stated a skin assessment should have been done prior to discharge.

On 8/13/20, at 2:45 p.m. RN-B stated she had been filling in for the RN manager on R200's unit that day, and did not know the resident. RN-B verified she did not do a skin assessment, and did not know if R200 had any wounds, other than

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VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

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the wound on his head. RN-B stated she did not fill out the discharge plan of care, and she just signed it. RN-B stated she should have put the status of the skin on the form, even if it was clear. RN-B stated the assisted living facility had called about a wound, so she checked documentation, and asked staff. Staff did not remember a wound on R200's shin when they got him dressed.

On 8/13/20, at 3:03 p.m. the director of nursing (DON) verified skin status should be included on the post discharge plan of care, and verified it was not documented on R200's form. The DON stated skin should be checked before discharge.

On 8/14/20, at 9:50 am. assisted living facility director (ALD) stated she was very concerned about R200's skin condition on his shin when he arrived at their facility. ALD stated the nurse looked at him right when he got there, and found a "Stage 3 diabetic ulcer" on his shin with yellow, draining tissue, and necrosis in the center. ALD stated RR-C was an RN, and was very upset by it, stating it was neglect. ALD stated R200's skin status was not communicated to the facility. ALD stated R200 was being seen by wound care, and was healing well. ALD stated R200 did not have compression stockings on either, and his legs were very swollen.

The facility policy Discharge Planning reviewed/amended 1/17, directed nursing to complete a discharge plan of care with a final summary of the resident 's status at the time of discharge, with an assessment of the resident, and provided to the facility receiving services.

SUGGESTED METHOD OF CORRECTION: The Administrator, Social Services Director, Director of Nursing or designee could develop,

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21475	Continued From page 12 review, and/or revise policies and procedures to ensure accurate discharge summaries are completed and prior to discharge to ensure a safe and appropriate discharge. The Administrator, Social Services Director, Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Administrator, Social Services Director, Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21475		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure development of a comprehensive care plan, and implement interventions to address suicidal ideation that included behavioral health services, provision of a safe environment, and meaningful activities and social interactions to promote psychosocial well-being and prevent a suicide attempt for 1 of	21810	Corrected in federal deficiencies.	9/18/20

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21810	Continued From page 13 1 residents (R201) reviewed for suicidal ideations and suicide attempt. This resulted in actual psychosocial and physical harm for R201 when she attempted suicide by strangulation. Findings include: R201's Face Sheet printed 8/13/20, indicated R201's diagnoses included suicide attempt, avoidant personality disorder, somatoform disorder (a group of psychological disorders that cause unexplained physical symptoms), anxiety, major depression, and Parkinson's disease (progressive nervous system disorder that affects movement). R201's quarterly Minimum Data Set (MDS) dated 7/17/20, identified R201's was cognitively intact, and was mildly depressed. R201's care plan dated 7/21/20, identified R201 was at risk for alteration in psychosocial well-being related to restriction on visitation due to COVID-19. The care plan dated further indicated R201 preferred activities in her room, and directed activity staff/volunteers to visit during daily rounds to provide socialization. R201's care plan lacked identification of suicidal ideation. R201's nursing assistant care sheet printed 8/10/20, lacked identification of R201's suicidal ideation, and lacked staff direction on what to do when R201 expressed thoughts of self-harm. R201's Quarterly assessment completed by the social service director (SS)-A dated 4/27/20, indicated R201 was cognitively intact, Patient Health Questionnaire (PHQ-9, a screening for the presence and severity of depression) indicated R201's mood was normal and further indicated	21810		

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R201 stated during the past week she felt more depressed due to her family being unable to visit. The assessment identification of R201's recent suicidal ideation.

On 6/8/20, an Incident Details report revealed R201 was in her room when she attempted to strangle herself with a stretch band (Theraband) that was attached to the mobility bar on her bed. The report indicated the Theraband was removed from R201's neck, and R201 was taken to the hospital by ambulance. The incident report revealed R201 was placed on 15 minute checks.

On 6/18/20, a hospital Behavioral Health Discharge Summary indicated R201 was seen in the emergency room after being found with a Theraband around her neck in attempt to kill herself. The summary further indicated nursing home staff noted R201 had been making suicidal statements two weeks prior to her attempt, and felt they could not keep R201 safe after being found with the Theraband around her neck. R201 was admitted to a mental health unit for stabilization, medication management, and assessment. The hospital Discharge Summary indicated at the time of discharge, R201's condition had improved and was stable and discharge to nursing home and instructed to follow up with primary care provider within 5 days.

On 6/24/20, a provider note indicated R201 had a physician visit via Zoom visit. The note indicated R201 was tearful through much of the visit, and expressed a lot of sadness. R201 expressed she was being quarantined, and would rather be back in her old familiar room. R201 stated, "I've missed so much, everything is gone." R201 expressed a friend of hers health had deteriorated, and he was in a nursing home, and

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she was unable to communicate with him. The note further indicated R201's distress reached a point earlier in the month that lead to an attempt of self-harm with a Theraband around her neck, and lead to an inpatient stay on the psychiatry unit from June 11-19, 20. During that stay, R201 received psychotherapy, and had medication adjustments. The note indicated R201 was emotionally distressed, and she struggled to compose herself, but was able to carry on a conversation. R201's physician discussed with the director of nursing (DON), and the facility's plan was R201 would return to her room after quarantine period ended, and R201 would have outdoor visits with her family.

On 8/10/20, at 3:52 p.m. family member (FM)-A was interviewed and stated R201 was having a difficult time being isolated to her room, and the lack of contact from the outside also was difficult for her. FM-A stated R201 had a history of depression for many years, and had experienced several losses including the death of immediate family members, and the most recent loss was her home and not being able to see or communicate with her significant other. FM-A expressed concern of R201's mental health, and stated R201 recently attempted suicide by trying to strangle herself with an exercise stretch band. FM-A stated R201 started making comments of suicidal ideation about six weeks prior to her attempt. FM-A stated the facility removed dangerous items from R201's room and placed R201 on 15 minute checks when R201 expressed self-harm. FM-A stated the nurse practitioner (NP) made medication changes, and the facility talked about setting up an appointment with a mental health provider for R201, but it never happened. FM-A stated R201 refused to go out to appointments, and feared R201 would

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have to go to a different room to quarantine for 14 days. FM-A stated R201 had to quarantine after her last hospitalization which was a difficult time for R201 mentally. R201 was unable to see family during this quarantine, and was not surrounded by her personal items. FM-A was unaware if the facility attempted to arrange a video visit for mental health services. FM-A stated she thought if R201 would attempt to commit suicide it would have been when R201 lived in the community, and FM-A never thought it would be at her age in a nursing home. FM-A stated she felt R201 would attempt to end her life again.

On 8/11/20, at 3:47 p.m. R201 was interviewed and stated she had been awake from 1:00 a.m. until 4:00 a.m., and thought she was having a heart attack. R201 stated the doctor was called, and was told R201 was having an anxiety attack. R201 stated it was upsetting that she had not been able to see her significant other since he was admitted to a nursing home. R201 stated staff were going to try and arrange an outside visit with R201's significant other sometime next week. R201 expressed feeling lonely and isolated since no one could leave their rooms, and all activities had stopped. R201 stated she was very close with her family, and talked with her daughter daily. R201 stated she video chatted with her daughter a couple of times, and they had two outdoor visits. R201 became teary eyed, and stated she felt like she had missed so much, and the summer was gone. R201 stated she struggled with depression for many years, and now she had so much time on her hands to think and stare at the four walls within her room. R201 stated no one came to her room to visit anymore, staff walked in, did what they had to do and walked out. R201 stated she had

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21810	Continued From page 17 Parkinson's disease and could no longer crochet or knit, but could still make snowflakes from paper. R201 stated she was unable to make the snowflakes because staff took her scissors away. R201 further explained she had tried to strangle herself with the exercise band she received from therapy a couple of months ago. R201 stated she told staff she was going to kill herself, but would not tell them how. R201 stated staff took her scissors away and removed her cordless phone base, because of the cords. R201 further stated if she wanted to strangle herself she would use the cords from the desk phone staff gave her, and proceeded to point at the desk phone on the side table between her recliner chair and bed. R201 stated she was currently not seeing a mental health provider, and she would not leave the facility in fear she would have to go to the isolation unit and quarantine for 14 days. R201 stated she could not handle that. R201 stated she had a psychiatric appointment scheduled for September, and she was told since she was in a private room with a private bath, she would not have to go to the isolation unit. R201 stated she visited with the NP via video chat, and expressed her concern of feeling anxious, depressed and lonely. R201 stated she was told a meeting was going to be scheduled to see if she could have her personal items returned, and stated the meeting had not been scheduled as of date. R201 stated the day she attempted to strangle herself she was feeling very alone and isolated, and stated staff bought in her lunch that day around 11:00 a.m. and did not come in her room again until the nursing assistant (NA) found her with the Theraband around her neck at 4:00 p.m. R201 stated her family bought her an IPad after hospitalization to stay connected, play Scrabble, and go on the internet, otherwise she had nothing to occupy her time.	21810		

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21810	Continued From page 18 Review of R201's progress notes from 4/19/20, to 7/29/20, revealed the following: - 4/19/20, R201 verbalized she was suicidal and had a plan, but would not elaborate further and stated, "You'll take it away from me." The NP was notified, clonazepam (tranquilizer) was increased for a one time dose, and R201 was placed on 15 minute checks. The note further indicated R201's family was updated, and R201 safety checks were decreased to 30 minute checks for the rest of the shift. -4/20/20, SS-A spoke with R201's daughter regarding a room change. The note lacked indication SS-A had a conversation with R201's daughter regarding R201's suicidal thoughts or her current state of mental health. - 4/21/20, SS-A spoke with R201 and followed up on room change. The note lacked any indication SS-A had a conversation with R201 regarding suicidal thoughts, or her current state of mental health. - 4/30/20, R201 expressed to the nurse of feeling sad all of the time. The note further indicated the NP was contacted to address R201 blood sugars and her non-compliance with dietary choices. The note lacked indication R201's mood was addressed. - 5/27/20, R201 was "very depressed" that morning due to hearing her house was cleared out and was being sold, and her boyfriend moved to an assisted living facility. R201 expressed to registered nurse (RN)-C she felt hopeless, and did not want to live anymore. RN-C asked R201 if she had a plan to hurt herself, and R201 stated	21810		

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she had nothing to hurt herself, with otherwise she may do it. R201 was put on 15 minute safety checks and R201's daughter was updated. R201's daughter planned a window visit for that afternoon.

- 5/28/20, SS-A met with R201 and discussed recent days of feeling down. R201 denied any suicidal thoughts at that time and stated she "cannot live like this." R201 expressed increased anxiety of not being able to see her significant other. SS-A discussed arranging a Zoom visit with R201's significant other.

-5/28/20, R201 was taken off of 15 minute safety checks, had spoken with family, and had a Zoom visit with the NP which addressed blood sugars, and her depression. The note lacked any indication if R201's NP changed any medications, addressed any suicidal ideations, or added any new interventions.

- 6/8/20, R201 was found by a NA with a stretch band around her neck which was attached to the mobility bar. R201 was pulling the stretch band tightly trying to strangle herself. The note further indicated the stretch band was removed, R201 had a reddened mark all around her neck, and R201 stated she was trying to kill herself. Potential harmful items were removed from R201's room, family was notified, and the NP ordered R201 to be sent to emergency department. R201 was placed on 15 minute checks until the ambulance arrived.

- 6/9/20, SS-A spoke with R201's daughter regarding R201's recent suicidal attempt, and having her bed held. The note indicated R201's daughter stated she talked to R201 daily, and felt R201 had been in a better mood, and R201 had

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21810	Continued From page 20 not made any recent comments about wanting to hurt herself. - 6/9/20, the hospital social worker stated R201 still had thoughts of harming herself, and the hospital was looking for in-house placement. -6/19/20, R201 was readmitted to the nursing home. R201 stated the two new medications were helping with her depression, she denied thoughts of self-harm, and stated did not plan on going down that road again. -6/25/20, R201's progress notes lacked any follow up from SS-A upon return to the facility from the hospital, until six days later. - 6/25/20, Interdisciplinary Team (IDT) reviewed R201's medications and blood glucose levels, weight, non-compliance with dietary choices and indicated no MDS concerns. The IDT lacked any information on R201's mental health. -7/4/20, R201 was crying and stated she was sick of being alone in her room. The note further indicated R201 requested the nurse to sit and talk with her for a while. The nurse sat with R201 and talked until R201 felt better. -7/7/20, R201 stated the new medications she was taking were making her fell more depressed, more tired than usual, and gave her a loss of appetite. The note further indicated the nurse explained R201 was not on any new medications, but had an increase dosages and she would update the physician. -7/10/20, IDT reviewed and discussed R201's pain medications. The IDT did not address R201's mental health.	21810		

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21810	Continued From page 21 -7/10/20, a progress note indicated FM-A called the facility and left a voice mail message for the nurse manager. FM-A stated R201 called and stated her anxiety medications were not effective. The note further indicated the NP changed R201's medications two weeks prior, and wanted to give the medications a chance to work. -7/15/20, R201 had been crying all day, and told staff she needed a mental health doctor. The note further indicated R201 stated she did not want to live anymore, then denied that statement to the nurse manager and assistant director of nursing (ADON). R201's bed remote was removed due to it having a cord and R201 having suicidal ideations. The NP was notified and requested R201 to be seen by her that next day. -7/16/20, NP ordered to continue to monitor and document R201's behaviors and sleep patterns for 14 days, and ordered Zofran for nausea. -7/27/20, the Spiritual Director (SP) visited with R201. -7/29/20, R201's quarterly care conference with IDT and FM-A via phone included a review of medications, diet, activities, and R201 recently received a new IPad. On 7/7/20, R201's Psychotropic medication review indicated on 4/3/20, R201's had a onetime dose increase in a medication (unnamed) related to suicidal thoughts. Review further indicated R201 was noted to be crying and depressed on 7/4, 7/7, 7/10, 7/15, and 7/16. R201's medical record lacked evidence of mental health service, suicide prevention evaluation and	21810		

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assessments, and documentation of supporting activity interactions and participation.

On 8/12/20, at 10:17 a.m. activities aide (AA)-A stated the only in-house activity for residents was Bingo. Bingo consisted of activities staff going from room to room marking the Bingo cards on the resident's door. AA-A verified activity staff were not interacting with the residents during Bingo except to let the residents know if they won something. AA-A stated activity staff were not allowed to go into the resident's rooms for activities due to COVID-19. AA-A stated the first month activities stopped was terrible, the residents were very upset and had a hard time without activities, and now they do not say anything. AA-A stated activity staff were busy screening staff and visitors at the front door, and bringing residents on outside visits. AA-A stated staff were being hired to do the screening at the front door which would allow more time for activities with residents.

On 8/12/20, at 10:19 a.m. registered nurse (RN)-D stated she was aware of R201's depression and attempt to end her life. RN-D further stated R201 had never made suicidal comments to her. RN-D stated R201 safety interventions included removal of unsafe items with cords from R201's room. RN-D then placed R201's desk phone down to the floor, out of R201's reach.

On 8/12/20, at 10:46 p.m. the DON stated R201 she was unsure how R201 got the desk phone. The DON stated there was no formal assessment to determine when it would be appropriate to return items that had been removed for safety, and stated R201 was doing better. The DON stated R201 had not been making comments

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about harming herself, and staff were able to recognize when R201 felt depressed and teary-eyed. The DON stated staff visited with R201 frequently, provided one-on-one activities, and R201 had Zoom and outdoor visits. The DON stated staff visits were documented on the room visit logs outside of the resident's doors. The DON stated anytime anyone enters a resident's room, they were to sign in and out. The DON stated R201 didn't start complaining about not being able to make snowflakes until her scissors were taken away.

On 8/12/20, at 11:19 a.m. the DON stated R201's phone was put out of R201's reach, and maintenance did not give R201 the desk phone. The DON further started the NP did a Zoom visit with R201 recently, and the NP stated R201 could have all of her items returned to her. The DON further stated she could try plastic scissors or rounded scissors for R201, if making snowflakes was important to her. The DON stated an assessment had not been completed to determine R201's mental health status or risks of self-harm.

On 8/12/20, at 12:06 p.m. SS-A stated she was aware R201's history of depression and suicidal ideation. SS-A stated she met with R201 frequently, but did not chart her visits or conversations in R201's medical record. SS-A stated she did not conduct any formal assessment to assess R201's suicide risk level, or complete a depression assessment after R201 verbalized suicidal ideations. SS-A was unsure if R201 was receiving any outside mental health services, and stated she did not make any mental health referrals.

On 8/13/20, at 9:54 a.m. activities director (AD)-A

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

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21810	Continued From page 24 stated it had been very frustrating for staff and residents since COVID-19 restrictions of stopping group activities, and residents being restricted to their rooms. AD-A stated activity staff had taken on additional responsibilities like delivering mail and packages to residents, and screening staff and visitors at the front door. AD-A stated all group activities had stopped since COVID-19, and there were no hallway activities occurring. AD-A stated resident activities included delivering packages to resident rooms, putting items away, dropping off puzzles, books, crossword puzzles, and crafts the residents could do independently in their rooms. AD-A stated activity staff were not allowed to go into resident rooms until recently. AD-A stated Zoom visits and outdoor visits were the main focus for activities due to the high requests from families. AD-A stated the activity department currently had two IPads for Zoom visits, and more were on order. AD stated residents had complained about not having activities like they were used to, and staff tried to accommodate residents, but it was difficult due to the restrictions set by the facility. AD-A stated R201 used to play dice, paint, attend Bingo, and had expressed frustrations of not being able to have regular Bingo or see her significant other. AD-A stated activity staff could visit with R201 more if requested. AD-A stated activity staff could provide one-on-one visits doing crafts or just talking if that would help with R201's feelings of depression and isolation. AD-A stated more staff were being hired, which would allow more time and opportunities for resident activities. AD-A stated activity staff don't chart or keep records on resident's participation in an activity. AD-A stated R201 has had window visits, two or three outdoor visits, and Zoom visits with family. On 8/12/20, at 4:02 p.m. RN-D was interviewed	21810		

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again. RN-D stated she noticed a decline in R201's ambulatory status and being weepier since COVID-19. RN-D stated R201 used to see her family every day, and now she only talked with them daily, but recently started outdoor visits which seemed to help with R201's mood.

On 8/13/20, at 10:44 p.m. housekeeper (H)-A stated R201 had made comments to her about wanting to die, which she reported to nursing. H-A stated when R201 made those comments, H-A would talk with R201 about positive things like her family, which seemed to help. H-A stated R201 stated she missed going to Bingo, socializing with other residents, and was going stir crazy.

On 8/13/20, at 1:48 p.m. the spiritual coordinator (SC)-A stated she worked 3 days a week, not full days, and visited with residents. SP-A stated she recently had a leave. SP-A stated she tried to check on R201 at least once a week, but had not seen her for a while because she had been on leave. SP-A stated she did not always chart her visits with the residents because a lot of the time she was just stopping by to say "hi." SP-A stated she had seen more depression in the residents since COVID-19. SP-A stated the focus was on nursing for the residents, and more focus needed to be on the mental health of the residents, and taking a holistic approach. SP-A further stated she tried to help out the activity department as much as she could, the activities department were shorthanded, and had additional responsibilities added to their day that did not involve activities with the residents. SP-A stated there were a few residents that really struggled with depression, and identified R201 as being one of them. SP-A stated she wanted to get those residents together wearing masks, and social distancing for their mental health. SP-A further

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stated groups of any kind were not permitted in the facility.

On 8/13/20, at 4:06 p.m. the ADON stated she was working the day R201 attempted to strangle herself. The ADON stated staff stayed with R201 until the ambulance arrived, family was notified, and R201 was transported to the hospital. The ADON stated she was aware of R201's previous suicidal ideation, but R201 had no plan. The ADON stated residents were to stay in their rooms and all hallway activities were canceled per corporate office policy. The ADON stated staff rotated and took a few residents outside for activities. The ADON stated isolation could impact a resident's depression, and it was difficult to balance keeping the residents safe from COVID-19 and socialization. The ADON stated residents that went out to appointments were put on contact precautions due to the risk of exposure outside of the facility.

On 8/13/20, at 4:40 p.m. another interview was conducted with the DON. The DON stated she was notified immediately by the ADON of R201's suicidal attempt. The DON stated she instructed staff to call 911, notified R201's medical provider and family, and placed R201 on 15 minute checks until R201 left the building. The DON stated the plan when R201 returned to the facility was to remove potentially harmful items from R201's room, and replace the call light with a call box without cords. The DON stated she would expect a comprehensive assessment to be completed within a week of R201's hospital return. The DON verified R201 was not seen by SS-A until 6/25/20, nor had a comprehensive assessment completed to determine R201's new baseline after readmission. The DON stated R201's nurse manager visited with her every day,

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and SS-A saw R201 frequently after R201's hospital return, although documentation in R201's electronic medical record (EMR) did not support that. The DON stated back in April 2020, R201 verbalized wanting to harm herself. The DON stated R201's medical provider was notified, and R201's care plan directed staff to watch for signs and symptoms of depression, and to allow R201 to talk. The DON further stated R201 did not have a plan to end her life, and no updates were made to R201's care plan at that time. The DON stated R201's care plan should have been updated in April after R201 expressed suicidal ideation. The DON stated updating R201's care plan and nursing assistant care sheets were important so staff knew what was going on with R201, and to ensure R201's safety. The DON verified R201's care plan was not updated following her suicide attempt, and stated it should have been updated. The DON stated upon R201's return from the hospital, staff were informally educated on R201 suicide attempt by memo and meetings. The DON stated R201 had not been seen by a mental health provider since R201 returned from the mental health unit, and further stated R201 had an appointment scheduled in September (three months after R201's suicide attempt). The DON stated group and hallway activities were canceled, and further stated resident's received socialization by activity staff delivering packages to resident rooms, offering snacks, and Zoom and outside visits. The DON stated R201's activities included one-on-one visits, outdoor and Zoom visits with family, and R201 recently received her own IPad. The DON verified IDT notes from 6/25/20, did not address R201's suicidal ideation, depression, or overall mental health status. The DON stated the facility did not have an assessment to determine resident's suicidal ideation risks, and recently found a

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21810	Continued From page 28 suicide contract on-line. On 8/13/20, at 5:48 p.m. the administrator stated if a resident verbalized wanting to harm themselves, she would expect the nurse to talk with the resident, and find out if the resident had a plan. The administer further stated an assessment would be completed to determine the level of seriousness, safety checks would be initiated, harmful objects would be removed from the room, and the medical provider and family would be notified. The administrator stated safety checks would be removed after the nurse or SS-A talked with the resident to determine if there was a need to continue, or if the resident needed to be sent to the hospital. The administrator stated SS-A could have completed a depression assessment to identify if there were other areas of concern after R201 expressed suicidal ideation. The administrator stated she would expect a comprehensive assessment to be completed upon R201's return from the hospital right away, within a day, by SS-A to create a new baseline and identify any concerns. The administrator stated she expected care plans to be updated with any resident changes, and verified R201's care plan should have been updated after R201 verbalized suicidal thoughts back in April 2020. The administrator stated they had never experienced a resident attempt to commit suicide, and did not have any formal assessment or tools to assess a resident's risk level that expressed suicidal ideation. The administrator stated staff were not formally educated on what to do if a resident verbalized suicidal ideation. The administrator stated staff were informed on reporting the smaller things like watching a resident's mood closely with medication changes. The administrator stated R201 had been offered mental health services in	21810		

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the past, and R201 declined. The administrator was unable to provide documentation to support the facility made referrals for mental health services for R201. The administrator verified R201 was not receiving mental health services at that time, and had an appointment scheduled for September. The administrator stated there was a mental health practitioner who made in-house visits for another resident, and the facility could have requested R201 to be seen. The administrator stated the facility was in the process of hiring more staff so the activity staff had more time for resident activities instead of using activities for screening staff and visitors. The administrator stated activity staff were allowed in resident rooms for one-on-one activities, and activity staff passed out mail, art projects, and books to the residents. The administrator stated the focus for the activities department had been on Zoom meetings and outdoor visits. The administrator stated residents were allowed out of their rooms as long as they wore a mask, and were social distancing. The administrator further stated staff had been used to keeping residents in their rooms, and need to be re-educated.

The facility provided the following on education provided to staff for residents that expressed suicidal ideation: Memo From The Desk Of The Administrator dated 6/22/20, and 6/29/20, reminded staff after an incident with a resident, exercise bands would no longer be stored in the residents rooms. The memo also reminded staff if a resident had a medication change to watch for adverse side effects including but not limited to changes in sleep/eating habits, depression, anxiety, mania, panic attacks, restlessness, or suicidal thoughts/ideation to notify the nurse.

The facility policy Suicide Precaution Policy

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21810	Continued From page 30 revised date 4/17, directed: 1. Residents observed attempting suicide call 911 2. Any employee hearing or observing any suicidal talk or behavior of a resident must report such to the nurse in charge immediately. 3. Employee to remain with the resident until the charge nurse assess. Determine if resident has a plan, remove all equipment that could be used and/cause harm, i.e. sharps, cords, belts, etc., and begin 15 minute visual checks on resident. 4. Charge nurse to contact resident's Physician, Administrator, Director of Nursing, Social Services, and Clergy (if appropriate). 5. Nursing personnel will be informed of the suicide threat and to report changes in the resident's behavior immediately. 6. Resident's may be temporarily secluded if there is a potential of danger to him/herself or others. 7. An assessment of the resident's behavior will be made by the interdisciplinary care plan team within 24-48 hours of such incident to determine interventions that may be necessary to prevent the recurrence of such threats. Revised care plans will be developed to reflect such interventions. 8. Document all the above and update the care plan. The facility policy Comprehensive Care Planning Process undated, was to ensure each resident's status is properly assessed and that the highest practicable functional status can be attained and maintained. The policy directed the following: -Nursing Department will be responsible for modifying, adding, updating the following focuses: Additional Vulnerability Areas (if applicable), Behavior, and Safety. -Activity Department in collaboration with Social	21810		

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21810	Continued From page 31 Service will be responsible for modifying, updating the following focus: Psycho-Social/Activities. -Nursing, Dietary, Social Service, Activity Departments will schedule new interventions or link interventions previously scheduled to improve resident's functioning or minimize decline as needed on the care plan. The Director of Social Services Job description undated, indicated the responsibilities and standard of the DSS for resident services were to provide individual, family, and group services designed to improve social functioning and reduce the psychosocial problems of residents. The facility policy on Behavioral Health Services and Activities were requested and not provided by the facility. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and/or revise policies and procedures to ensure residents receive adequate behavioral health services. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		