DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 53MB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00075

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245559**
2.STATE VENDOR OR MEDICAID NO.
(L2) **734040100**

3. NAME AND ADDRESS OF FACILITY
(L3) **VIKING MANOR NURSING HOME**
(L4) **317 FIRST STREET NORTHWEST**
(L5) **ULEN, MN** (L6) **56585**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/08/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **45** (L18)
13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 09/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/20/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
06/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/18/2017
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5559

On April 14, 2017, May 5, 2017 and September 13, 2017 revisits were conducted to verify correction of deficiencies issued pursuant to the standard survey completed March 22, 2017 and Federal Monitoring Survey (FMS) completed on September 13, 2017. Based on the revisits we have determined all deficiencies had been corrected, effective May 19, 2017.

As a result of the revisit findings, we recommended and CMS concurred and authorized the Department to notify the facility of the following:

- Mandatory denial of payment for new Medicare and Medicaid Admissions, effective June 22, 2017, be rescinded

Since denial of payment did not go into effect the NATCEP prohibition is also rescinded.

Effective May 19, 2017, the facility is certified for 45 skilled nursing facility beds.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245559

September 20, 2017

Mr. Todd Kjos, Administrator
Viking Manor Nursing Home
317 First Street Northwest
Ulen, MN 56585

Dear Mr. Kjos:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 19, 2017 the above facility is certified:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Electronically delivered

September 20, 2017

Mr. Todd Kjos, Administrator
Viking Manor Nursing Home
317 First Street Northwest
Ulen, MN 56585

RE: Project Number S5559025, F5559028

Dear Mr. Kjos:

On April 7, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 22, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On April 26, 2017, a surveyor representing the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The FMS found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 8, 2017, CMS forwarded the results of the FMS to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed the following enforcement remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 22, 2017. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of May 8, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 22, 2017.

On May 8, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 14, 2017 and September 13, 2017, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained

compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 22, 2017 and an FMS completed on April 26, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 19, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 22, 2017 and FMS survey completed on April 26, 2017, effective May 19, 2017.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in their letter of May 8, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 22, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective June 22, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective June 22, 2017, is to be rescinded.

In their letter of May 8, 2017, CMS advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 22, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 19, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded

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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

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
	245559	A. BUILDING **01 - 1965 BUILDING 01** B. WING _____	**04/26/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIKING MANOR NURSING HOME	**317 FIRST STREET NORTHWEST** **ULEN, MN 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
K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 4/26/17 following a Minnesota Department of Health Survey on 3/21/17. At this Comparative Federal Monitoring Survey, Viking Manor Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.90(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2012 edition. Viking Manor Nursing Home is a one story building of construction Type II (000). The entire facility is fully sprinklered and there is supervised smoke detection located in the corridors, spaces open to the corridors and some resident rooms. The facility has 45 certified beds and all beds are dually certified for Medicare and Medicaid. At the time of the survey, the census was 37. The requirement at 42 CFR, Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 321 SS=F	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING 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. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and	K 321		5/9/17

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

Electronically Signed | 05/12/2017

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K 321	Continued From page 1 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 Area Automatic Sprinkler Separation N/A 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 interview, the facility failed to ensure that hazardous areas were protected as required in accordance with the requirements of NFPA 101-2012 Edition, Section 19.3.2.1. This could affect all 37 residents in the facility. Findings include: 1.) On 4/26/17 at 12:50pm, observation revealed a maintenance shop/electrical room and the door was not self-closing. 2.) On 4/26/17 at 1:05pm, observation revealed a janitor closet that was in excess of 50 square feet with many cardboard boxes and various pieces of equipment stored in the room. The door was not	K 321	Viking Manor will ensure that all hazardous areas (over 50 square feet) protected by an automatic fire extinguishing system will have doors that are self-closing. Based on our survey dated 4/26/2017 the following doors were found to not self-close. 1) Electrical room door by main nurse□s station 2) Janitor closet door in center hall 3) Storage closet door in Physical Therapy Department The janitor door in the center hall did have a self-closing hinge on the door that needed adjustment so the door would	

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K 321	Continued From page 2 self-closing. 3.) On 4/26/17 at 1:35pm, observation revealed a closet in the Physical Therapy department that was in excess of 50 square feet with many boxes containing records and various pieces of equipment stored in the room. The door was not self-closing. These findings were confirmed by the Administrator and Assistant Maintenance Director at the time of discovery who stated they were not aware of the requirement.	K 321	close completely. The electrical room door by the main nurse□s station and the storage closet door in physical therapy have had self-closing hinges installed so the doors will close automatically. These doors and other door requiring self-closures will be inspected monthly by our maintenance department to ensure they operate properly.	
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing 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: Based on observation, interview and record review, the facility failed to ensure that sprinklers	K 353	Viking Manor will ensure our sprinklers are maintained free of dirt and/or grease	5/18/17

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K 353	Continued From page 3 were maintained free of foreign materials in accordance with NFPA 101 - 2012 edition, Section 9.7.5 and NFPA 25 2011 edition, Section 5.2.1. This had the potential to affect all 37 residents in the facility. Findings include: 1.) On 4/26/17 at 11:10am, review of a document from Summit Sprinkler Maintenance Company dated 10/13/16 revealed a statement that read "sprinklers dirty and greasy." The facility was unable to provide any documentation that revealed an action to remedy the problems identified in that inspection report. 2.) On 4/26/17 at 2:15pm, observation in the kitchen vegetable cooler revealed two sprinklers with visible evidence of an accumulation of dirt and debris that could affect the normal operation of the sprinklers. These findings were confirmed by the Administrator and Assistant Maintenance Director at the time of discovery and they stated the sprinklers required maintenance.	K 353	or any other foreign material. Our maintenance department will inspect all sprinklers every 6 months and document their findings, identifying any problems and a plan showing what was done to correct the problem. This will be in addition to our annual sprinkler inspection by a Sprinkler Maintenance Company. We will also ensure that any problems identified by the sprinkler company are corrected when identified. Summit Sprinkler Company will be here on May 18, 2017 to change the sprinkler heads identified in the 10/13/16 inspection report as needing attention and any other heads identified in our inspection. Two sprinklers in the kitchen cooler have been cleaned and will be inspected per our plan to ensure they remain free from debris that could affect their operation.	
K 372 SS=F	NFPA 101 Subdivision of Building Spaces - Smoke Barrie 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	K 372		5/12/17

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K 372	Continued From page 4 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 interview, the facility failed to provide and maintain smoke barrier walls in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.3.7, 19.3.7.1, 19.3.7.3, 8.5, 8.5.2 and 8.5.6. These deficient practices could affect all 37 residents in the facility. Findings include: 1.) On 4/26/17 at 12:15pm, observation revealed that above the ceiling at the southeast smoke barrier door, there were penetrations by an armored cable and a conduit pipe that were not properly firestopped. 2.) On 4/26/17 at 12:20pm, observation revealed that above the ceiling at the dining room smoke barrier door, there was a penetration by a conduit pipe with a three inch annular hole that was properly firestopped. 3.) On 4/26/17 at 12:30pm, observation revealed that above the ceiling at the northeast smoke barrier door, there were penetrations by two conduit pipes that were not properly firestopped. 4.) On 4/26/17 at 12:40pm, observation revealed that above the ceiling at the northeast barrier door, where the ceiling met the wall, there was an open space with only fiberglass insulation material visible, inserted in the open space. This did not represent a proper firestop.	K 372	Viking Manor will maintain smoke barrier walls in accordance with the requirements of NFPA 101-2012 edition. The areas identified during our survey have had fire-barrier sealant applied to the penetrations which will prevent fire, smoke, and toxic grass from passing through the smoke barrier. Our maintenance department will inspect any construction/wiring that is completed to ensure fire barrier sealant is applied as needed.	

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K 372	Continued From page 5 5.) On 4/26/17 at 12:50pm, observation in the electrical room revealed a penetration by a conduit that was not properly firestopped. 6.) On 4/26/17 at 1pm, observation revealed that above the ceiling at the central corridor barrier door, there were penetrations by a large bundle of cables and a conduit pipe that were not properly firestopped. 7.) On 4/26/17 at 1:20pm, observation revealed that above the ceiling at the west end smoke barrier door, there were penetrations by an armored cable and a bundle of wires that were not properly firestopped. These findings were confirmed by the Administrator and Assistant Maintenance Director at the time of discovery who stated they were not aware of the unsealed penetrations.	K 372		
K 711 SS=F	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is not met as evidenced by: Based on record review and interview, the facility	K 711	Our Fire and Evacuation Plan has been	5/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 711	Continued From page 6 failed to develop an effective fire response plan that included evacuation from the area affected by a fire emergency to an area of safety and making direct contact with emergency responders in the case of a fire related emergency, as required by NFPA 101-Edition, Section 19.7.2.2. This had the potential to affect all 37 residents in the facility. Findings include: 1. A review of the facility fire plan on 4/26/17 at 10:40am, revealed a document titled "Fire & Evacuation Plan" with a review date 12/08. In that procedure, there was no specific mandate to evacuate the immediate area of a fire emergency to an adjacent protected area as an initial response to a fire related emergency. 2. Further review of the procedure also revealed the plan did not contain a directive to call the fire department in addition to the use of the automatic alarm system. The Administrator and Assistant Maintenance Director verified the findings at the time of discovery and stated they were not aware of the inconsistencies in the plan.	K 711	updated with specific instruction to evacuate the immediate area of a fire emergency to an adjacent protected area. Our plan states Move all Residents from the smoke compartment. (Fire door to Fire door evacuate everyone to a non-fire compartment). Our plan also includes language that states In event of actual Fire call 911. Staff will be trained as to these changes to our Fire & Evacuation Plan and the plan is available at the main nurse□s station for employee review.	
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and	K 712		5/19/17

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

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K 712	Continued From page 7 conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to complete fire drills per NFPA 101, Chapter 19.7.1.4 through 19.7.1.7. This had the potential to affect all 37 residents in the facility. Findings include: Review of the monthly fire drills for the previous 12 months revealed the facility failed to document the transmission of the alarm signal in conjunction with any of the drills recorded. These findings were confirmed by the Administrator and Assistant Maintenance Director at the time of discovery and they stated they recognized the importance of this action.	K 712	During our monthly fire drills we will place a call to a firefighter to confirm they received the call made by our automatic dialer. This documentation will be included on our monthly fire drill report.	
K 920 SS=E	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for	K 920		5/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245559	A. BUILDING **01 - 1965 BUILDING 01** B. WING _____	**04/26/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIKING MANOR NURSING HOME	**317 FIRST STREET NORTHWEST** **ULEN, MN 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
K 920	Continued From page 8 PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to properly utilize Underwriters Laboratory (UL) approved power strips and plug multipliers in accordance with the requirements of NFPA 101 - 2012 edition, Sections 9.1.2 and NFPA 70, 2011 Edition, Sections 400-8 and 590.3. This deficient practice could potentially affect 20 of the 37 residents in the facility. Findings include: 1.) On 4/25/17 at 1:30pm, observation in room 36 revealed a power strip plugged into an extension cord. 2.) On 4/26/17 at 1:45pm, observation in room 26 revealed a lift chair and a fan plugged into a power strip. These findings were confirmed by the Administrator and Assistant Maintenance Director at the time of discovery and they stated the devices were being used incorrectly and they were uncertain of the UL certification	K 920	Our admission packet to residents that move into Viking Manor will state that power strips must be a Medical Grade Power Strip that meets UL 1363A or UL 60601-1. Power strips identified during the survey in room 36 and room 26 have been removed and replaced with a UL 1363A Medical-Grade Power Strip. Residents and their families will be instructed on admission of the requirement to have a Medical-Grade Power Strip that meets UL 1363A or UL 60601-1 requirement. Our maintenance department will check monthly for any new power strips that may have been brought in by family member that don't meet UL 1363A or UL 60601-1 standards.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245559	A. BUILDING **01 - 1965 BUILDING 01** B. WING _____	**04/26/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIKING MANOR NURSING HOME	**317 FIRST STREET NORTHWEST** **ULEN, MN 56585**

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K 920	Continued From page 9 requirements for the use of strip outlets.	K 920		

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 53MB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00075

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245559**

2.STATE VENDOR OR MEDICAID NO.
(L2) **734040100**

3. NAME AND ADDRESS OF FACILITY
(L3) **VIKING MANOR NURSING HOME**
(L4) **317 FIRST STREET NORTHWEST**
(L5) **ULEN, MN** (L6) **56585**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/22/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Susan Bachleitner, HFE NE II — 04/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/17/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
06/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 7, 2017

Mr. Todd Kjos, Administrator
Viking Manor Nursing Home
317 First Street Northwest
Ulen, Minnesota 56585

RE: Project Number S5559025

Dear Mr. Kjos:

On March 22, 2017, a standard 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) has been electronically delivered.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 1, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions

are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 June 22, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 22, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245559	A. BUILDING _____ B. WING _____	03/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIKING MANOR NURSING HOME	317 FIRST STREET NORTHWEST ULEN, MN 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
F 000	INITIAL COMMENTS 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 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329		4/10/17

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

Electronically Signed | 04/11/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 1 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure laboratory monitoring was completed to ensure therapeutic dosing for 1 of 5 residents (R40) reviewed for unnecessary medication use. Findings include: R40's annual Minimum Data Set (MDS) dated 2/28/17, identified R40 had severe cognitive impairment and required extensive assistance with personal hygiene. Further, the MDS identified R40 had anxiety and depression, however, did not have any seizure related disorders. R40's Physician's Telephone Orders sheet dated 4/29/16, identified an order for, "Depakote 250 [milligrams; a medication used to treat seizure disorders or certain psychiatric conditions]," by mouth every 12 hours.	F 329	Resident R-40's primary Physician was updated on pharmacy request and Valporic acid level was drawn 3/23/17. Director of Nursing and Pharmacy Consultant reviewed all residents' most current pharmacy recommendations to ensure they were all followed up on. All pharmacy recommendations will be brought to QA for DON or designee, and medical director to review and will sign off. DON or designee will do monthly audits to ensure that pharmacy requests are being followed up on. Staff educated and policy reviewed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 2	F 329		

R40's care plan dated 3/14/17, identified R40 used psychotropic medications due to a, "Potential for injury to self or others," and listed a goal for R40, "Be/remain free of drug related complications..." The care plan listed several interventions for staff to implement which included administer medications as ordered. Monitor/document for side effects and effectiveness." However, R40's care plan lacked any routine laboratory monitoring.

R40's Medication Administration Record (MAR) dated 1/1/17 through 3/22/17, identified an order for Depakote Tablet Delayed Release ... Give 250 [milligrams] by mouth..., with administration twice a day. The MAR identified R40 had been administered all doses as directed with no doses being missed, held or refused.

R40's Consultant Pharmacist Progress Note dated 9/13/16, identified a pharmacy request to consider checking CBC [complete blood count], BMP [basic metabolic panel], and VPA [valporic acid (Depakote) level] for routine medication monitoring.

R40's medical record was reviewed and lacked any collected valporic laboratory value (a way to ensure Depakote is at a therapeutic dose with normal value being 50-125 microgram per milliliter) to ensure R40's administered Depakote was within therapeutic range.

During interview on 3/22/17, at 11:11 a.m. registered nurse (RN)-A stated the facility had never drawn a valporic acid laboratory value on R40 as it, "Kinda got missed." RN-A stated elevated valporic acid levels could cause

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F 329	Continued From page 3 someone to be drowsy and have, "Serious side effects," and having no valporic acid level for reference on R40 was, "A little concerning." During interview on 3/22/17, at 12:19 p.m. the director of nursing (DON) stated a valporic acid level had never been drawn on R40 as it, "Wasn't noticed it was requested [by pharmacist]." Further, DON stated staff would obtain a valporic acid level on R40 during the next laboratory visit. On 3/22/17, at 12:37 p.m. a call was placed to R40's primary physician with a request for call back; however, no return call was received.	F 329		
F 411 SS=D	483.55(a)(1)(2)(4) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS (a) Skilled Nursing Facilities A facility- (a)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; (a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; (a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; This REQUIREMENT is not met as evidenced	F 411		4/10/17

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F 411	Continued From page 4 by: Based on observation, interview and document review, the facility failed to ensure dental recommendations were acted upon timely for 1 of 1 residents (R40) reviewed for dental hygiene and who had missing teeth. Findings include: R40's annual Minimum Data Set (MDS) dated 2/28/17, identified R40 had severe cognitive impairment, required extensive assistance with personal hygiene. Further, the MDS section labeled Oral / Dental Status section had not been completed and left blank. R40's Payer Setup Information sheet dated 3/22/17, identified R40 was private pay. During observation on 3/21/17, at 9:15 a.m. R40 was seated in her wheelchair in her room. R40 smiled and showed the surveyor she had a missing tooth on her upper palate along with visible brown colored staining on several other teeth. R40 denied having any oral pain; however, was unable to recall when she had last been to the dentist. When interviewed on 3/21/17, at 10:43 a.m. family member (FM)-A stated R40's teeth were getting worse and, "Looking more and more decayed." FM-A stated R40 had not been seen by a dentist in the past several years to her knowledge, but added it, "Probably wouldn't be a bad idea." FM-A stated she was unaware of the nursing home's process for having a resident seen by a dentist. R40's Apple Tree Dental, Oral/Dental Assessment Form dated 1/19/17, signed by a dental hygienist,	F 411	Family was contacted on 3/22/17 and did not want to act on the dental request. All residents most recent dental consults were reviewed by Director of Nursing and addressed if needed. DON will complete audits of monthly dental exams to ensure recommendations were followed up on and will bring results of audits to QA. RN's continue with oral health assessments on admission, quarterly and as needed on each resident. Staff educated and policy reviewed and updated.	

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	245559	A. BUILDING _____ B. WING _____	03/22/2017

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F 411	Continued From page 5	F 411		

identified R40 had obvious or likely cavity or broken natural teeth. The assessment note identified R40 had natural teeth, moderate amount of plaque and some caries and suggested [R40] be seen by a dentist for a dental cleaning [and] exam.

R40's facility Oral Health Assessment Form completed 2/28/17, identified R40 did not wear any dentures, had no obviously broken teeth or cavities; however, identified R40 had inflamed or bleeding gums or loose natural teeth.

R40's medical record lacked any evidence R40 had been referred to or seen by a dentist as requested in the 1/19/17, dental hygienist assessment, nor after her gums were identified to be bleeding in the subsequent 2/28/17, facility completed assessment.

A facility provided Appletree Dentist Master Patient List dated 3/22/17, identified several residents on the dentist' list to be seen during the next visit. R40's name was not identified on the list.

When interviewed on 3/22/17, at 10:20 a.m. nursing assistant (NA)-A stated R40 had her own teeth and did not wear dentures. NA-A stated R40 was, "Somedays," able to complete her own oral care, however, staff would help her at other times. Further, NA-A stated R40's teeth were, "Not the greatest," adding she was unaware if R40 had ever seen a dentist.

On 3/22/17, at 10:34 a.m. registered nurse (RN)-A and RN-B were interviewed. RN-A stated R40's teeth, "Are not the greatest," and, "Look like they have some build up [plaque]." RN-A

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F 411	Continued From page 6 stated the facility had a dentist coming on-site to see residents, however, it was dependent on if their was, "Enough people to be seen," otherwise residents could be taken to off-site dentists for appointments. RN-A stated R40 had never been referred to the dentist, and stated "I didn't see that note." RN-A stated R40 should have been referred to the dentist as worsening teeth, "Can cause a lot of issues [trouble eating, pain]." An undated Facility Visits & Dental Patient Schedule policy identified the on-site dentist services varied from three or four times a year or four times a month depending on the size of the facility and the rate at which dental services were utilized and directed the list of residents to be seen at facility be updated on a monthly basis.	F 411		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired insulin was not administered to 1 of 1 residents (R58) identified to have expired insulin available for use.	F 425	Insulin pen was removed from medication cart on 3/20/17. All insulin pens that were in use were evaluated on 3/21/17 to ensure that they were within the	4/10/17

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F 425	Continued From page 7 Findings include: R58's 14-day Minimum Data Set (MDS) dated 3/2/17, identified R58 had intact cognition, and had Diabetes Mellitus (disease where the body cannot produce enough insulin on its own) and received daily insulin injections. A Novolog Highlights of Prescribing Information insert dated 3/2017, identified the, "Recommended Storage," for Novolog FlexPen(s) and directed the medication was good for, "28 days," after being opened. On 3/20/17, at 6:32 p.m. the West medication cart was inspected with licensed practical nurse (LPN)-A present. In the top drawer was a single Novolog (fast acting insulin) FlexPen with a white sticker wrapped around the top. The sticker had handwritten information on it which identified the insulin belonged to R58, and included a date of, "2-16-17 [34 days prior]." LPN-A reviewed the FlexPen and stated the date listed was the date it had been opened adding R58 was still receiving insulin from the FlexPen, "Three times a day." Further, LPN-A stated Novolog, "Should be good for a month," after being opened, and R58's FlexPen, "Should be thrown away and another one gotten." R58's Medication Administration Record (MAR) dated 3/1/17 to 3/20/17, identified an order for, "Insulin Aspart Solution [Novolog]," with administration three times a day. The MAR identified R58 had been administered the insulin as directed. During interview on 3/22/17, at 11:44 a.m. the	F 425	correct dates. In addition to the pharmacy label on the insulin pens, a new label will be added to include how many days the type of insulin is good for, once opened, and an area for nursing staff to write the opened date on it. Pharmacy consultants and DON to continue to do monthly audits of medication cart. DON will complete weekly audits to ensure insulin pens are dated and will bring results of audits to QA. Policy reviewed and updated to state all insulin pens and vials are to be marked with the date of opening, and staff education provided.	

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F 425	Continued From page 8 consulting pharmacist (CP) stated an opened Novolog FlexPen was good for, "About 28 days," and staff should not use it after that date as the manufacturer was unable to, "Guarantee the same effectiveness." When interviewed on 3/22/17, at 12:19 p.m. the director of nursing (DON) stated Novolog should be used or discarded within 28 days of being opened. She stated "Its less effective," if used beyond then. A facility Insulin Pen Policy date 10/11/16, identified a purpose to provide guidelines for the administration of insulin through the insulin pen. However, the policy lacked any direction or procedures on how to ensure insulin was discarded after the recommended period(s).	F 425		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities	F 428		4/10/17

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F 428	Continued From page 9 to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations were acted upon timely for 1 of 5 residents (R40) reviewed for unnecessary medication use.	F 428	Resident R-40's primary Physician was updated on pharmacy request and Valporic acid level was drawn 3/23/17. Director of Nursing and Pharmacy Consultant reviewed all residents' most current pharmacy recommendations to	

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F 428	Continued From page 10 Findings include: R40's annual Minimum Data Set (MDS) dated 2/28/17, identified R40 had severe cognitive impairment and required extensive assistance with personal hygiene. Further, the MDS identified R40 had anxiety and depression, however, did not have any seizure related disorders. R40's Physician's Telephone Orders sheet dated 4/29/16, identified an order for, "Depakote 250 [milligrams; a medication used to treat seizure disorders or certain psychiatric conditions]," by mouth every 12 hours. R40's Medication Administration Record (MAR) dated 1/1/17 through 3/22/17, identified an order for, "Depakote Tablet Delayed Release ... Give 250 [milligrams] by mouth...," with administration twice a day. The MAR identified R40 had been administered all doses as directed with no doses being missed, held or refused. Review of R40's monthly Consultant Pharmacist reviews from 9/13/16 to 3/2/17 revealed a Consultant Pharmacist Progress Note dated 9/13/16, which included a pharmacy request to consider checking CBC [complete blood count], BMP [basic metabolic panel], and VPA [valporic acid (Depakote) level] for routine medication monitoring. No further documentation of follow up on the status of the VPA level was found in the monthly notes. R40's medical record was reviewed and lacked any collected valporic laboratory value (a way to ensure Depakote is at a therapeutic dose with normal value being 50-125 microgram per	F 428	ensure they were all followed up on. All pharmacy recommendations will be brought to QA for DON or designee, and medical director to review and will sign off. DON or designee will do monthly audits to ensure that pharmacy requests are being followed up on. Staff educated and policy reviewed.	

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milliliter) to ensure R40's administered Depakote was within therapeutic range.

During interview on 3/22/17, at 11:11 a.m. registered nurse (RN)-A stated the facility had never drawn a valproic acid laboratory value on R40 as it, "Kinda got missed." RN-A stated she was unaware the pharmacist had requested a laboratory value be done. Further, RN-A stated she felt a resident with elevated valproic acid levels could become drowsy and have, "Serious side effects."

When interviewed on 3/22/17, at 11:44 a.m. the consulting pharmacist (CP) stated a valproic acid level was, "Not routinely requested," in someone without a seizure disorder, however, it had been requested back in September 2016 to address with R40's physician as the medication still had, "Potential risks associated with its use," including over-sedation. CP confirmed the valproic acid level had been requested to be done on September 2016 and stated the facility should have addressed the identified medication irregularity with, "The next physician rounds [or two months]."

During interview on 3/22/17, at 12:19 p.m. the director of nursing (DON) stated a valproic acid level had not been collected on R40 according to the pharmacist request as it, "Wasn't noticed it was requested." Further, the DON stated she expected the nursing staff to follow up on consulting pharmacist' requests by the next follow up visit.

An undated facility Pharmacy Consultant/Drug Regimen Review Policy identified a pharmacist would review each residents chart monthly and,

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F 428	Continued From page 12 "All items needing attention will be documented in the residents chart ... for the nursing staff to address." Further, the policy directed, "Each item needs to be addressed prior to the next visit."	F 428		

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Viking Manor Nursing Home 01 Main Building 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145	K 000	EPOC	

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

Electronically Signed — 04/11/2017

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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K 000	Continued From page 1 St. Paul, MN 55101 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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	K 000		

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K 000	Continued From page 2 Type II(000) constriction, 1-story without a basement. The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems . The facility has a fire alarm system with smoke detection 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 installed in accordance with NFPA 72 "The National Fire Alarm Code". The facility has a capacity of 45 beds and had a census of 37 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 211 SS=E	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide unobstructed access to the means of egress as required by the Life Safety Code (NFPA 101) 2012 edition section 19.2.2 & 7.1.10.1. This deficient practice could affect the exiting ability of 12 of the 37 residents	K 211	The delayed egress door in the Northwest Wing has been adjusted so the door will open when activated. Our maintenance department will make monthly checks to see the doors work properly.	3/22/17

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K 211	Continued From page 3 and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 03/21/2017 observations and staff interview revealed the delayed egress door in the Northwest wing did not open when activated. This deficient condition was confirmed by the Facility Administrator and the Director of Maintenance.	K 211		
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. 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	K 363		4/5/17

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

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K 363	Continued From page 4 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 provide one corridor door with a means suitable for resisting the passage of smoke in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.6.3.1 & 19.3.6.3.5. This deficient practice could allow for smoke to enter the corridor making it difficult to exit in the case of fire, affecting 14 of the 37 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 03/21/2017 observations and staff interview revealed resident room 31 did not fit tightly in the frame. This deficient condition was confirmed by the Facility Administrator and the Director of Maintenance.	K 363	We have applied a fire and smoke seal to the door frame of room 31 so the door fits tightly to the frame. To prevent reoccurrence maintenance will make monthly checks of our doors to ensure a tight fit which resists the passage of smoke.	

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 7, 2017

Mr. Todd Kjos, Administrator
Viking Manor Nursing Home
317 First Street Northwest
Ulen, Minnesota 56585

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5559025

Dear Mr. Kjos:

The above facility was surveyed on March 20, 2017 through March 22, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the

statement, "This Rule 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 Gail Anderson at (218)332-5140 or email: gail.anderson@state.mn.us**.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00075	A. BUILDING: _____ B. WING _____	03/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIKING MANOR NURSING HOME	317 FIRST STREET NORTHWEST ULEN, MN 56585

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 3/20/17, 3/21/17, 3/22/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental recommendations were acted upon timely for 1 of 1 residents (R40) reviewed for dental hygiene and who had missing teeth. Findings include: R40's annual Minimum Data Set (MDS) dated 2/28/17, identified R40 had severe cognitive impairment, required extensive assistance with personal hygiene. Further, the MDS section labeled Oral / Dental Status section had not been completed and left blank. R40's Payer Setup Information sheet dated 3/22/17, identified R40 was private pay.	21325	Corrected	4/10/17

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21325	Continued From page 3 During observation on 3/21/17, at 9:15 a.m. R40 was seated in her wheelchair in her room. R40 smiled and showed the surveyor she had a missing tooth on her upper palate along with visible brown colored staining on several other teeth. R40 denied having any oral pain; however, was unable to recall when she had last been to the dentist. When interviewed on 3/21/17, at 10:43 a.m. family member (FM)-A stated R40's teeth were getting worse and, "Looking more and more decayed." FM-A stated R40 had not been seen by a dentist in the past several years to her knowledge, but added it, "Probably wouldn't be a bad idea." FM-A stated she was unaware of the nursing home's process for having a resident seen by a dentist. R40's Apple Tree Dental, Oral/Dental Assessment Form dated 1/19/17, signed by a dental hygienist, identified R40 had obvious or likely cavity or broken natural teeth. The assessment note identified R40 had natural teeth, moderate amount of plaque and some caries and suggested [R40] be seen by a dentist for a dental cleaning [and] exam. R40's facility Oral Health Assessment Form completed 2/28/17, identified R40 did not wear any dentures, had no obviously broken teeth or cavities; however, identified R40 had inflamed or bleeding gums or loose natural teeth. R40's medical record lacked any evidence R40 had been referred to or seen by a dentist as requested in the 1/19/17, dental hygienist assessment, nor after her gums were identified to be bleeding in the subsequent 2/28/17, facility completed assessment.	21325		

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21325	Continued From page 4 A facility provided Appletree Dentist Master Patient List dated 3/22/17, identified several residents on the dentist' list to be seen during the next visit. R40's name was not identified on the list. When interviewed on 3/22/17, at 10:20 a.m. nursing assistant (NA)-A stated R40 had her own teeth and did not wear dentures. NA-A stated R40 was, "Somedays," able to complete her own oral care, however, staff would help her at other times. Further, NA-A stated R40's teeth were, "Not the greatest," adding she was unaware if R40 had ever seen a dentist. On 3/22/17, at 10:34 a.m. registered nurse (RN)-A and RN-B were interviewed. RN-A stated R40's teeth, "Are not the greatest," and, "Look like they have some build up [plaque]." RN-A stated the facility had a dentist coming on-site to see residents, however, it was dependent on if their was, "Enough people to be seen," otherwise residents could be taken to off-site dentists for appointments. RN-A stated R40 had never been referred to the dentist, and stated "I didn't see that note." RN-A stated R40 should have been referred to the dentist as worsening teeth, "Can cause a lot of issues [trouble eating, pain]." An undated Facility Visits & Dental Patient Schedule policy identified the on-site dentist services varied from three or four times a year or four times a month depending on the size of the facility and the rate at which dental services were utilized and directed the list of residents to be seen at facility be updated on a monthly basis. SUGGESTED METHOD OF CORRECTION: The	21325		

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21325	Continued From page 5 Director of Nursing or designee could review the policies and procedures regarding the acquisition of dental services for residents. Training for all personnel to ensure compliance could be done. Audits of the resident medical records could be completed to ensure that dental services if indicated or needed have been ordered or done. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21325		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must	21530		4/10/17

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21530	Continued From page 6 refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations were acted upon timely for 1 of 5 residents (R40) reviewed for unnecessary medication use. Findings include: R40's annual Minimum Data Set (MDS) dated 2/28/17, identified R40 had severe cognitive impairment and required extensive assistance with personal hygiene. Further, the MDS identified R40 had anxiety and depression, however, did not have any seizure related disorders. R40's Physician's Telephone Orders sheet dated 4/29/16, identified an order for, "Depakote 250 [milligrams; a medication used to treat seizure disorders or certain psychiatric conditions]," by mouth every 12 hours. R40's Medication Administration Record (MAR) dated 1/1/17 through 3/22/17, identified an order	21530	Corrected	

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21530	Continued From page 7	21530		

for, "Depakote Tablet Delayed Release ... Give 250 [milligrams] by mouth...," with administration twice a day. The MAR identified R40 had been administered all doses as directed with no doses being missed, held or refused.

Review of R40's monthly Consultant Pharmacist reviews from 9/13/16 to 3/2/17 revealed a Consultant Pharmacist Progress Note dated 9/13/16, which included a pharmacy request to consider checking CBC [complete blood count], BMP [basic metabolic panel], and VPA [valporic acid (Depakote) level] for routine medication monitoring. No further documentation of follow up on the status of the VPA level was found in the monthly notes.

R40's medical record was reviewed and lacked any collected valporic laboratory value (a way to ensure Depakote is at a therapeutic dose with normal value being 50-125 microgram per milliliter) to ensure R40's administered Depakote was within therapeutic range.

During interview on 3/22/17, at 11:11 a.m. registered nurse (RN)-A stated the facility had never drawn a valporic acid laboratory value on R40 as it, "Kinda got missed." RN-A stated she was unaware the pharmacist had requested a laboratory value be done. Further, RN-A stated she felt a resident with elevated valporic acid levels could become drowsy and have, "Serious side effects."

When interviewed on 3/22/17, at 11:44 a.m. the consulting pharmacist (CP) stated a valporic acid level was, "Not routinely requested," in someone without a seizure disorder, however, it had been requested back in September 2016 to address with R40's physician as the medication still had,

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21530	Continued From page 8 "Potential risks associated with its use," including over-sedation. CP confirmed the valporic acid level had been requested to be done on September 2016 and stated the facility should have addressed the identified medication irregularity with, "The next physician rounds [or two months]." During interview on 3/22/17, at 12:19 p.m. the director of nursing (DON) stated a valporic acid level had not been collected on R40 according to the pharmacist request as it, "Wasn't noticed it was requested." Further, the DON stated she expected the nursing staff to follow up on consulting pharmacist' requests by the next follow up visit. An undated facility Pharmacy Consultant/Drug Regimen Review Policy identified a pharmacist would review each residents chart monthly and, "All items needing attention will be documented in the residents chart ... for the nursing staff to address." Further, the policy directed, "Each item needs to be addressed prior to the next visit." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of pharmacy consultant recommendations. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME FRAME FOR CORRECTION: twenty-one (21) days.	21530		

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21535	Continued From page 9	21535		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure laboratory monitoring was completed to ensure therapeutic dosing for 1 of 5 residents (R40) reviewed for unnecessary medication use. Findings include: R40's annual Minimum Data Set (MDS) dated	21535	Corrected	4/10/17

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21535	Continued From page 10 2/28/17, identified R40 had severe cognitive impairment and required extensive assistance with personal hygiene. Further, the MDS identified R40 had anxiety and depression, however, did not have any seizure related disorders. R40's Physician's Telephone Orders sheet dated 4/29/16, identified an order for, "Depakote 250 [milligrams; a medication used to treat seizure disorders or certain psychiatric conditions]," by mouth every 12 hours. R40's care plan dated 3/14/17, identified R40 used psychotropic medications due to a, "Potential for injury to self or others," and listed a goal for R40, "Be/remain free of drug related complications..." The care plan listed several interventions for staff to implement which included administer medications as ordered. Monitor/document for side effects and effectiveness." However, R40's care plan lacked any routine laboratory monitoring. R40's Medication Administration Record (MAR) dated 1/1/17 through 3/22/17, identified an order for Depakote Tablet Delayed Release ... Give 250 [milligrams] by mouth..., with administration twice a day. The MAR identified R40 had been administered all doses as directed with no doses being missed, held or refused. R40's Consultant Pharmacist Progress Note dated 9/13/16, identified a pharmacy request to consider checking CBC [complete blood count], BMP [basic metabolic panel], and VPA [valporic acid (Depakote) level] for routine medication monitoring. R40's medical record was reviewed and lacked	21535		

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21535	Continued From page 11 any collected valporic laboratory value (a way to ensure Depakote is at a therapeutic dose with normal value being 50-125 microgram per milliliter) to ensure R40's administered Depakote was within therapeutic range. During interview on 3/22/17, at 11:11 a.m. registered nurse (RN)-A stated the facility had never drawn a valporic acid laboratory value on R40 as it, "Kinda got missed." RN-A stated elevated valporic acid levels could cause someone to be drowsy and have, "Serious side effects," and having no valporic acid level for reference on R40 was, "A little concerning." During interview on 3/22/17, at 12:19 p.m. the director of nursing (DON) stated a valporic acid level had never been drawn on R40 as it, "Wasn't noticed it was requested [by pharmacist]." Further, DON stated staff would obtain a valporic acid level on R40 during the next laboratory visit. On 3/22/17, at 12:37 p.m. a call was placed to R40's primary physician with a request for call back; however, no return call was received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies and procedures for proper monitoring of pharmacy consultant recommendations and laboratory results. Nursing staff could be educated as necessary to the importance of the pharmacist's review and follow up. The DON or designee could audit medication reviews, laboratory results on a regular basis to ensure compliance. TIME FRAME FOR CORRECTION: twenty-one (21) days.	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00075	A. BUILDING: _____ B. WING _____	03/22/2017

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21545	Continued From page 12	21545		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or	21545		4/10/17

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21545	Continued From page 13 resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired insulin was not administered to 1 of 1 residents (R58) identified to have expired insulin available for use. Findings include: R58's 14-day Minimum Data Set (MDS) dated 3/2/17, identified R58 had intact cognition, and had Diabetes Mellitus (disease where the body cannot produce enough insulin on its own) and received daily insulin injections. A Novolog Highlights of Prescribing Information insert dated 3/2017, identified the, "Recommended Storage," for Novolog FlexPen(s) and directed the medication was good for, "28 days," after being opened. On 3/20/17, at 6:32 p.m. the West medication cart was inspected with licensed practical nurse (LPN)-A present. In the top drawer was a single Novolog (fast acting insulin) FlexPen with a white sticker wrapped around the top. The sticker had handwritten information on it which identified the insulin belonged to R58, and included a date of, "2-16-17 [34 days prior]." LPN-A reviewed the FlexPen and stated the date listed was the date it had been opened adding R58 was still receiving insulin from the FlexPen, "Three times a day."	21545	Corrected	

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21545	Continued From page 14 Further, LPN-A stated Novolog, "Should be good for a month," after being opened, and R58's FlexPen, "Should be thrown away and another one gotten." R58's Medication Administration Record (MAR) dated 3/1/17 to 3/20/17, identified an order for, "Insulin Aspart Solution [Novolog]," with administration three times a day. The MAR identified R58 had been administered the insulin as directed. During interview on 3/22/17, at 11:44 a.m. the consulting pharmacist (CP) stated an opened Novolog FlexPen was good for, "About 28 days," and staff should not use it after that date as the manufacturer was unable to, "Guarantee the same effectiveness." When interviewed on 3/22/17, at 12:19 p.m. the director of nursing (DON) stated Novolog should be used or discarded within 28 days of being opened. She stated "Its less effective," if used beyond then. A facility Insulin Pen Policy date 10/11/16, identified a purpose to provide guidelines for the administration of insulin through the insulin pen. However, the policy lacked any direction or procedures on how to ensure insulin was discarded after the recommended period(s). SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop policies and procedures, educate staff, and conduct random audits of resident medication expiration dates to ensure compliance with state and federal regulatory requirements.	21545		

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21545	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		