Electronically Delivered

August 19, 2024

Licensee
Viking Manor Nursing Home
317 1st Street Northwest
Ulen, MN 56585

RE: Project Number(s) SL30460015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 24, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30460	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIKING MANOR NURSING HOME	317 1ST STREET NW 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) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30460015-0 On July 22, 2024, through, July 24, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 15 residents receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one or more persons were available 24 hours per day, seven days per week, who were responsible for responding to the requests of residents, were located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 2 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license with a capacity of 24 residents, with a current census of 15 residents, all of whom received assisted living services. On July 22, 2024, at 10:20 a.m., during the entrance conference, the licensed assisted living director (LALD)-A stated most shifts in assisted living are 12-hour shifts, and have coverage from 7:00 a.m. to 7:30 p.m., and a register nurse (RN) on call. LALD-A stated the licensee had no staff assigned to the assisted living facility after 7:30 p.m. and had a variance for the attached nursing home staff to assist and answer call lights after that time. LALD-A stated the assisted living call lights also notified the nursing home staff, and all residents are able to use the call button. The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule Policy reviewed June 6, 2024, indicated one or more persons will be available 24-hours per day, seven days per week who are responsible for responding to the requests of the residents for assistance for health and safety needs. Persons will be awake, located in the same building or an attached building ([name] nursing home), be capable of communication with residents, capable of summoning appropriate assistance and capable of following directions.	0 470		

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0 470	Continued From page 3 The licensee's Direct-Care Staffing Plan, reviewed June 6, 2024, indicated there will be 24-hour, awake staff available to respond to resident requests for assistance with health and safety needs. After hours there will be awake direct-care staff able to respond to a resident's request for assistance with health and safety needs within a reasonable amount of time. These staff will be located at the [name] nursing home in order to respond within a reasonable amount of time. The July 2024 staffing schedule included one 12-hour unlicensed ULP on days, 7:00 a.m. to 7:30 p.m., and one licensed practical nurse (LPN) whose days varied, Monday through Friday and worked 6:30 a.m. to 3:00 p.m. After 7:30 p.m., nursing home staff are available to the assisted living residents, which usually included one registered nurse (RN) and three certified nursing assistants. Additionally, an on-call RN is assigned for the assisted living 24 hours a day, 7 days a week. The licensee's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) dated January 3, 2024, indicated unlicensed staff may either be in the building, in an attached building, or within the campus and available to respond to resident 24 hours/7 days, and licensed staff are either in the building, an attached building, or within the campus and available to respond to resident requests 24 hours/7 days. The UDALSA also indicated number of unlicensed direct care staff typically scheduled per shift was one for day shift and one for evening shift. An MDH Assisted Living Licensure Innovation Variance Request Form dated and emailed to the	0 470		

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0 470	Continued From page 4 MDH assisted living inbox on August 30, 2022, by LALD-A indicated Health Facility Identification number 30460 requested a "new innovation variance request." The innovation variance details included the following: a. Statute and subdivision(s) (as applicable) which the innovation is requested: Statute 144G.33 Innovation Variance, 144G.41 Minimum Assisted Living Facility Requirements. Variance request as required for the 24-hour staffing rule in our attached assisted living facility. The assisted living statue allows responses from another portion of the campus. b. Time period for which the innovation variance is requested: September 1, 2022, to September 1, 2023. c. Specific alternative action the licensee proposes: No alternative requests, we would like to continue to utilize our attached licensed nursing home personnel to assist as needed at our assisted living facility to remain in compliance with all the current and ongoing assisted living requirements. d. Reason(s) for request: We would like to continue to use our staff in our attached/adjacent licensed setting to respond to calls in our assisted living facility, for overnight hours. Our residents in our assisted living require minimal care and our staff working our long term care nursing homes facility will respond to call that occur overnight. We will ensure that one or more persons are available 24 hours per day 7 days a week. Such persons will be: awake; located in an attached building and will be able to respond within a reasonable amount of time; capable of communicating with residents; capable of providing or summoning the appropriate assistance; capable of following directions; capable of calling on call registered nurse (RN) or assisted living director if any issues/concerns	0 470		

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0 470	Continued From page 5 arise for further direction; offer services as required (meals and snacks to meet the United States department of agriculture (USDA) guidelines, appropriate menus in advance, food prepared and served according to the food code of Minnesota, weekly housekeeping and laundry, provide direction or assistance in arranging medical, social service appointments, shopping transportation needs). e. Explanation or justification of how the innovation variance will not impair the services provided, will not adversely affect health, safety, or welfare of residents, and is likely to improve the services provided: No services will be impaired, residents may contact staff at any time and call will be answered as quickly as possible. We will ensure this will not affect safety, health, or welfare of any of our residents at all times. We will also be able to assist with any evacuations, if necessary, in an emergency. We will ensure sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents assessments and service plans on a 24 hour per day basis. We will ensure that our facility can respond promptly and effectively to individual resident emergencies and to emergency life safety and disaster situations affecting staff or residents in the facility. On July 24, 2024 at 9:49 a.m., LALD-A stated she had not received an approval for the variance, and should have checked on the variance, but assumed it was approved as LALD-A stated "I continue to get licensed and was sending the UDALSA in with the license renewal that states staff from nursing home assists the assisted living residents." No further information was provided.	0 470		

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0 470	Continued From page 6 TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.	01470		

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01470	Continued From page 7 (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of two employees (unlicensed personnel (ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01470		

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01470	Continued From page 8 ULP-C was hired December 4, 2023, to provide direct care to the licensee's residents. ULP-C's employee record did not include the following required orientation content, overview of the 144 G statutes. On July 23, 2024, at 10:40 a.m., licensed assisted living director (LALD)-A and surveyor reviewed employee record and training transcripts. LALD-A stated ULP-C was assigned Guide to Assisted Living in electronic training system. LALD-A stated she was not aware the training was not completed. The licensee's Assisted Living Orientation-All Staff policy dated August 1, 2021, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirement and regulations before providing services to residents. At minimum, orientation must include the following topic, an overview of Minnesota's assisted living law. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must	01530		

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01530	Continued From page 9 have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP-C) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01530		

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01530	Continued From page 10 ULP-C was hired December 4, 2023, to provide direct care to the licensee's residents. ULP-C's employee record did not indicate a total of 8 hours of the required dementia training was completed with 160 hours of employee start date. ULP-C's employee record indicated ULP-C had completed 2 hours of dementia training. On July 23, 2024, at 10:40 a.m., licensed assisted living director (LALD)-A and surveyor reviewed employee record and training transcripts. LALD-A stated ULP-C was assigned the 8 hours of dementia training. LALD-A was not aware all the dementia training was not completed. On July 24, 2024, at 3:25 p.m., surveyor received email correspondence from LALD-A stating ULP-C had worked over 700 hours and is over the 160 hours. The licensee's Dementia Training Staff policy dated August 1, 2021, indicated direct care staff will complete a minimum of 8 hours of initial training on dementia care topics and initial training will be completed within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01790 SS=E	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed	01790		

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01790	Continued From page 11 nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of	01790		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01790	Continued From page 12 medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of two unlicensed personnel (ULP)-C, ULP-F) were trained and demonstrated competency to prepare and give medications for residents having unplanned time away when licensed nurse is not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30460	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIKING MANOR NURSING HOME	317 1ST STREET NW 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) COMPLETE DATE
01790	Continued From page 13 During the entrance conference on July 22, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. ULP-C ULP-C was hired December 4, 2023, to provide direct care to the assisted living residents. ULP-F ULP-F was hired on May 9, 2013, and began providing services to the licensee's residents on August 1, 2021. On July 24, 2024, at 7:34 a.m., ULP-F stated if the nurses are at the facility, they will set up medications if residents go out on unplanned time away. ULP-F stated if there are no nurses at the facility, staff are taught to get the medications ready and put them in a box. On July 24, 2024, at 8:50 a.m., the surveyor observed ULP-F administer R1's morning medications. ULP-C and ULP-F's training record lacked evidence to indicate ULP-C and ULP-F was trained and had demonstrated competency to provide medications for residents for unplanned time away from home. On July 24, 2024, at 9:49 a.m., the clinical nurse supervisor (CNS)-B stated the ULPs are trained to bring the medications to the nursing home and a registered nurse (RN) would set them up. The licensee's Delegation of Medications to be Given to Clients for Clients Time Away from Home policy dated August 1, 2021, indicated the agency will provide the necessary medications,	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30460	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIKING MANOR NURSING HOME	317 1ST STREET NW 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) COMPLETE DATE
01790	Continued From page 14 education, instructions, and support to meet the client's medication needs when they are away from home if the agency provides assistance with self-administration of medication, administration, administration or storage of medications. Only staff that that have been trained and satisfactorily demonstrated competency will be assigned to place medications prepared by a pharmacist or a licensed nurse in the appropriate container for an unplanned leave of absence not to exceed 7 days of medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards with regards to safety of oxygen storage for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30460	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIKING MANOR NURSING HOME	317 1ST STREET NW 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) COMPLETE DATE
02310	Continued From page 15 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included chronic obstructive pulmonary disease (COPD), depression and anxiety. On July 23, 2024, at 1:03 p.m., the surveyor observed two (2) unsecured oxygen cylinders being stored directly on R3's floor. Clinical nurse supervisor (CNS)-B stated she was unaware R3 had oxygen tanks in her room, and thought she only had a concentrator. CNS-B stated when R3 first moved in the staff assisted with medications and oxygen but now manages her own medications and oxygen. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

MN Department of Health
Food Pools and Lodging Services
PO Box 64975
St. Paul, MN, 55164
218-332-5150

Type: Full
Date: *07/23/24*
Time: 11:49:36
Report: 1042241101

Food and Beverage Establishment Inspection Report

Location:
Viking Manor Nursing Home
317 1st Street Nw
Ulen, MN56585
Clay County, 14

Establishment Info:
ID #: 0038920
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2185968847
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Sanitizer Bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Walk-In Cooler
Temperature: 36.1 Degrees Fahrenheit - Location: Half and Half
Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: 8.2 Degrees Fahrenheit - Location: Frozen Peas
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.

3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.

4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

Type: Full
Date: *07/23/24*
Time: 11:49:36
Report: 1042241101
Viking Manor Nursing Home

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MN Department of Health inspection report number 1042241101 of 07/23/24.

Certified Food Protection Manager: Melanie Kjos

Certification Number: FM66034 Expires: 01/05/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Tyler Pyle
Environmental Health Specialist
Fergus Falls Area Office
tyler.pyle@state.mn.us

Report #: 1042241101

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MN Department of Health
Food Pools and Lodging Services
PO Box 64975
St. Paul, MN, 55164

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 07/23/24
Time In 11:49:36
Time Out

Viking Manor Nursing Home	Address: 317 1st Street Nw	City/State: Ulen, MN	Zip Code: 56585	Telephone: 2185968847
License/Permit #: 0038920	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
Supervision				
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
Employee Health				
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices				
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands				
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
Approved Source				
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination				
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
Time/Temperature Control for Safety				
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
Consumer Advisory				
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations				
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances				
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures				
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 07/24/24

Inspector (Signature)