Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 14, 2025

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

RE: CCN: [245559
Cycle Start Date: June 11, 2025

Dear Administrator:

On July 11, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 14, 2025

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

Re: Reinspection Results
Event ID: L2RF11

Dear Administrator:

On July 11, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 11, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 20, 2025

Administrator
Viking Manor Nursing Home
317 First Street Northwest
Ulen, MN 56585

RE: CCN: 245559
Cycle Start Date: June 11, 2025

Dear Administrator:

On June 11, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 11, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 11, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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 _____	06/11/2025

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
E 000	Initial Comments On 6/9/25 to 6/11/25 a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 6/9/25 to 6/11/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		6/25/25

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

Electronically Signed | 06/25/2025

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

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F 880	Continued From page 1 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 2 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn to prevent the spread of infection for 2 of 3 residents (R17, R29) observed for enhanced barrier precautions (EBP), (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). Findings Include:	F 880	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also no to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident found to have been affected	

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F 880	Continued From page 3 Review of Centers for Disease Control (CDC) guidance dated 4/1/24, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for EBP included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. R17's quarterly Minimal Data Set (MDS) dated 4/8/25, identified R17 was cognitively intact and had diagnoses of cerebral infarction (stroke), benign prostatic hyperplasia (prostate increasing in size making urination difficult), hemiplegia (paralysis), and hemiparesis (weakness on one side). R17 needed maximal assistance with upper body dressing and was dependent on staff for lower body dressing and toileting hygiene. R17's care plan revised on 2/14/24, identified that R17 required the assistance of one staff and a mechanical standing lift for toileting. R17 had a Foley catheter, and staff were to empty the urinary catheter as needed. R17's care plan revised on 5/10/25, identified staff needed to follow EBP when changing the Foley catheter, emptying the urinary drainage bag, performing peri care, and assisting the resident with bowel hygiene. R17's order summary report dated 6/5/25, identified staff needed to change the suprapubic catheter with 18 French once every 42 days and	F 880	include: R-17 and R-29s care plan was reviewed to ensure proper interventions are in place. Discussed residents R-17 and R-29s plan of care at our IDT meeting. All staff re-educated on the importance of why we use EBP, who is on EBP, and when to use EBP. They are to sign off that they acknowledge and understand policies and procedures in place. Current policy on EBP has been reviewed. 2. Identification of other residents having the potential to be affected was accomplished by: DON completed a Validation Checklist on all residents that are on EBP to ensure that interventions were appropriate and in place. Care plans of all residents on EBP were reviewed to ensure that proper interventions were in place. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: DON/designee will conduct random weekly audits to ensure that EBP procedures are sustained by following the recommended guidelines for EBP. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Random audits will be completed by DON/designee for six weeks or until such time consistent substantial compliance has been achieved. Audits will be done to ensure that the staff are following the recommended guidelines & our policies/procedures in place for EBP. The results of the audits will be reviewed by the Quality Assurance Committee.	

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F 880	Continued From page 4 give the resident a new leg/bed catheter bag at bedtime every Sunday for catheter care. During an interview on 6/9/25 at 2:45 p.m., R17 indicated that staff typically did not wear a gown while providing care. During an observation on 6/11/25 at 7:21 a.m., nursing assistant (NA)-A applied gloves and did not apply a gown. NA-A took the mechanical standing lift into R17's room, applied R17's shoes and helped R17 sit on the side of the bed. NA-A assisted R17 with putting his feet on the standing mechanical lift. NA-A hooked R17's catheter bag on the mechanical lift and put the sling around R17. NA-A lifted R17 from the bed and transferred him to the bathroom and removed his brief and placed in the garbage. NA-A transferred R17 to the shower chair and brought R17 to the shower room down the hallway. At 8:11 a.m., NA-A came out of the shower room without a gown to grab the standing mechanical lift and brought the lift into the shower room. During an interview on 6/11/25 at 7:33 a.m., NA-A indicated staff would wear a gown when changing the catheter and switching the night bag to a leg bag. NA-A did not believe staff needed to wear a gown when getting R17 dressed or during a bath. During an interview on 6/11/25 at 8:55 a.m., licensed practical nurse (LPN)-A, indicated staff needed to wear a gown when changing the suprapubic catheter or the urine night bag to a leg bag. LPN-A did not think a gown would need to be worn when giving R17 a bath or dressing R17. R29's quarterly MDS dated 4/30/25, identified	F 880		

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F 880	Continued From page 5 R29 was severely cognitively impaired and had diagnoses of Alzheimer's disease, dementia and depression. R29 needed total assistance with dressing, toileting and transfers. R29's care plan revised 3/31/25, identified R29 had an alteration in gastro intestinal status related to the presence of a cholecystectomy (gallbladder) tube and R29 was on EBP. R29's signed physicians orders dated 6/5/25, identified staff were to monitor the dressing to the biliary (gallbladder) draining daily and as needed (PRN). Further indicated staff were to change the dressing when soiled PRN. During an observation and interview on 6/9/25 at 4:30 p.m., NA-B and NA-C were in R29's room and transferred R29 into bed using a mechanical lift. NA-C grabbed two pairs of gloves from R29's bedside table and gave NA-B one pair. NA-C and NA-B applied gloves and removed R29's brief. NA-B provided R29 the urinal and R29 voided. RN-B removed the urinal and disposed the urine in the bathroom. NA-B returned to assist NA-C with cleaning R29's bottom and applying a new brief. NA-C and NA-B removed their gloves and transferred R29 back into the wheelchair with the mechanical lift. NA-B and NA-C did not wear gowns while providing cares to R29. NA-B and NA-C stated staff only needed to wear a gown when they were providing cares to R29's cholecystectomy tube. NA-B and NA-C confirmed they had not worn a gown when they were changing or transferring R29. During an interview on 6/11/25 at 9:28 a.m., director of nursing (DON) who also worked as the infection preventionist indicated staff should be	F 880		

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F 880	Continued From page 6 wearing gowns when providing activities of daily living such as dressing, catheter care, transferring, and changing bedding. DON indicated wearing gowns was important to prevent the spread of possible infections to other residents. Review of facility policy titled Enhanced Barrier Precautions dated 2025, personal protective equipment (PPE) for enhanced barrier precautions was only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. High-contact resident care activities included dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC (peripherally inserted central catheter) lines, midline catheters.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		6/25/25

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F 883	Continued From page 7 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 883		

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F 883	Continued From page 8 Based on interview and document review, the facility failed to ensure 2 of 6 residents (R40, R21) were offered or received pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: Review of the Pneumococcal Vaccine Timing for Adults, dated 10/24, from the CDC identified adults 50 years of age or older who had previously received the Pneumococcal 13-valent Conjugate Vaccine (PCV13) and the Pneumococcal Polysaccharide Vaccine 23 (PPSV23) should receive one dose of the 20-valent Pneumococcal Conjugate Vaccine (PCV20) or 21-valent Pneumococcal Conjugate Vaccine (PCV21). Review of R40's Minnesota Immunization Information Connection (MIIC) identified R40 had received the PPSV23 vaccination on 9/21/18. R40's medical record lacked documentation R40 had been offered or received the PCV20 or PCV21 vaccination. R40's medical record further revealed R40 had consented to receive the PCV20 or PCV21 vaccination on 5/6/25. Review of R21's MIIC identified R21 had received the PCV-13 vaccination on 2/25/16, and the PPSV23 vaccination on 10/1/09. R21's medical record lacked documentation R21 had been offered or received the PCV20 or PCV21 vaccination. R21's medical record further revealed R21's significant other consented for R21 to receive the PCV20 or PCV21 vaccination on 4/28/25. During an interview on 6/10/25 at 12:17 p.m.,	F 883	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also no to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident found to have been affected include: R-40 was offered the Pneumococcal vaccine on 6-23-25, he refused. His chart was updated to reflect his choice. R-21 was given the Pneumococcal vaccine on 6-24-25. Current policy on Pneumococcal vaccines reviewed. 2. Identification of other residents having the potential to be affected was accomplished by: DON reviewed all residents charts to ensure that all the recommended vaccines were offered. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: DON will continue to do weekly audits on all new admissions to ensure that they have been offered the most current recommended Pneumococcal vaccine. Education has been provided to Primary RNs who complete the resident admissions, RN will notify pharmacy of vaccine requested and will document that information in resident chart. Audits will ensure that resident has received requested vaccination within (30) days of admission following facility policy in place. 4. How the corrective action(s) will be	

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	245559	A. BUILDING _____ B. WING _____	06/11/2025

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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F 883	Continued From page 9 infection preventionist (IP) indicated she contacted the pharmacist via email on 6/9/25, requesting residents get caught up on their pneumococcal immunizations. IP did not specify R40 or R21 were included in the email. During a follow-up interview on 6/10/25 at 3:11 p.m., IP stated she was unaware why R40 did not receive the PCV20 or PCV21 vaccination. IP further stated the vaccinations were given by the pharmacist and it would only take one to two days after placing the order for the immunization to be available. IP confirmed R40 and R21 had consented to the PCV20 or PCV21 however, had not received the immunizations. IP further confirmed the pharmacist had not been contacted prior to the email on 6/9/25, to provide the immunizations to R40 and R21. During an interview on 6/11/25 at 9:35 a.m., director of nursing (DON) stated R40 and R21 should have received either the PCV20 or PCV21 immunizations. DON stated her expectations were every resident was to receive up to date immunizations following CDC guidelines. Review of facility policy titled, Pneumococcal Vaccine undated, indicated the facility would offer residents immunizations against pneumococcal disease in accordance with current CDC guidelines and recommendations.	F 883	monitored to ensure the practice will not recur: The results of the audits will be conducted for 6 weeks or until such time consistent substantial compliance has been achieved, audits will be reviewed and determined if solutions are sustained by the Quality Assurance Committee.	

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	245559	A. BUILDING **01 - 1965 BUILDING 01** B. WING _____	**06/10/2025**

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 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division 06/10/2025. At the time of this survey, Viking Manor Nursing Home was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Viking Manor Nursing Home is a 1-story building without a basement and constructed at five different times. The original building was constructed in 1965 and was determined to be of Type II (000) construction. An addition to the west was constructed in 1981 that was determined to be Type V (111) construction and is separated from the original building with a 2-hour fire barrier. A connecting link was constructed in 1994 to the north end of the east wing to connect the facility to an apartment building and a connecting link was constructed in 1998 to the south of the west wing to connect the facility to a clinic. Both buildings are separated from the existing nursing home with 2-hour fire barriers. In 2005 a 24 foot by 42 foot, PT addition was constructed to the south of the east wing that is Type II(000) constriction, 1-story without a basement. The entire building is fire sprinkler protected and the facility has a fire alarm system with smoke	K 000		

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

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

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K 000	Continued From page 1 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. The facility was surveyed as one building. The facility has a capacity of 45 beds and had a census of 39 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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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 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. The facility was surveyed as one building. The facility has a capacity of 45 beds and had a census of 39 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 20, 2025

Administrator
Viking Manor Nursing Home
317 First Street Northwest
Ulen, MN 56585

Re: State Nursing Home Licensing Orders
Event ID: L2RF11

Dear Administrator:

The above facility was surveyed on June 9, 2025 through June 11, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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 _____	06/11/2025

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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: On 6/9/25 to 6/11/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota 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. 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	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	21390	Corrected	6/25/25

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21390	Continued From page 3 review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn to prevent the spread of infection for 2 of 3 residents (R17, R29) observed for enhanced barrier precautions (EBP), (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). Findings Include: Review of Centers for Disease Control (CDC) guidance dated 4/1/24, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for EBP included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. R17's quarterly Minimal Data Set (MDS) dated 4/8/25, identified R17 was cognitively intact and had diagnoses of cerebral infarction (stroke), benign prostatic hyperplasia (prostate increasing in size making urination difficult), hemiplegia (paralysis), and hemiparesis (weakness on one side). R17 needed maximal assistance with upper body dressing and was dependent on staff for lower body dressing and toileting hygiene. R17's care plan revised on 2/14/24, identified that R17 required the assistance of one staff and a mechanical standing lift for toileting. R17 had a Foley catheter, and staff were to empty the urinary catheter as needed.	21390		

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21390	Continued From page 4 R17's care plan revised on 5/10/25, identified staff needed to follow EBP when changing the Foley catheter, emptying the urinary drainage bag, performing peri care, and assisting the resident with bowel hygiene. R17's order summary report dated 6/5/25, identified staff needed to change the suprapubic catheter with 18 French once every 42 days and give the resident a new leg/bed catheter bag at bedtime every Sunday for catheter care. During an interview on 6/9/25 at 2:45 p.m., R17 indicated that staff typically did not wear a gown while providing care. During an observation on 6/11/25 at 7:21 a.m., nursing assistant (NA)-A applied gloves and did not apply a gown. NA-A took the mechanical standing lift into R17's room, applied R17's shoes and helped R17 sit on the side of the bed. NA-A assisted R17 with putting his feet on the standing mechanical lift. NA-A hooked R17's catheter bag on the mechanical lift and put the sling around R17. NA-A lifted R17 from the bed and transferred him to the bathroom and removed his brief and placed in the garbage. NA-A transferred R17 to the shower chair and brought R17 to the shower room down the hallway. At 8:11 a.m., NA-A came out of the shower room without a gown to grab the standing mechanical lift and brought the lift into the shower room. During an interview on 6/11/25 at 7:33 a.m., NA-A indicated staff would wear a gown when changing the catheter and switching the night bag to a leg bag. NA-A did not believe staff needed to wear a gown when getting R17 dressed or during a bath.	21390		

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

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21390	Continued From page 5 During an interview on 6/11/25 at 8:55 a.m., licensed practical nurse (LPN)-A, indicated staff needed to wear a gown when changing the suprapubic catheter or the urine night bag to a leg bag. LPN-A did not think a gown would need to be worn when giving R17 a bath or dressing R17. R29's quarterly MDS dated 4/30/25, identified R29 was severely cognitively impaired and had diagnoses of Alzheimer's disease, dementia and depression. R29 needed total assistance with dressing, toileting and transfers. R29's care plan revised 3/31/25, identified R29 had an alteration in gastro intestinal status related to the presence of a cholecystectomy (gallbladder) tube and R29 was on EBP. R29's signed physicians orders dated 6/5/25, identified staff were to monitor the dressing to the biliary (gallbladder) draining daily and as needed (PRN). Further indicated staff were to change the dressing when soiled PRN. During an observation and interview on 6/9/25 at 4:30 p.m., NA-B and NA-C were in R29's room and transferred R29 into bed using a mechanical lift. NA-C grabbed two pairs of gloves from R29's bedside table and gave NA-B one pair. NA-C and NA-B applied gloves and removed R29's brief. NA-B provided R29 the urinal and R29 voided. RN-B removed the urinal and disposed the urine in the bathroom. NA-B returned to assist NA-C with cleaning R29's bottom and applying a new brief. NA-C and NA-B removed their gloves and transferred R29 back into the wheelchair with the mechanical lift. NA-B and NA-C did not wear gowns while providing cares to R29. NA-B and NA-C stated staff only needed to wear a gown when they were providing cares to R29's	21390		

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 _____	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21390	Continued From page 6 cholecystectomy tube. NA-B and NA-C confirmed they had not worn a gown when they were changing or transferring R29. During an interview on 6/11/25 at 9:28 a.m., director of nursing (DON) who also worked as the infection preventionist indicated staff should be wearing gowns when providing activities of daily living such as dressing, catheter care, transferring, and changing bedding. DON indicated wearing gowns was important to prevent the spread of possible infections to other residents. Review of facility policy titled Enhanced Barrier Precautions dated 2025, personal protective equipment (PPE) for enhanced barrier precautions was only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. High-contact resident care activities included dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC (peripherally inserted central catheter) lines, midline catheters. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policies and procedures to ensure, proper infection control regarding EBP practices were followed. Facility staff could be reeducated and an auditing system developed to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21390		