



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 3, 2026

Administrator
VIKING MANOR NURSING HOME
317 FIRST STREET NORTHWEST
ULEN, MN 56585

RE: CCN: 245559
Cycle Start Date: August 26, 2026

Dear Administrator:

On August 26, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: stacy.line@state.mn.us
Office: 218-332-5159

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 26, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 26, 2027 (six months after the identification of noncompliance) your provider agreement will be

terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

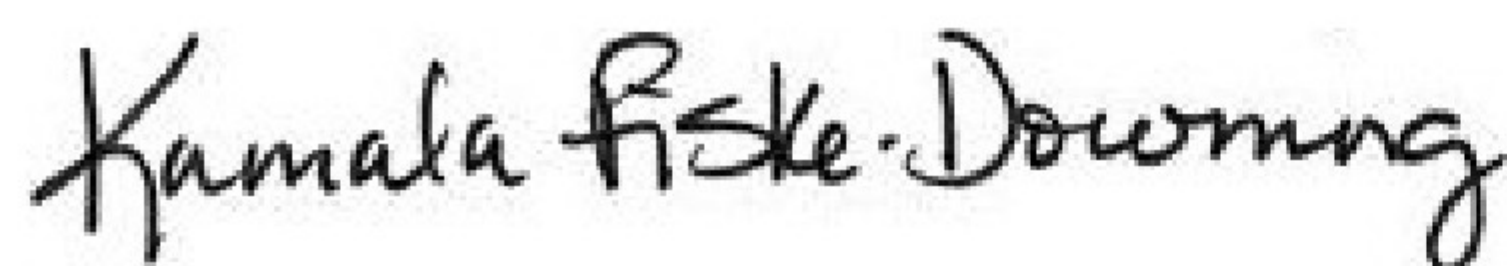
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing

Compliance Analyst | Federal Enforcement

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245559		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - 1965 BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER VIKING MANOR NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST , ULEN, Minnesota, 56585			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 08/26/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Viking Manor Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			09/03/2026

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 reverse for further 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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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Viking Manor Nursing Home is a 1-story building without a basement and constructed at five different times. The original building was constructed in 1965 and was determined to be of Type II (000) construction. An addition to the west was constructed in 1981 that was determined to be Type V (111) construction and is separated from the original building with a 2-hour fire barrier. A connecting link was constructed in 1994 to the north end of the east wing to connect the facility to an apartment building and a connecting link was constructed in 1998 to the south of the west wing to connect the facility to a clinic. Both buildings are separated from the existing nursing home with 2-hour fire barriers. In 2005 a 24 foot by 42 foot, PT addition was constructed to the south of the east wing that is Type II(000) constriction, 1-story without a basement. The entire building is fire sprinkler protected and the facility has a fire alarm system with smoke detection			K0000			09/03/2026

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K0000 Bldg. 01	Continued from page 2 in the corridor system and in common areas in the 1965 building, with sleeping room smoke detectors in the 1981 addition and the 1965 building that are on the fire alarm system. The facility was surveyed as one building. The facility has a capacity of 45 beds and had a census of 41 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET.			K0000			09/03/2026
K0372 SS = F Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier construction per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, and 8.5.2.2. These deficient findings could have a widespread impact on residents within the facility. Findings include: On 08/26/2026 at 11:02 AM, it was revealed by observation that there was an unsealed penetration around a conduit containing multiple wires above the smoke barrier doors leading to the Southeast Hall. On 08/26/2026 at 11:04 AM, it was revealed by observation that the fire caulking had fallen out of the penetration around wires going through the			K0372	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. A detailed description of the corrective action taken or planned to correct the deficiency. Unsealed penetration around conduit containing multiple wires and or pipe above the smoke barrier doors in the Southeast Hall, Northeast Hall and Center Hall were observed. New camera installation was completed by cabling company recently and observed no fire caulking in place by the wires added and or pipe areas. This was corrected by adding fire caulking immediately after survey exit on 08/26/2026 to ensure penetrations are properly fire stopped. Address the measures that will be in place to ensure the deficiency does not reoccur. Monthly audits will be completed by the Maintenance Department and followed up by the Administrator to ensure all areas of Penetrations shall be properly fire stopped to prevent the deficiency from recurring. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.		08/27/2026

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K0372 SS = F Bldg. 01	Continued from page 3 smoke barrier above the doors for the Center Hall. On 08/26/2026 at 11:06 AM, it was revealed by observation that there was an unsealed penetration around a pipe going through the smoke barrier above the smoke barrier doors for the Northeast Hall. An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.			K0372	Continued from page 3 Monthly and as needed, ongoing audits will be completed by the Maintenance Supervisor, with follow-up by Administrator, to ensure all areas in the smoke barrier locations penetrations shall be properly fire stopped to prevent deficiency from recurring. Identify who is responsible for the corrective actions and monitoring of compliance. Monthly and as needed, ongoing audits will be completed by the Maintenance Supervisor, with follow-up by Administrator, to ensure compliance. The actual or proposed date for completion of the remedy. Maintenance Director added fire caulking in Northwest, Southeast and Center Hall on 08/26/2026.		08/27/2026
K0353 SS = E Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by:			K0353	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. A detailed description of the corrective action taken or planned to correct the deficiency. Storage rack in West Wing Linen Storage Room top shelf was removed on 08/27/2026 to ensure the 18 inches clearance under the sprinkler head. Address the measures that will be in place to ensure the deficiency does not reoccur. Monthly door audits will be completed by the Maintenance Department and followed up by the Administrator to ensure all areas of the nursing home maintain storage at least 18 inches away from sprinkler heads and to prevent the deficiency from recurring.		08/27/2026

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K0353 SS = E Bldg. 01	Continued from page 4 Based on review of available documentation, observation, and staff interview, the facility failed to test and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.2, and 5.3.3.1. These deficient findings could have a patterned impact on residents within the facility. Findings include: On 08/26/2026 at 11:40 AM, it was revealed by observation that a storage rack with shelving in the West Wing Linen Storage Room was placed too close to a sidewall sprinkler head. An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.			K0353	Continued from page 4 Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Monthly and as needed, ongoing audits will be completed by the Maintenance Supervisor, with follow-up by Administrator, to ensure storage is not kept within 18 inches of sprinkler heads in accordance with NFPA25 requirements. Identify who is responsible for the corrective actions and monitoring of compliance. Monthly and as needed, ongoing audits will be completed by the Maintenance Supervisor, with follow-up by Administrator, to ensure compliance. The actual or proposed date for completion of the remedy. Maintenance Director removed the shelf in the West Wing Linen Storage Room on 08/27/2026.		08/27/2026
K0321 SS = D Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A			K0321	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. A detailed description of the corrective action taken or planned to correct the deficiency. Self closing device for the Door on the Clean Linen storage room has been adjusted so the self-closure is working properly Maintenance Supervisor completed the adjustment after survey on 08/26/2026. Address the measures that will be in place to ensure the deficiency does not reoccur.		08/27/2026

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K0321 SS = D Bldg. 01	Continued from page 5 a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, and 19.3.2.1.3. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 08/26/2026 at 11:17 AM, it was revealed by observation that the self-closing device for the Clean Linen Storage Room door had been disconnected so the door is not able to close as designed. An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery.			K0321	Continued from page 5 Monthly door audits will be completed by the Maintenance Department followed up by Administrator to ensure door shall fully self-close and is not obstructed to ensure deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Monthly and as needed, ongoing audits will be completed by the Maintenance Supervisor, followed up by Administrator, overseeing this completion to ensure all the self-closing devices on doors are functioning properly. Identify who is responsible for the corrective actions and monitoring of compliance. Monthly door audits will be completed by the Maintenance Department to monitor compliance followed up by Administrator, overseeing this completion to ensure all the self-closing devices on doors are functioning properly. The actual or proposed date for completion of the remedy. Maintenance Director corrected the error of the disconnection of the self-closing device on the door on 08/26/2026.		08/27/2026
K0363 SS = D Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.			K0363	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. A detailed description of the corrective action taken or planned to correct the deficiency. Door on the Visitor's lounge has been adjusted so the self-closure is working properly. Latch is working properly and ensured there is no gap		08/27/2026

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K0363 SS = D Bldg. 01	Continued from page 6 Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3.1, and 19.3.6.3.5. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 08/26/2026 at 11:13 AM, it was revealed by observation that the self-closing door for the Visitor's Lounge did not close and latch properly leaving a gap around the door. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.			K0363	Continued from page 6 around the door. Maintenance Supervisor completed the adjustment after survey on 08/26/2026. Address the measures that will be in place to ensure the deficiency does not reoccur. Monthly door audits will be completed by the Maintenance Department followed up by Administrator to ensure deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Monthly and as needed, ongoing audits will be completed by the Maintenance Supervisor, followed up by Administrator, overseeing this completion to ensure all doors are functioning properly. Identify who is responsible for the corrective actions and monitoring of compliance. Monthly door audits will be completed by the Maintenance Department to monitor compliance followed up by Administrator, overseeing this completion to ensure all the doors are functioning properly. The actual or proposed date for completion of the remedy. Maintenance Director corrected the error of the door not self-closing on 08/26/2026.		08/27/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E0000	Initial Comments On 8/24/26 to 8/26/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			09/03/2026	
F0000	INITIAL COMMENTS On 8/24/26 to 8/26/26, a standard recertification survey (S5559037-0) was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.		F0000			09/03/2026	
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -		F0812			08/26/2026	
				Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's			

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 reverse for further 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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F0812 SS = F	Continued from page 1 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to properly store food under sanitary conditions by placing medical gel ice packs in a freezer designated for resident food in a common area. This had the potential to affect all residents storing food in the freezer. During an observation on 08/26/2026 at 11:11 a.m., five medical gel ice packs were in the freezer of the unit. The Following items were in the freezer with the medical gel ice packs: Five undated and not labeled Ziploc bags of dough. Two one-gallon pails of ice cream that did not contain opened date. One pint ice cream in a bag that was labeled with resident name. Three opened boxes of ice cream bars unlabeled with name or date opened. One undated Ziplock bag of doughnuts with name of resident. During interview on 08/26/2026 at 11:17 a.m., with licensed practical nurse (LPN)-A confirmed that ice packs used for patients should be stored in freezer in med room and not in the common area. LPN-A reports the aids have been putting them in common area freezer and education continues to be provided			F0812	Continued from page 1 credible allegation of compliance. Corrective Action: Upon identification of the deficiency, all ice packs were immediately removed from the resident food storage refrigerator and relocated to the designated storage area for ice packs. The refrigerator was inspected to ensure that no additional non-food items were being stored with resident food. Immediate action(s) taken for the resident(s) found to have been affected include: A review of all refrigerators used for resident food storage was completed to determine whether ice packs or other non-food items were stored inappropriately. Any identified items were immediately removed and stored in the appropriate designated location. Any identified food items not labeled or dated were immediately removed. Staff Education: All applicable staff will be educated regarding proper storage of ice packs and the requirement that resident food refrigerators be used only for approved food and food-related items. Staff will be instructed on the designated storage location for ice packs and the importance of maintaining appropriate separation between resident food and non-food items. Message sent to all employees on Breakroom Messaging Platform on 08/26/2026. Staff have been re-educated on the importance of dating and labeling the items stored in the freezer and refrigerator. Actions taken/systems put into place to reduce the risk of future occurrence include: The facility will reinforce designated storage location for ice packs that is clearly identified and accessible to staff. Refrigerator storage expectations will be incorporated into facility housekeeping and/or dietary monitoring procedures. Monitoring: The Director/Designee will conduct weekly audits of resident food storage refrigerators for four weeks, followed by monthly audits for two additional months. Audits will verify that ice packs and other inappropriate non-food items are not stored in resident food refrigerators. Audits will also verify the		08/26/2026

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 18, 2026

Administrator
VIKING MANOR NURSING HOME
317 FIRST STREET NORTHWEST
ULEN, MN 56585

RE: CCN: 245559

Cycle Start Date: September 14, 2026

Dear Administrator:

On September 14, 2026, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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