

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Viewcrest Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 Church Street Duluth, MN 55811	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109</p> <p>Based on observation, interview, and record review the facility failed to ensure nebulized medications were administered safely for 1 of 1 resident (R8) who was observed to self-administer a nebulizer and had not been assessed as safe to do so.</p> <p>Findings include:</p> <p>R8's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and diagnoses of spastic quadriplegic cerebral palsy (CP), asthma, chronic cough, and shortness of breath. R8 had functional limitations in range of motion of both upper extremities, needed substantial assistance with oral care, and was dependent for hygiene and transfers.</p> <p>R8's care plan dated 4/2/24, identified an alteration in respiratory status related to asthma and spastic CP with interventions for a nurse to administer inhalers and nebulizer's as ordered as R8 was unable to do so for herself. It further identified nursing staff to monitor lung sounds, report concerns, keep head of bed elevated when in bed, and observe for the need for oxygen.</p> <p>An assessment for self-administration of medication dated 1/4/24, identified R8 was unable to self-administer medication.</p> <p>R8's provider orders dated 9/1/22, identified orders for albuterol sulfate (a medication used to treat and prevent breathing problems) three milliliters (mL) two times daily to be administered via inhalation with a nebulizer (a machine used to directly administer medications into the lungs).</p> <p>During an observation on 7/10/24 at 7:30 a.m., R8 was observed in her bed with the head of bed elevated to about 45 degrees, her eyes were closed, and head was bent to the left and forward. There was a nebulizer machine running and the pipe (the mouthpiece for the medication delivery) was near the left side of her face. It could not be seen how much medication was left in the chamber of the device, if any. At 7:48 a.m., licensed practical nurse (LPN)-A was observed to go into R8's room, wake resident and remove the mouthpiece and tubing from her and set it on the table to the left of the bed and went back to the medication cart.</p> <p>During an interview on 7/10/24 at 1:08 p.m., R8 confirmed she uses the nebulizer two times a day and the nurse would set it up and hand it to her.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/10/24 at 1:12 p.m., LPN-A confirmed setting up R8's nebulizer treatment that morning. The medication administration record did not reflect an order to self-administer nebulizer treatments, which LPN-A thought she had.</p> <p>During an interview on 7/11/24 at 9:42 a.m., registered nurse (RN)-A confirmed the self-administration of medication assessment for R8 indicated she could not administer her own medications.</p> <p>During an interview on 7/11/24 at 11:01 a.m., the director of nursing (DON) stated it would be her expectation that residents who are self-administering medication would be assessed and have an order to do so. The DON further stated this was important for safety.</p> <p>A policy, Self-Administration of Medication by Residents dated 5/1/24, identified the purpose was to provide guidance to staff for assessing and accommodating resident's wish to self-administer their medications. All residents would be asked their preference for self-administration and an assessment would be done on those wishing to do so. An assessment would be performed based on the resident's cognitive status, physical status, and which medication to evaluate if they were clinically appropriate to self-administer medication.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49877</p> <p>Based on interview and document review, the facility failed to ensure a Level I Pre-Admission Screening and Resident Review (a requirement to help ensure individuals are not inappropriately placed in nursing homes for long term care (PASSAR)) was completed, retained in the medical record, and readily available to ensure continuity of care with mental health needs for 1 of 1 resident's (R30) reviewed for PASARR.</p> <p>Findings include:</p> <p>R30's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and diagnoses of anxiety, depression, and manic depression (bipolar disease).</p> <p>R30's undated face sheet, received on 7/11/24, identified R30 was admitted to the facility on [DATE], and diagnoses included bipolar disorder, major depressive disorder, and panic disorder.</p> <p>During interview on 7/10/24 1:43 p.m., the director of social services (DSS) reviewed the document labeled PAS in R30's medical record. The PAS document dated 1/8/18, identified Senior LinkAge Line did not complete the PAS and forwarded the PAS request to a county/managed care organization for PAS processing. DSS confirmed the document did not identify if a PASSAR level 1 was completed or if a PASSAR level II was recommended.</p> <p>During interview on 7/10/24 at 3:15 p.m., the director of nursing (DON) stated the director of social services was responsible for the PASARR and would expect them to complete the task.</p> <p>A policy, Pre-Admission Screening dated 3/7/22, identified the care center will ensure all individuals seeking admission will receive a Pre-Admission Screening (PAS) and the PAS notice indicating he/she has been screened will be retained by the care center.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109</p> <p>Based on observation, interview, and record review the facility failed to properly care for oxygen and nebulizer equipment for 1 of 2 residents (R8) reviewed for respiratory equipment to help prevent the potential for infection.</p> <p>Findings include:</p> <p>R8's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and diagnoses of spastic quadriplegic cerebral palsy (CP), asthma, chronic cough, and shortness of breath.</p> <p>R8's care plan dated 4/2/24, identified an alteration in respiratory status related to asthma and spastic CP with interventions for a nurse to administer inhalers and nebulizers as ordered as R8 was unable to do so for herself, monitor lung sounds, report concerns, keep head of bed elevated when in bed, and observe for the need for oxygen.</p> <p>R8's provider orders dated 9/1/22, identified orders for albuterol sulfate (a medication used to treat and prevent breathing problems) three milliliters (mL) two times daily to be administered via inhalation with a nebulizer (a machine used to directly administer medications into the lungs), oxygen via mask or cannula at one to four liters per minute (LPM) as needed, to change the nebulizer mouthpiece and tubing every week on Friday, and daily at bedtime to wash nebulizer mask, mouthpiece, and reservoir and leave out to dry overnight. The orders did not contain an order set to change the oxygen tubing, cannula, or bubbler (a bottle used for water to help humidify the oxygen).</p> <p>On 7/8/24 at 2:13 p.m., R8's nebulizer machine was sitting on a table near her bed with the tubing hooked up to the chamber (the piece the liquid medication is placed in), and the chamber attached to the mouthpiece. There was a small amount of clear liquid in the bottom of the chamber and clear droplets of liquid covering the upper portions of the chamber. Oxygen tubing was draped over the table and did not contain a date. R8 confirmed she used the oxygen at night and the nebulizer two times a day.</p> <p>On 7/10/24 at 1:08 p.m., R8 was wearing oxygen and her nebulizer machine was sitting on a table near her bed with the tubing hooked up to the chamber and mouthpiece with a small amount of clear liquid in the bottom of the chamber and clear droplets of liquid covering the upper portions of the chamber. R8 confirmed she used the nebulizer twice a day.</p> <p>During an interview on 7/10/24 at 1:12 p.m., LPN-A stated oxygen tubing was to be changed every Friday night for everyone, it was the same for nebulizer mouthpiece and tubing. LPN-A confirmed she did not disassemble and rinse out the nebulizer chamber and mouthpiece after R8's treatment this morning.</p> <p>During an interview on 7/11/24 at 9:42 a.m., RN-A stated the oxygen and nebulizer tubing, and mouthpieces were changed out weekly on the overnight shift and were to be dated when changed. RN-A also stated the nebulizer mouthpiece and chamber should be disassembled, rinsed out, and left to air dry after use.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/11/24 at 11:01 a.m., the director of nursing (DON) stated her expectation was for tubing to be dated when replaced weekly, and for a nebulizer mouthpiece and chamber to be taken apart and rinsed out after use. These items were important for infection control and medication safety.</p> <p>A document, Viewcrest Health Care Nebulizer Cleaning dated 2/15/23, identified the purpose was to provide guidelines for the cleaning of a nebulizer. After each use, disassemble the nebulizer, rinse each piece with warm water, and let air dry on a clean paper or cloth towel. Daily the pieces were to be washed with warm soapy water and let air dry on a clean paper or cloth towel.</p> <p>A document, Viewcrest Health Care Oxygen dated 9/23/23, identified oxygen tubing and cannula would be replaced and marked with the date weekly.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>49877</p> <p>Based on interview and document review, the facility failed to consistently offer and provide a nutrient and/or calorie substantive snack after the dinner meal and before bedtime, leaving 15 hours between the evening and morning meals. This had the potential to affect 93 out of 94 residents who take in sustenance orally.</p> <p>Findings include:</p> <p>During interview on 7/08/24 at 5:19 p.m., R47 stated it has been months since a snack was offered after the dinner meal and before bedtime.</p> <p>R47's quarterly Minimum Data Set (MDS) date 4/16/24, identified intact cognition and a diagnosis of diabetes mellitus.</p> <p>During interview on 7/08/24 at 12:14 p.m., dietary manager (DM) stated mealtimes are 7:30 a.m., 11:30 a.m., and 4:30 p.m. with snacks offered at 2:30 p.m. (siesta snack pass) and 7:30 p.m. (bedtime snack pass). Snack carts are prepared and delivered to the units by kitchen staff. Kitchen staff complete the 2:30 p.m. snack pass and nursing staff complete the 7:30 p.m. snack pass. DM used a snack sheet log to ensure each resident was offered a snack twice a day.</p> <p>During interview on 7/09/24 at 3:05 p.m., nursing assistant (NA)-A confirmed working afternoon's on R47's unit. NA-A stated kitchen staff do not deliver a snack cart to the unit in the evenings and a bedtime snack pass never occurs.</p> <p>During interview on 7/09/24 at 3:17 p.m., NA-B confirmed working afternoons on a unit other than R47's unit. NA-B stated a bedtime snack pass sometimes occurred on this unit. If snacks were distributed/offered, it would be by kitchen staff, not nursing staff.</p> <p>During interview on 7/09/24 at 3:23 p.m., NA-C confirmed working afternoons on a unit other than R47's and NA-B's unit. NA-C stated kitchen staff will sometimes provide a snack cart in the evenings. A bedtime snack was not offered to each resident. The snack cart remained next to the nurse's station and if a resident wanted a snack, they would have to ask for one.</p> <p>During interview on 7/10/24 at 1:38 p.m., the director of nursing (DON) explained a bedtime snack pass was required at the facility because there was too many hours between dinner and breakfast. The DON stated it would be her expectation kitchen staff deliver an evening snack cart to each unit and nursing staff brought the cart room to room, offering a snack to each resident. DON stated it was important to offer a bedtime snack for medical and quality of care purposes.</p> <p>During interview on 7/11/24 at 8:29 a.m., the administrator stated having the expectation a bedtime snack was offered to each resident every evening. A bedtime snack was important for medical and quality of care purposes.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>June and July 2024 snack sheet logs were requested, but not provided. The last documented snack pass occurred on May 4th, 2024.</p> <p>A policy, Weight Monitoring Program dated 1/18/21, identified the care center will ensure there are no more than 14 hours between a substantial evening meal/snack and breakfast the following day, expect when a nourishing snack is served at bedtime.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49877</p> <p>Based on observation, interview, and document review, the facility failed to ensure cold beverage items were stored at temperature to prevent foodborne illness. This had the potential to affect 16 out of 94 residents who were served beverages from the dining room beverage cart.</p> <p>Findings Include:</p> <p>On 7/10/24 at 7:28 a.m., dietary aid (AD)-A was preparing five cold beverage carts. Each cart had a bin on the top shelf which contained half gallon containers of assorted milk and juice. One of the five carts also contained milk and juice containers on the second shelf which was not in a bin. Ice was added to all 5 bins containing milk and juice and no ice or other cooling source was applied to the milk or juice on the cart which contained milk and juice on the second shelf.</p> <p>Items on the second shelf included following:</p> <ul style="list-style-type: none"> -opened whole milk -opened and unopened 2% milk -unopened chocolate milk -opened and unopened almond milk -opened cranberry, pineapple, prune, and orange juice <p>Each juice container stated to refrigerate after opening.</p> <p>On 7/10/24 08:05 a.m., the beverage cart was brought to the dining room. All 16 residents in the dining room received milk or juice from the beverage cart. All milk or juice served to the resident's during meal service was held on ice.</p> <p>On 7/10/24 at 8:49 a.m., meal service concluded. DA-A removed the beverage cart from the dining room and returned it to the kitchen.</p> <p>During interview on 7/10/24 at 8:50 a.m., DA-A stated she was planning to return the beverage cart items to the refrigerator so they could be served tomorrow. DA-A stated she always stocked the second shelf of the dining room beverage cart with extra beverages and these extra beverages are never held on ice. DA-A did not express any awareness of the hazards related to this practice.</p> <p>On 7/10/24 at 8:51 a.m., dietary manager (DM) obtained the temperatures of the beverage items stored on the second shelf of the dining room beverage cart. The temperatures ranged from 48 to 54 degrees Fahrenheit (F). DM stated it was not safe to serve these items and threw each item away. DM stated she has educated staff on the importance of keeping cold beverages ice and plans to re-educate staff.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview on 7/11/24 at 8:27 a.m., the administrator stated having the expectation cold beverages were stored and served at safe temperatures. This was important to prevent the risk of illness.</p> <p>A facility policy, Food Temperature dated 7/9/11, identified all cold items must be served at a temperature of 40 degrees F or below.</p> <p>The United States Food and Drug Administration (FDA) Food Code dated 2022, identified milk as a temperature control for safety food and foods requiring refrigeration should be maintained at or below 41 degrees F to prevent foodborne illness.</p>		