STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	05/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VIEWCREST HEALTH CENTER	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)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately (within two hours) to the administrator and State Agency (SA) for 1 of 3 residents (R10) reviewed for abuse. Findings include: R10's Face Sheet printed 5/14/20, indicated R10's [DIAGNOSES REDACTED]. R10's care plan initiated on 5/20/17, indicated R10 required assistance with toileting, personal hygiene, and transfers. R10's care plan also indicated she may not understand all of a conversation, had a history of [REDACTED]. R10's care plan indicated R10 was an assist of one with cares until 5/14/20, when she became an assist of two. R10's care plan indicated staff were to allow time for resident to discuss her feelings, to express herself, allow time for decision making, and to speak to resident calmly. A facility incident report submitted to the SA on 5/10/20, at 9:45 a.m. indicated R10 communicated that two people pushed her down onto the toilet on 5/9/20, at 10:00 a.m. R10 communicated that as a result, she now had pain in her right shoulder and rib cage. On 5/14/20, at 11:30 a.m. registered nurse (RN)-A was interviewed. RN-A stated he first heard about the alleged abuse on 5/9/20, around 10:00 a.m. to 11:00 a.m. from the trained medication aide (TMA)-A. RN-A stated the alleged abuse did not make sense to him as R10 was an assist of one. RN-A stated he did however reassign R10 to a different nursing assistant, and asked the alleged perpetrator (AP) if she had dropped R10, and the AP denied dropping R10. RN-A stated the next day, on 5/10/20, it was reported to him that R10 was asking for x-rays. At that time RN-A stated he interviewed R10, and did a brief assessment. RN-A called the on-call physician for x-rays, notified the administrator, reassigned R10 to the nursing assistants on a different unit, and filed the vulnerable adult report to the SA. RN-A stated he should have investigated the alleged abuse on 5/9/20, when he first heard about it. RN-A verified he had previous training on abuse identification, prevention, and reporting requirements. RN-A stated the director of nursing (DON) talked to him on 5/13/20, and told him he should have reported it to the administrator on 5/9/20. -at 12:06 p.m. TMA-A was interviewed. TMA-A stated she notified RN-A on 5/9/20, sometime after 8:30 a.m. that R10 was alleging staff dropped her. On 5/15/20, at 11:16 a.m. the administrator was interviewed and verified the abuse allegation should have been reported immediately on 5/9/20. The facility policy Skilled Nursing Facility Maltreatment Reporting Guidelines dated 4/1/19, directed staff that immediate notification to the administrator of any suspected maltreatment is necessary in order to fully assess the situation and proceed with reporting to officials according to regulation.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure an abuse allegation was thoroughly investigated and the alleged perpetrator (AP) was immediately removed from the facility for safety of the residents pending investigation for 1 of 3 residents (R10) reviewed for abuse. Findings include: R10's Face Sheet printed 5/14/20, indicated R10's [DIAGNOSES REDACTED]. R10's care plan initiated on 5/20/17, indicated R10 required assistance with toileting, personal hygiene, and transfers. R10's care plan also indicated she may not understand all of a conversation, had a history of [REDACTED]. R10's care plan indicated R10 was an assist of one with cares until 5/14/20, when she became an assist of two. R10's care plan indicated staff were to allow time for resident to discuss her feelings, to express herself, allow time for decision making, and to speak to resident calmly. A facility incident report submitted to the SA on 5/10/20, at 9:45 a.m. indicated R10 communicated that two people pushed her down onto the toilet on 5/9/20, at 10:00 a.m. R10 communicated that as a result, she now had pain in her right shoulder and rib cage. On 5/14/20, at 11:30 a.m. registered nurse (RN)-A was interviewed. RN-A stated he first heard about the alleged abuse on 5/9/20, around 10:00 a.m. to 11:00 a.m. from the trained medication aide (TMA)-A. RN-A stated the alleged abuse did not make sense to him as R10 was an assist of one. RN-A stated he did however reassign R10 to a different nursing assistant, and asked the alleged perpetrator (AP) if she had dropped R10, and the AP denied dropping R10. RN-A stated the next day, on 5/10/20, it was reported to him that R10 was asking for x-rays. At that time RN-A stated he interviewed R10, and did a brief assessment. RN-A called the on-call physician for x-rays, notified the administrator, reassigned R10 to the nursing assistants on a different unit, and filed the vulnerable adult report to the SA. RN-A stated he should have investigated the alleged abuse on 5/9/20, when he first heard about it. RN-A verified he had previous training on abuse identification, prevention, and reporting requirements. RN-A stated the director of nursing (DON) talked to him on 5/13/20, and told him he should have investigated the allegation. -at 12:06 p.m. TMA-A was interviewed. TMA-A stated she notified RN-A on 5/9/20, sometime after 8:30 a.m. that R10 was alleging staff dropped her. On 5/15/20, at 11:16 a.m. the administrator was interviewed and verified the abuse allegation should have been investigated immediately on 5/9/20. The facility policy Maltreatment Investigation & Reporting dated 1/30/16, directed staff were to conduct an initial investigation immediately to determine what happened, and whether the incident requires reporting to the Office of Health Facility Complaints (OHFC) or the Minnesota Adult Abuse Reporting Center (MAARC).
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene, infection control procedures, and use of PPE (personal protective equipment) were followed in accordance with Centers for Disease Control (CDC) guidelines for COVID-19, to prevent or mitigate the risk of cross-contamination by staff for 3 of 3 residents (R13, R14, R16) reviewed for transmission based precautions. This had the potential to affect all 78 residents residing in the facility. Findings include: R13's Face Sheet printed 5/14/19, indicated R13's [DIAGNOSES REDACTED]. R13's nursing assistant care guide undated, indicated R13 was on isolation precautions. R13's progress notes dated 5/13/20, indicated R13 had a severe change in condition, oxygen saturation level dropped to 48 on four liters of oxygen, and had a harsh chronic cough. R13 was tested for Coronavirus (COVID-19), had a chest x-ray, and was transferred to a private room on droplet precautions. R14's Face Sheet printed 5/14/20, indicated R14's [DIAGNOSES REDACTED]. R14's nursing assistant care guide undated, indicated R14 was on droplet precautions. R14's progress note dated 5/7/20, indicated R14 complained of a headache, being nauseated, had a productive cough, and was not feeling well. R14 was tested for COVID-19, transferred into a private room, and placed on precautions pending COVID-19 test results. R16's Face Sheet printed 5/14/20, indicated R14 [DIAGNOSES REDACTED]. R16's progress note dated 5/1/20, indicated R16 was admitted to the facility from the hospital for therapy. R16's lab report indicated on R16 was tested for COVID-19 on 4/29/20, and received negative results on 4/30/20. On 5/14/20, at 12:17 p.m. R14's room was observed. On the outside of R14's door was a hanging cart with PPE containing gloves, gowns, surgical masks, disposable plastic bags, and instruction on what PPE to use for droplet precautions. Nursing assistant (NA)-C was observed entering R14's room delivering a meal tray. NA-C was wearing goggles, a face shield, and a surgical mask. NA-C did not perform hand hygiene, or don gloves or a gown before entering R14's room.

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

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) NA-C set up R14's meal tray, walked to the PPE cart hanging on the door, grabbed a pair of gloves, and shut the door. At 12:19 p.m. NA-C exited R14's room, carrying R14's meal tray. NA-C did not perform hand hygiene, change the surgical mask or disinfect the face shield. NA-C proceeded to place R14's uneaten meal tray on top of the meal cart in the hallway. NAR-C walked behind the nurses' station, poured a cup of coffee, heated a cup of water in the microwave, and prepared oatmeal in the cup. NA-C re-entered R14's room without performing hand hygiene, or putting on gloves or a gown. NA-C set up R14's oatmeal and coffee, exited R14's room, and did not perform hand hygiene, change the surgical mask, or disinfect the face shield. NA-C then entered R16's room and did not perform hand hygiene before entering. NA-C straightened up R16's tray table then exited R16's room with the meal tray, and delivered to the tray to the meal cart in the hallway. NA-C did not perform hand hygiene after exiting R16's room. On 5/14/20, at 12.30 p.m. NA-C was interviewed. NA-C stated R14 was on droplet precautions because of a cough. NA-C stated the required PPE needed to enter a resident's room on droplet precautions would be to put on goggles, face shield, mask, gloves, and gown. NA-C stated she did not put on gloves or a gown before entering R14's room. NA-C verified she did not change her surgical mask or disinfect her face shield after exiting R14's room. NA-C stated she wasn't in R14's room very long, and did not provide any personal cares, so those steps were not required. NA-C stated she did not perform hand hygiene before entering or exiting R14 and R16's rooms. On 5/14/20, at 1:16 p.m. R13's door had a stop sign on the outside of the door indicating droplet precaution, and instructing to perform hand hygiene, apply surgical mask, gloves, and a gown before entering. R13's door was open, with a PPE holder hanging on the outside of R13's door containing gloves, and surgical masks. Inside of R13's room were double linen bins, and reusable gowns. Registered nurse (RN)-A was observed exiting R13's room wearing a face mask, face shield, a stethoscope around the neck, and carrying a pulse oximeter. RN-A was not wearing gloves or a gown, and did not replace his face mask or disinfect his face shield after exiting R13's room. On, 5/14/2020, at 1:37 p.m. RN-A was interviewed. RN-A stated R13 transferred to room an isolation room on 5/13/20, and was put on droplet precautions. RN-A stated R13 developed a cough, and oxygen levels dropped. RN-A stated R13 was tested for COVID-19 on 5/13/20, and the results were still pending. RN-A stated he was in with R13 completing an assessment to give R13's family an update. RN-A stated he did not put on the appropriate PPE before entering R13's room. RN-A stated he should have put on gloves and a gown before entering R13's room. RN-A further stated he did not change his face mask or disinfect his face shield after exiting R13's room. On 5/15/20, at 11:40 a.m. the RN infection control preventionist (RN-C) verified R13 was on droplet precautions, was tested for COVID-19 on 5/13/20, and lab results were pending. RN-C verified R14 was on droplet precautions, was tested for COVID-19 on 5/7/20, and results came back negative on 5/11/20. RN-C stated R16 was a new admit on 5/1/20, and was put in isolation for 14 days. RN-C stated facility staff were expected to perform hand hygiene, put on gloves, gown, face mask, eye shield, and goggles prior to entering resident rooms on droplet precautions. RN-C further stated staff were expected to perform hand hygiene, put on a new face mask, and disinfect their face shield after exiting a droplet precaution room. On 5/15/20, at 12:05 p.m. the director of nursing (DON) stated staff were expected to perform hand hygiene anytime entering a resident's room, and either washing hands, or use hand sanitizer before exiting a resident's room. The DON further stated staff were expected to don and doff the appropriate PPE indicated for that resident before entering a room on droplet precautions to prevent further spread of illness, and to ensure residents and staff are kept safe. The facility policy Hand Hygiene revised 5/17, directed hand washing before and after contact with environment surfaces or equipment in the immediate vicinity of the resident, after removing gloves or gowns, and prior to handling food. The policy further directed use of hand-sanitizer before leaving the room and if not in direct physical contact with the resident or resident's environment surfaces or equipment since last washing hands. The facility policy COVID-19 Segregation and Isolation Measures dated 4/2/20, directed the use of recommended PPE designated for COVID-19.