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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: M6T7
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 **11/21/2013** (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:

X 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 :
Denise Erickson, HFE NEII 02/26/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
(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
11/26/2013
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5559

On November 7, 2013 a Post Certification Revisit (PCR) was completed by review of the plan of correction for the health deficiencies. Lack of verfication of the life safety code deficiencies by the 70th day resulted in imposition of the following remedy:

- Mandatory Denial of Payment for new Medicare and Medicaid Admissions (DOPNA), effective December 12, 2013

If Mandatory DOPNA goes into effect the facility would be subject to a two year loss of NATCEP, beginning December 12, 2013.

On November 7, 2013 a life safety code PCR was complete. Correction of all life safety code deficiencies was verified. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 12, 2013, as of November 30, 2013. As a result of this visit, we recommended the following to the CMS RO for imposition:

- Mandatory Denial of Payment for new Medicare and Medicaid Admissions (DOPNA), effective December 12, 2013, be rescinded.

Since DOPNA did not go into effect. The facility would not be subject to a two year loss of NATCEP.

Refer to the CMS 2567b revisit forms for both health and life safety code.

Effective November 30, 2013, the facility is certified for 45 skilled nursing facility beds..

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number: 24-5559

February 26, 2014

Mr. Todd Kjos, Administrator
Viking Manor Nursing Home
317 First Street Northwest
Ulen, Minnesota 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 November 30, 2013 the above facility is certified for:

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5205
.
November 21, 2013

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

RE: Project Number S5559021

Dear Mr. Kjos:

On October 29, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 12, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On November 7, 2013, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 12, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 31, 2013. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on September 12, 2013.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the September 12, 2013 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard survey were found 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.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 12, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective December 12, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 12, 2013. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Viking Manor Nursing Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 21, 2013. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Post Certification Revisit Form (CMS-2567B) from the November 7, 2013 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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 March 12, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5559r1_70DayNotice.rtf

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245559	A. Building B. Wing	11/7/2013

Name of Facility	Street Address, City, State, Zip Code
VIKING MANOR NURSING HOME	317 FIRST STREET NORTHWEST ULEN, MN 56585

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item: ID Prefix	Reg. #	LSC	(Y5) Date Correction Completed
F0241	483.15(a)		10/30/2013
F0252	483.15(h)(1)		10/30/2013
F0279	483.20(d), 483.20(k)(1)		10/30/2013
F0280	483.20(d)(3), 483.10(k)(2)		10/30/2013
F0282	483.20(k)(3)(ii)		10/30/2013
F0309	483.25		10/30/2013
F0310	483.25(a)(1)		10/30/2013
F0311	483.25(a)(2)		10/30/2013
F0318	483.25(e)(2)		10/30/2013
F0323	483.25(h)		10/30/2013
F0353	483.30(a)		10/30/2013
F0431	483.60(b), (d), (e)		10/30/2013
F0441	483.65		10/30/2013
F0465	483.70(h)		11/30/2013
F0520	483.75(o)(1)		10/30/2013

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	MM/GA	11/21/2013	31256	11/07/2013
Reviewed By CMS RO				

Followup to Survey Completed on: 9/12/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245559	A. Building / B. Wing: 01 - 1965 BUILDING 01	11/21/2013

Name of Facility	Street Address, City, State, Zip Code
VIKING MANOR NURSING HOME	317 FIRST STREET NORTHWEST ULEN, MN 56585

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	10/22/2013	ID Prefix Reg. # NFPA 101 LSC K0050	10/22/2013	ID Prefix Reg. # NFPA 101 LSC K0056	10/22/2013
ID Prefix Reg. # NFPA 101 LSC K0062	10/22/2013	ID Prefix Reg. # NFPA 101 LSC K0147	10/22/2013	ID Prefix Reg. # NFPA 101 LSC K0154	10/22/2013
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PS	02/26/2014	03006	11/21/2014
CMS RO				

Followup to Survey Completed on: 9/18/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245559	03 - BUILDING 0202	11/21/2013

Name of Facility	Street Address, City, State, Zip Code
VIKING MANOR NURSING HOME	317 FIRST STREET NORTHWEST ULEN, MN 56585

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	10/22/2013	ID Prefix Reg. # NFPA 101 LSC K0056	10/22/2013	ID Prefix Reg. # NFPA 101 LSC K0062	10/22/2013
ID Prefix Reg. # NFPA 101 LSC K0154	10/22/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/PS	02/26/2014	03006	11/21/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/18/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Protecting, Maintaining and Improving the Health of Minnesotans

February 26, 2014

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

RE: Project Number F5559022

Dear Mr. Kjos:

On November 21, 2013, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 12, 2013. (42 CFR 488.417 (b))

Also, we notified you in our letter of November 21, 2013, 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 December 12, 2013.

This was based on the deficiencies cited by this Department for a standard survey completed on September 12, 2013, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our November 21, 2013 notice.   The most serious LSC deficiencies in your facility at the time of the standard survey were found 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 November 21, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 12, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 31, 2013.   Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 12, 2013, as of November 30, 2013.

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 our letter of November 21, 2013. 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 December 12, 2013, 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 December 12, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 12, 2013, is to be rescinded.

In our letter of November 21, 2013, we 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 December 12, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 30, 2013, 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 PCR with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5559r2_1470dayAllcorr

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: M6T7
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 **09/12/2013** (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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle HFE Nursing Eval. II 11/21/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate Johnson Enforcement Specialist 11/26/2013 (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 (L33)

DETERMINATION APPROVAL

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

CCN 24-5559

At the time of the standard survey completed September 12, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G) whereby corrections were required as evidenced by the attached CMS-2567 whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5755

October 29, 2013

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

RE: Project Number S5559021

Dear Mr. Kjos:

On September 12, 2013, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - 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;**

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

<u>Informal Dispute Resolution</u> - 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
Licensing and Certification Program
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537

Telephone: (218)332-5158
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 October 22, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 22, 2013 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC 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 PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility will be conducted to verify that

substantial compliance with the regulations has been attained. The revisit 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 December 12, 2013 (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 March 12, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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.

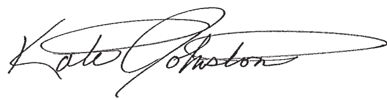
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992   Fax: (651) 215-9697

Enclosure (s)

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 ____ B. WING ____	09/12/2013

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation of compliance. Upon receipt of an acceptable 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		11/4/13
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to ensure each residents' dignity was maintained during meal observations in the main dining room. Staff were observed to scrape off dirty plates when 10 of 21 residents (R3, R24, R12, R25, R21, R22, R23, R29, R30, R1) were still eating. Findings include: On 9/9/13, at 6:00 p.m. observations of the evening meal in the facility dining room were conducted. The dining room contained 12 resident tables at which 29 residents received their meals, and included an attached "sun room "	F 241	Policy and procedure will be written and implemented to assure dignified clearing of tables with the exception of breakfast due to the open breakfast. 1) Tables will not begin to be cleared until 20 minutes after the last plate has been dished up. 2) Staff will bring dishes to area outside the soiled dishwasher room. 3) Dirty dishes will be scraped into a garbage can and liquids will be placed into a soiled liquid pail. 4) Dirty dishes placed into container that when full will be transferred to soil dishwasher room. 5) Dishes will be placed into dishwasher for cleaning. 6) When clearing tables after meal	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 11/4/13

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.

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

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 ______	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 241	Continued From page 1 area with 4 tables for 12 residents to eat their meals. At 6:33 p.m. a few of the residents had completed their meal and began wheeling themselves out of the dining room. Dietary aide (DA)-B wheeled a bus cart out of the main kitchen. The cart had three shelves, and contained a green pail and large plastic tub on the top shelf. In addition to wheeling out the bus cart, DA-B was observed to have a large garbage can (approximately 33 gallon can) on wheels which she wheeled out at the same time. At 6:35 p.m. DA-B wheeled the bus cart to a unoccupied table, picked up the dirty plates and used a fork to push the food debris into the garbage can. DA-B poured the left over fluids (coffee milk, and/or juice) into the green pail and placed the cups and silverware into the tub and the plates onto the first level of the cart. DA-B then wheeled the cart to the next table. As DA-B removed the dirty dishware and food debris, 21 residents were observed still eating their meals at the adjoining tables. At 6:36 p.m. DA-B wheeled the cart within (approximately) 10 inches of R12. R12 was eating as DA-B cleared the table behind him, again scraping food items into the uncovered garbage can, pouring the liquids into a pail and placing the dishes onto the cart. At 6:38 p.m. DA-B wheeled the bus cart across the main dining room and into the Sun room. At 6:47 p.m. 17 residents remained in the dining room and the sun room. DA-B continued to move the bus cart around the dining room, scraping food debris from plates and removing dirty dishware from the tables. At 6:47 p.m. DA-B wheeled the garbage can directly next to R25. R25 continued to eat as tablemates handed DA-B their dishes to be cleared. At 6:47 p.m. 17 residents in the main dining and the sun room were still eating their meals. DA-B had cleared all of the other residents	F 241	service, no table will be cleared while any residents are sitting at that table. 7) Certified Dietary Manager will educate all staff regarding procedure and will monitor procedure 3 times a week for 2 months. 8) Certified Dietary Manager will perform random audits. Audit findings will be presented at QA meeting and QA committee will determine how long to continue audits.	10/31/13

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 241	Continued From page 2 dishes and placed the other residents' soiled clothing protectors on the bottom shelf of the bus cart. At 7:05 p.m. all of the residents had completed their meals except R1 who was still sipping on coffee. DA-B had cleared all of the dirty dishware, food debris and beverage while residents were still eating in the dining room. During observations of the lunch meal on 9/11/13, from 12:35 p.m. to 12:42 p.m., DA-A was observed pushing a large garbage bin and cart used to place dirty plates, glasses and utensils from table to table in the main dining room. DA-A scraped off left over food on the plates into the garbage bin, and placed the dirty plates, glasses and utensils on the cart. During this time there were 24 residents still in the main dining room eating their lunch meal. On 9/11/13, at 12:42 p.m. director of nursing (DON) observed DA-A cleaning off the dirty dishes from the dining room tables as residents continued to finish eating. The DON confirmed it was not a dignified dining experience. On 9/11/13, at 12:45 p.m. the dietary manager confirmed busing tables and pushing along the garbage bin while residents continued to eat their meal was not a dignified dining experience. On 9/12/13, a policy regarding clearing tables and dignified dining was requested but not provided.	F 241		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing	F 252	Resident R1 and other residents of Viking Manor will be provided an odor free, safe, clean, comfortable and homelike environment. Regarding R1, to combat the odors	

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F 252	Continued From page 3 the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide an odor free environment for 1 of 1 resident (R1) with a strong urine odor in the room. Findings include: The facility failed to provide an odor free and clean environment for R1. R1 had diagnoses which include arthritis and osteoporosis. The quarterly Minimum Data Set, dated 6/23/13, identified R1 had moderate cognitive impairment and required extensive assistance from staff with all activities of daily living. During observation of R1's room on 9/11/13, at 8:40 a.m. a strong urine odor permeated out into the hallway outside of R1's room. The pungent urine odor was strongest in R1's room which contained the resident's bed, a cloth recliner and floor mats. During observation on 9/12/13, at 9:04 a.m., a pungent odor of urine was again noted in R1's room and adjoining hallway. On 9/12/13 at 9:06 a.m. the house keeping supervisor confirmed R1's room had a strong urine smell that permeated into the hallway and stated housekeeping staff cleaned the room routinely and stated, "A lot of the problem I think	F 252	CNA's are to change her linen every other day, her Hoyer bucket is to be hand-washed nightly and machine washed weekly and more often if needed. Her wheel chair is to be cleaned daily, deodorizer drops have been purchased to put in her catheter bag daily, clean mats daily and swap them out twice a week, clean her recliner and clue chair pad weekly. Also, a vent was not working during the survey and has now been fixed. Training will be provided to staff responsible to implement this plan. The DON or designee will be auditing these interventions randomly to ensure they are being completed. Our Head Housekeeping will monitor all areas of Viking Manor to ensure an odor free and clean environment exists for our residents. Audit findings will be presented at QA meeting. The QA committee will determine how long to continue audits.	10/30/13

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F 252	Continued From page 4 are the mats and recliner." On 9/12/13 at 10:17 a.m. the administrator confirmed the strong urine smell was present in R1's room and in the hallway of the facility. On 9/12/13 at 11:13 a.m. registered nurse (RN)-A confirmed R1's room had a strong urine odor and stated, "[R1's] had that since admission and the smell is urine." On 9/12/13 at 11:46 p.m. the contracted electrician confirmed the ventilation system in the facility was functioning properly and stated, "The smell would come from the source or cause of it." On 9/12/13, at 1:58 p.m. director of nursing (DON) confirmed the presence of strong urine smell in R1's room that permeated into the hallway. The DON stated, "I expect good cleaning of her equipment and room."	F 252		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	R21's care plan has been updated to include a focus on bruising. Additional interventions have been added to reduce the number of bruises R21 sustains, including but not limited to derma sleeves to bilateral arms and skin monitoring BID. R21's physician ordered lab work and will also be monitoring R21's skin status. All RNs have received education and instruction on on adding bruising	

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F 279	Continued From page 5 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop the care plan to include identified interventions for 1 of 2 (R21) reviewed for bruising; 1 of 6 residents (R43) reviewed for ambulation; and 1 of 2 residents (R34) reviewed for range of motion (ROM). Findings include: R21's plan of care dated 5/1/13, did not indicate interventions to minimize the risk for bruising. On 9/10/13, at 10:50 a.m. R21 was observed wearing a short sleeved t-shirt sitting in a recliner in his room. R21's arms had multiple bruises from the finger tips to the upper forearms. The bruises ranged in color from deep purple to yellow/green. (R21's skin had a very thin appearance which could be compared to tissue paper). On 9/11/13, at 9:50 a.m. nursing assistant (NA)-A was observed to assist R21 with morning cares. NA-A washed the upper body and stated since R21 bruised so easily would attempt to put a shirt on after R21 was out of bed. At 9:53 p.m. NA-C entered the room and assisted transferring R21 from the bed to a recliner. Once in the recliner NA-A dressed R21 in a short sleeved t-shirt.	F 279	focus to care plans for any residents receiving anticoagulant medications and/or steroids. Staff were initially informed of need to wear geri-sleeves on 9/16/13.All staff will have received education regarding bruising interventions by 10/30/13. The DON or her designee will perform random audits to ensure implementation of interventions. Findings will be presented to QA committee and QA committee will determine how long audits need to be continued. R43's care plan has been updated to include an intervention related to nursing rehab/ambulation. Resident is offered nursing rehab/ambulation 3-5 times a week. All ambulatory residents are offered to ambulate to meals daily. Any resident currently receiving ambulation/nursing rehab services will have their care plan reviewed and updated to include ambulation and any other nursing rehab the resident is receiving. Any resident being added to an ambulation/nursing rehab program	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VIKING MANOR NURSING HOME	317 FIRST STREET NORTHWEST ULEN, MN 56585

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F 279	Continued From page 6 On 9/12/13, at 11:00 a.m. the trained medication administration aide (TMA)-A stated R21 had a new open area on the elbow. TMA-A stated had filled out an incident report and turned the report into the nurse. TMA-A stated R21 bruised easily. TMA-A stated R21 was to wear long sleeve shirts to protect arms from bruising. On 9/12/13, at 11:40 a.m. registered nurse (RN)-C reviewed the plan of care and confirmed the plan of care did not include R21's frequent bruising or interventions to minimize the risk for further bruising. The Reporting of Bruises Policy dated 8/11/10, directed the staff to document new bruises and complete an incident report. "Residents that are prone to bruising that are wanders, on Coumadin (used to prevent heart attacks, strokes, and blood clots in veins and arteries), ASA [Aspirin] or Prednisone (anti-inflammatory medication) will be care planned for." On 9/12/13, at 12:12 p.m. the director of nursing (DON) confirmed the facility had not identified or consistently attempted alternative interventions to minimize R21's risk for further bruising and the concern had not been care planned. R43's plan of care did not include an intervention related to a restorative nursing program for ambulation, as directed by the Physical Therapy	F 279	will have a related intervention added to their care plan. All staff will receive education regarding comprehensive care plans by 10/30/13. The DON or her designee will perform random audits of care plans to ensure the care plans are current. RNs for each wing will be auditing nursing rehab flow sheets weekly to ensure all residents are receiving ambulation as care planned. Care plans will continue to be reviewed quarterly and PRN. Audit findings will be presented to QA committee and QA committee will determine how long audits need to be continued. R 23 and R34's care plan has been updated to include an intervention for ROM. R23 and R34 are offered nursing rehab/ROM 3-5 times a week. Additional staff available for assistance in providing ROM exercises. Any resident currently receiving ROM/nursing rehab services will have their care plan reviewed and updated to include ROM and any other nursing rehab the resident is receiving. Any	

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F 279	Continued From page 7 staff. A Physical Therapy Discharge Summary dated 2/4/13, included a Discharge Recommendation to continue ambulation program with nursing staff and to encourage/assist with ambulation. In addition, a Physical Therapy Discharge Summary dated 10/26/12, included a Discharge Recommendation of restorative nursing program with close supervision. During interview on 9/11/13, at 1:02 p.m., registered nurse (RN)-A verified a restorative nursing program was not included on R43's plan of care. During interview on 9/12/13, at 11:00 a.m., the director of nursing verified nursing staff were responsible to keep resident care plans updated and accurate. R23's plan of care did not include range of motion services (ROM), as directed by Physical Therapy. R23's plan of care, revised 9/5/13, identified a focus of Mobility with several interventions which included two staff assist for transfers, as resident was no longer safe to ambulate. The plan of care did not include ROM. A Physical Therapy Discharge note dated 10/26/12 revealed Discharge Recommendations: "RNP (restorative nursing program) with close supervision." A Restorative Care Program form dated 2/8/13 from a Physical Therapist included the following "Approach/Recommendations: play catch with ball, pegs and foam board, overhead pulleys, incline board, arm bike, and knee extension with 23 pounds, three sets of 10 each	F 279	resident being added to a ROM/ nursing rehab program will have a related intervention added to their care plan. All staff will receive education regarding comprehensive care plans by 10/30/13. The DON or her designee will perform random audits of care plans to ensure the care plans are current. RNs for each wing will be auditing nursing rehab flow sheets weekly to ensure all residents are receiving ROM as care planned. Care plans will continue to be reviewed quarterly and PRN. Audit findings will be presented to QA committee and QA committee will determine how long audits need to be continued.	10/30/13

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	245559	A. BUILDING ______ B. WING ______	09/12/2013

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 279	Continued From page 8 leg." During interview on 9/11/13 at 11:20 a.m., RN-A confirmed ROM was not included on R23's plan of care. During interview on 9/12/13, at 11:00 a.m., the director of nursing verified nursing staff were responsible to keep resident care plans updated and accurate. R34's plan of care (POC) dated 9/5/13, was not developed to maintain flexibility and range of motion (ROM) to participate in activities of daily living (ADLs). On 9/11/13, at 8:59 a.m. R34 was observed needing extensive assistance from nursing assistant (NA)-F and NA-G to sit up on edge of bed, dressing, and personal hygiene. At 9:05 a.m. R34 was observed being lifted to a standing position, peri cares performed, brief and pants were pulled up by NA-G, then R34 was transferred by mechanical lift to the recliner. R34 was able to grab onto the handles of the mechanical lift with guidance and verbal cueing from NA-G. On 9/11/13, at 9:25 a.m. NA-F confirmed R34 was receiving ROM services from restorative nursing and stated, "R34 is dependent on staff, and he has not really changed." On 9/11/13, at 1:55 p.m. NA-D confirmed R34 was receiving ROM services from restorative nursing and stated, "we can get restorative nursing done if we are not pulled to the floor, but lately we have been working the floor and it's just not getting done." On 9/11/13, at 2:30 p.m. RN-A reviewed and	F 279		

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F 279	Continued From page 9 confirmed the plan of care did not include R34's ROM services to maintain flexibility and ROM to participate in ADLs. The facilities Goals and Objectives, Care Plan policy dated 10/22/09, revealed the POC was derived from the resident's comprehensive assessment and provided goals and objectives for all disciplines.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the plan of care to include identified interventions for 2 of 6	F 280	R25 and R29 were identified related to not receiving revision of plan of care related to ambulation and ROM. R29 has was hospitalized on 9/11/13 and was deceased on 9/23/13 without return to facility. R25 received a comprehensive assessment on 9/17/13. An order for PT evaluation and treatment was obtained on 9/17/13. R25's plan of care has been updated to include current ambulation ability and recommendations from PT evaluation. R25 is offered ambulation and ROM 3-5 times weekly. One activity aide was trained to nursing rehab and is scheduled for rehab 2-3 hours/day 2-3 days a week. The activity aide focuses on providing ROM exercises. R25 is offered to ambulate to meals. All residents	

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F 280	Continued From page 10 residents (R25, R29) related to ambulation and ROM. Findings include: R25's plan of care (POC) had not been revised regarding ambulation and range of motion needs. R25's POC dated 7/6/12, indicated R25 was able to ambulate with a front wheeled walker in room and for short distances in the hallway. It indicated R25 had a history of refusing to ambulate but was to work with restorative services three to five times per week. The POC identified R25 with limitations in mobility, but it did not include directions related to a range of motion program or how far R25 was to ambulate. On 9/11/13, at 6:55 a.m. R25 was observed sitting on the toilet receiving assistance with cares from NA-A. R25 was connected to a standing mechanical lift when the cares were completed. R25 was transferred out of the bathroom and positioned in a wheelchair via the standing lift. R25's legs were fully extended during the transfer. On 9/11/13, at 12:20 a.m. NA-D and registered nurse (RN)-C assisted R25 into a standing positioning. R25 used a four wheeled walker and was able to ambulate six feet with extensive assistance of both staff. R25 stated had pain in the right hip and the left knee when ambulating. The resident stated "I just can not walk like I used to." Review of the Rehab Flow Sheets identified the following information for ambulation:	F 280	capable of ambulation will be offered to ambulate to meals. All residents will receive annual PT screenings and more frequently if needed and care plans will be updated/revised with recommendations. All resident plans of care will be reviewed at quarterly care conferences and updated with any changes each care conference and more frequently if needed. Changes to care plans will be communicated to staff via communication book and/or orally. All staff will receive education to be completed by 10/30/13 related to revision of care plans. The DON or her designee will be performing random care plan audits to ensure revisions are occurring as needed. Audit findings will be reviewed at IDT and QA meetings and QA committee will determine when to stop audits.	10/30/13

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F 280	Continued From page 11	F 280		

- In September 1-11, 2013, R25 had been offered and refused to ambulate one time.
- In August 2013, R25 had ambulated 7 times. The documentation did not indicate how far the resident ambulated.
- In July 2013, R25 had ambulated 14 times. The documentation did not indicate how far the resident ambulated.

Review of the Rehab Flow Sheets identified the following information for range of motion:

- In September 1-11, 2013, the documentation was blank..
- In August 2013, the documentation was blank.
- In July 2013, the documentation was blank. .

R29's plan of care had not been revised to been revised regarding ambulation and range of motion needs.

R29's plan of care dated 6/6/12, directed the staff to assist ambulation using a walker and 1-2 staff members. The plan also directed the staff informed the staff R29 was participating with restorative nursing but it did not direct the staff as to what R29 was doing with restorative nursing

On 9/10/13, at 2:00 p.m. R29 was observed to be assisted onto a Nustep (exercise machine) in the restorative therapy room by nursing assistant (NA)-B. R29 was not observed to be able to hold her balance during the transfer and physical therapy assistant (PTA)-A joined NA-B to assist R29 onto the machine.

On 9/11/13, at 8:50 a.m. nursing assistant (NA)-A assisted R29 with morning cares. At 9:00 a.m. NA-A assisted R29 into a sitting position on the

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F 280	Continued From page 12	F 280		

edge of the bed. R29 was not able to hold herself up while sitting on the bed. NA-A held her steady as trained medication aide (TMA)-A entered the room to assist with the transfer. A transfer belt was applied and a walker was placed in front of R29. R29 did not reach for the walker as the two staff assisted her to stand. R29 cried out as she stood, took two steps with extensive assistance of the two staff and sat in a wheelchair. Once in the chair, NA-A assisted R29 to donn her shirt. R29 made facial grimaces when her arms were moved.

On 9/11/13, at 9:20 a.m. NA-A stated R29 usually did not complain of pain with cares or transfers. She stated there has to be something wrong with R29. She stated in the past R29 had the ability to ambulate from the bed to the bathroom several times a day, but she had not been able to do that for a couple of months.

The Rehab Flow sheets directed the staff to "ambulate." The sheets did not direct the staff as to what type of devices were to be used while ambulating, how many staff members were to assist, how far the resident was to ambulate or the frequency of which the services were to be provided.

Review of the Rehab Flow Sheets for ambulation revealed the following information:

- In September 1-11. 2013, R29 had not ambulated.
- In August 2013, R29 had ambulated 4 times. The distance to which R29 had ambulated was not identified.
- In July 2013, R29 had ambulated five times. The distance to which R29 had ambulated was

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F 280	Continued From page 13	F 280		

not identified.

The Rehab Flow sheets directed the staff to provide a "Nu-Step, sink standing activity (cones, pegs or arch)" and gave the staff a list of four exercise to choose from including "red theraband exercise, a two pound wand exercise over the head, side to side, chest in and out, pulleys or arm bike." The restorative flow sheets did not directed the staff as to the frequency the activities were to be performed or the length of time in which the exercises were to be provided.

Review of the Rehab Flow Sheets for range of motion revealed the following information:

- In September 1-11. 2013, R29 had completed the Nu step on two occasion, and the pulleys one once. The length of time spent on each activity was not documented.

- In August 2013, R29 had completed the Nu-step on five occasions and had completed the pulleys twice. The length of time spent on each exercise was not documented.

- In July 2013, R29 had competed the Nu-Step 12 times and had worked with the pulleys six times. The length spent on each exercise was not documented.

On 9/11/13, at 12:05 p.m. the director of nursing (DON) confirmed the plans of care had not been revised to reflect R25's and R29's current ambulation and range of motion needs.

The Goals and Objectives, Care Plan policy dated 10/22/09, directed the staff to review and revise the plans of cares quarterly and with any

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F 280	Continued From page 14 change to refect the residents' condition.	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in accordance with the resident's written plan of care for 1 of 3 residents (R43) who utilized a personal alarm for fall prevention, and for 4 of 8 (R27, R13, R22, R26) requiring range of motion services. Findings include: R43's plan of care (POC) had not been followed for the use of a personal alarm (Tabs) unit while in the wheelchair. R43's plan of care last revised 7/10/13, included a focus area for risk of falls. The plan of care indicated R43 was not aware of safety needs and listed various interventions which directed staff to utilize a Tabs alarm at all times when up in wheelchair. During observations on 9/9/13, from 5:58 p.m. to 6:54 p.m., R43 was seated in a wheelchair in the dining room of the facility. A white alarm box was attached to the back of the wheelchair with a metal clip attached to an orange string, which hung down behind the backside of the wheelchair. The metal clip had not been attached to R43. At 6:55 p.m., RN-A confirmed the clip	F 282	R43's tabs unit was discontinued on 9/16/13. A chair alarm was initiated in place of the tabs unit. This alarm type is sensitive to R43's weight and will alarm when R43's weight is removed from the pad. R43's care plan has been updated to include the chair alarm as an intervention for fall prevention. Staff were educated initially via communication book when alarm changed and all staff will receive education by 10/30/13. R43 continues to have a laser alarm when in bed. Nursing staff are to sign off each shift that alarms have been checked and are on/clipped to residents. All resident care plans will be updated to reflect changes in care and all staff will be informed and educated as needed to ensure ability to carry out the care plan. DON or designee will be performing random audits to ensure alarms are in place and turned on. Audit findings will be discussed at IDT meetings and QA meetings and	

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F 282	Continued From page 15 was not attached and she then attached the clip to R43's shirt. During observations on 9/11/13, from 6:55 a.m. to 7:20 a.m., R43 was seated in a wheelchair near the nurses station with the white alarm box attached to the back of the wheelchair. The metal clip had not been attached to R43 and the orange string was hanging down the backside of the wheelchair. At 7:20 a.m., the director of nursing (DON) approached R43 and attached the metal clip of the Tabs alarm to the back of R43's shirt. The DON then confirmed the clip was not attached to R43's back as it should have been. During an interview conducted on 9/11/13, at 12:33 p.m. nursing assistant (NA)-F stated R43 was usually content in the wheelchair but occasionally would become restless or anxious. NA-F stated R43 had a laser alarm on the bed and a TABs alarm on at all times while up in the wheelchair. During an interview on 9/12/13, at 9:11 a.m., registered nurse (RN)-A indicated R43 had two falls in the recent past and confirmed she would expect the alarm to be clipped to his body while in the wheelchair. During an interview on 9/12/13, at 11:00 a.m., the DON confirmed R43's current plan of care and verified she would expect all fall interventions to be implemented by nursing staff. R27's POC interventions related to range of motion (ROM) exercises were not being implemented consistently. R27's POC included a focus of Parkinson's,	F 282	IDT/QA will determine when to stop audits. R27, R13, R22, and R26's care plans have each been updated to include ROM/nursing rehab intervention. R27, R13, R22 and R26 are each offered ROM/nursing rehab exercises 3-5 times a week. To ensure R27, R13, R22, and R26 and all other residents are receiving services as per plan of care, Viking Manor Nursing Home has implemented staff schedule changes. One activity aide was trained to nursing rehab and is scheduled for rehab 2-3 hours/day 2-3 days a week. The activity aide focuses providing ROM exercises. Viking Manor Nursing Home will continue to schedule a rehab aide Monday-Friday. One additional activity aide is enrolled in Certified Nursing Assistant (CNA) classes and will also be trained to rehab upon completion of CNA classes. One additional RRA (registered resident assistant) has also been trained to	

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F 282	Continued From page 16 initiated 6/5/12, with interventions which included: encourage gentle ROM as tolerated with daily care; and encourage her to wear her tennis shoes during the day for more support for her feet. Also, a focus of Mobility, revised 7/16/13, with interventions which included: assist of 2 staff using Pal lift (mechanical lift) to transfer, currently working with nursing rehab 3-5 days a week, no longer ambulating due to Parkinson's, and activities of daily living (ADL's) extensive assist. During a family interview on 9/10/13 at 10:33 a.m., family (F)-A stated he would visit R27 on a daily basis. F-A stated he was concerned because R27 was supposed to be getting exercises and ROM, but staff were not providing this. F-A also stated R27 was no longer getting walked at all and hadn't been walked for approximately 3 months. F-A stated staff quit walking R27 because it required 2-3 staff and "they have a staffing shortage." F-A further stated ROM is not provided because therapy staff gets pulled from therapy to work on the floor. During an interview on 9/10/13 at 2:14 p.m., NA-B stated she worked as a restorative aide and nursing assistant. She stated staffing was a problem and she would often get pulled from restorative to work on the floor. NA-B stated this would happen 2-3 times/week and ROM was then not provided for R27. During interview on 9/11/13, at 11:32 a.m., NA-D stated, "I am pulled from restorative to work on the floor and lately it's happen a lot." She confirmed when this happens, ROM does not get done for R27 or any other resident who was on the program.	F 282	nursing rehab and will be scheduled 1-2 days biweekly. All residents will receive annual PT screenings and more frequently if needed and care plans will be updated/revised with recommendations. All staff will complete education of new nursing rehab staffing by 10/30/13 plus an educational in-service "Restorative Care/ROM" was assigned to all nursing staff to complete in the month of October so that in the absence of a rehab aide on the schedule other staff are knowledgeable to nursing rehab program and can perform assigned exercises. The physical therapy department will also be hosting an educational in-service for staff 10/30/13 focused on ROM and transferring. RNs for both wings and/or DON will be auditing nursing rehab flow sheets weekly. All audit findings will be presented to the QA committee and the QA committee will determine how long to continue audits.	10/30/13

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F 282	Continued From page 17 During interview on 9/12/13, at 11:00 a.m., the DON confirmed staffing was a problem and she confirmed the staff did not always have time to provide ROM for R27, as directed. The DON confirmed R27's current plan of care and confirmed she would expect ROM interventions to be implemented by staff. R13 did not receive ROM consistently three times a week as directed by her POC. R13's POC dated 6/18/12, directed she was to receive rehabilitation nursing for ROM three to five times a week. R13's Rehab Flow Sheet directed nursing rehabilitation staff to assist with ROM on R13's upper and lower extremities. Review of R13's Rehab Flow Sheet revealed the following: September 1-11, 2013--R13 had received ROM services on one day of the month. August 1-31, 2013--R13 had received ROM services on 8 days of the month. July 1-31, 2013--R13 had received ROM services 17 days of the month. On 9/11/13, at 1:55 p.m. NA-C confirmed R13 had not received range of motion services routinely from restorative nursing. She stated the rehab aide had been consistently reassigned to direct care and stated the rehab aid duties "it's not all getting done." R22 did not receive ROM exercises consistently three times a week as directed by his POC. R22's POC dated 9/11/12, directed he was to recieve rehabilitation nursing for ROM three to five times a week. R22's Rehab Flow Sheet directed nursing	F 282		

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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 282	Continued From page 18 rehabilitation staff to conduct various exercises such as: ambulation with front wheeled walker, nu-step 10 minutes, sits to stand five times, pulleys/gentle stretch, leg kicks, and standing frame 10 minutes. Review of the Rehab Flow Sheets identified the following information: For the month of September 1st-11, 2013 R 22 received services for only two days during the month, and for the month of August 1st-31st, 2013 R 22 received services for nine days during the month, and furthermore the month of July 1st-31st, 2013 R 22 received services for thirteen days during the month. However R 22 only received services for 24 days out of a total of 73 days. On 9/11/13, at 1:55 p.m. NA-C confirmed R22 had not received range of motion services routinely from restorative nursing. She stated the rehab aide had been consistently reassigned to direct care and stated the rehab aid duties "it's not all getting done." R26 did not consistently receive ROM three times a week as directed by her POC. R26's POC dated 9/19/12, revealed she had rehabilitation nursing three times a week. R26's Rehab Flow Sheet directed nursing rehabilitation staff to conduct ROM on R26's upper and lower extremities. Review of R26's Rehab Flow Sheet revealed the	F 282		

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F 282	Continued From page 19 following: Week of 9/1/13, had the opportunity for three nursing rehabilitation sessions and received one. Week of 8/25/13, had the opportunity for three nursing rehabilitation sessions and received zero. Week of 7/28/13, had the opportunity for three nursing rehabilitation sessions and received two. Week of 7/7/13, had the opportunity for three nursing rehabilitation sessions and received two. On 9/10/13, at 2:04 p.m. NA-B revealed she is often pulled to the floor when assigned to do nursing rehabilitation. The facility's Rehabilitative Nursing Care policy dated 8/7/13, directed rehabilitative nursing care to perform three to five times weekly for those residents who require such service. The facility's Goals and Objectives, Care Plans policy dated 10/22/2009, revealed the POC is derived from the resident's comprehensive assessment and provides goals and objectives for all disciplines.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate	F 309	R21's care plan has been updated to include a focus on bruising. Additional interventions have been added to reduce the number of bruises R21 sustains, including but not limited to derma sleeves to bilateral arms and skin monitoring BID. R21's physician has been consulted. Lab work has been ordered and R21's physician will be monitoring R21's skin status. Care plans of all residents with	

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F 309	Continued From page 20 interventions to minimize the risk of bruising for 1 of 2 residents (R21) who had frequent bruising. Findings include: R21 bruised easily and appropriate interventions were not developed to minimize the risk of bruising. R21's diagnoses included status post stroke, history of anemia, and cardiac disorders to include a dysthrymic disorder. On 9/10/13, at 10:50 a.m. R21 was observed wearing a short sleeved t-shirt sitting in a recliner in his room. R21's arms had multiple bruises from the finger tips to the upper forearms. The bruises ranged in color from deep purple to yellow/green. (R21's skin had a very thin appearance which could be compared to tissue paper). On 9/11/13, at 9:50 a.m. nursing assistant (NA)-A was observed to assist R21 with morning cares. NA-A washed the upper body and stated since R21 bruised so easily would attempt to put a shirt on after R21 was out of bed. At 9:53 p.m. NA-C entered the room and assisted transferring R21 from the bed to a recliner. Once in the recliner NA-A dressed R21 in a short sleeved t-shirt. Physician's Orders dated 9/4/13, indicated R21 took medications that may cause the skin to become frail and easily bruised. The medications were Prednisone (a steroid) 5 milligrams (mg) daily and aspirin 81 mg daily. The aspirin was placed on hold 9/9/13. R21's Accident or Incident Reports from 8/10/13 through 9/12/13, were reviewed and revealed the following information. 8/10/13, at 5:00 p.m. R21 had a 5.5 cm (centimeter) by 3 cm bruise on the	F 309	frequent bruising have been reviewed and updated. Resident bruises are reviewed at IDT and QA meetings to discuss interventions and current plan of care. All RNs have received education and instruction on adding bruising focus to care plans for any residents receiving anticoagulant medications and/or steroids. All staff will have received education regarding bruising interventions by 10/30/13. The DON or her designee will perform random audits of ensure implementation of interventions. Findings will be presented to QA committee and QA committee will determine how long audits need to be continued.	10/30/13

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

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F 309	Continued From page 21 left wrist. Staff members asked if anything had happened, R21 denied harm. -8/11/13, at 6:00 p.m. R21 had a bruised area on the top of the right forearm measuring 2 cm by 3 cm, three bruises on the top of the right hand each measuring 1 cm by 1 cm, 2 cm x 2.5 cm, and 0 .5 cm x 0.5 cm, There was also an irregular shaped area with red "specks" running along the entire forearm measuring 12 cm x 5 cm. The incident report indicated nobody had hurt R21. -8/14/13, at 9:00 a.m. R21 had a bruise across the top of the right hand measuring 2 cm by 3 cm. R21 denied being hurt by any person. The incident report indicated R21 bruised frequently. -8/21/13, at 3:25 p.m. R21 had a 2.5 cm skin tear on the right elbow. R21 pointed to the arm of the wheelchair when asked how the skin tear occurred. The report did not include interventions to minimize the risk for skin tears. -9/5/13, R21 had a previous skin tear on the right elbow that reopened, (measuring 1.3 cm by 0.4 cm) while being dressed by the nursing assistants. -9/6/13, at 10:00 a.m. R21 had a bruise on the left hand going up into the left wrist. The bruise measured 11.6 cm by 10 cm. The report indicated R21 bruised easily and was currently on aspirin. R21 denied being hurt. -9/9/13, R21 had new bruises on both arms. The right arm bruise measured 6 cm by 6 cm. The left arm had four new bruises measuring 2.5 cm by 2 cm, 3 cm by 2 cm, 3 cm by 2 cm and 12 cm by 6 cm. Although the report indicated R21 took aspirin and Prednisone, it did not include interventions to minimize the potential risk for further bruises. -9/12/13, at 10:00 a.m. R21 had two open areas	F 309		

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F 309	Continued From page 22	F 309		

on the back of the right arm measuring 0.5 cm by 0.5 cm.

R21's incident reports dated 8/10/13 through 9/12/13, did not include interventions to minimize the risk of bruising, or skin tears.

The quarterly Minimum Data Set (MDS) dated 7/17/13, identified R21 with severe cognitive impairment and requiring extensive assistance with all activities of daily living. The MDS did not identify any concerns with R21's skin.

R21's plan of care dated 5/1/13, did not indicate any interventions to minimize the risk for bruising.

On 9/12/13, at 11:00 a.m. the trained medication administration aide (TMA)-A was observed filling out an incident report. TMA-A stated R21 had a new open area on the elbow. TMA-A stated R21 bruised easily and also bruised from the laboratory staff placing tourniquets on the arms to draw blood. TMA-A stated R21 was to wear long sleeve shirts to protect the arms from bruising.

On 9/12/13, at 11:40 a.m. registered nurse (RN)-C stated had talked to R21's primary physician about the frequent bruising. RN-C stated residents currently taking Prednisone and aspirin bruise easier so the MD placed R21's aspirin on hold. RN-C stated two staff were to assist R21 with cares. RN-C stated the facility had made attempts to decrease the risk of bruising by asking R21's family to bring in bigger clothes but had not asked for long sleeve shirts. RN-C reviewed and confirmed the plan of care did not include R21's frequent bruising or interventions to minimize the risk for further bruising.

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F 309	Continued From page 23 The Reporting of Bruises Policy dated 8/11/10, directed the staff to document new bruises and complete an incident report. "Residents that are prone to bruising that are wanderers, on Coumadin (used to prevent heart attacks, strokes, and blood clots in veins and arteries), ASA [Aspirin] or Prednisone (anti-inflammatory medication) will be care planned for." On 9/12/13, at 12:12 p.m. the director of nursing (DON) reviewed R21's record and confirmed the facility had not identified or consistently attempted alternative interventions to minimize R21's risk for further bruising and the concern had not been care planned.	F 309		
F 310 SS=G	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services to prevent loss of function for 1 of 6 residents (R25) who required physical assistance with ambulation. R25 was not provided assistance with ambulation, and was not	F 310	R25 received a comprehensive assessment on 9/17/13. An order for PT evaluation and treatment was obtained on 9/17/13. R25's plan of care has been updated to include current ambulation ability and recommendations from PT evaluation. R25 is offered ambulation and ROM 3-5 times weekly. The nursing rehab flow sheets have been altered to include room for documentation of number of repetitions for ROM and number of feet ambulated, as well as a space for documentation of refusal or other	

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F 310	Continued From page 25 the staff had been instructed to use the standing lift for transfer. NA-A stated R25 became very anxious when ambulating and was no longer participating. NA-A stated if a resident was unable to participate in the restorative program as directed, they would report the concern to the registered nurse (RN). NA-B explained several times a month, residents were not able to receive their restorative programs because the NA assigned to complete the restorative program would be reassigned to assist with general nursing assistant duties (direct resident care). NA-B stated if the resident did not receive rehabilitation services, the documentation sheets would be blank. The most current Occupational Therapy (OT) Discharge Summary dated 4/16/13, indicated the resident had refused therapy services for transfer ability and OT was discontinued. At that time, R25 was being transferred with minimal assistance of one staff and she was able to ambulate to in her room. On 9/11/13, at 6:55 a.m. R25 was observed sitting on the toilet receiving assistance with cares from NA-A. R25 was connected to a standing mechanical lift when the cares were completed. R25 was transferred out of the bathroom and positioned in a wheelchair via the standing lift. R25's legs were fully extended during the transfer. On 9/11/13, at 11:18 a.m. family member (FM)-A stated R25 had not been able to walk in a while. FM-A was unable to recall the last time R25 was able to ambulate. On 9/11/13, at 11:25 a.m. NA-A stated R25	F 310	Changes to care plans will be communicated to staff via communication book and/or orally. All staff will receive education to be completed by 10/30/13 related to revision of care plans. The DON or her designee will be performing random care plan audits to ensure revisions are occurring as needed. RNs will be performing weekly auditing of nursing rehab flow sheets to monitor frequency being completed. Audit findings will be reviewed at IDT and QA meetings and QA committee will determine when to stop audits.	10/30/13

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F 310	Continued From page 24 reassessed upon a decline in ambulation. The resident's decline in ability to ambulate resulted in actual harm. Findings include: R25's diagnoses included anxiety, depression, and cognitive impairment. The quarterly Minimum Data Set (MDS) dated 5/29/13, identified R25 with moderate cognitive impairment and as requiring extensive assistance of one staff to ambulate. The annual MDS dated 8/14/13, identified R25 with severe cognitive impairment and as requiring extensive assistance of two staff to ambulate. The activities of daily living Care Area Assessment (CAA) dated 8/18/13, identified R25 as having the ability to ambulate in her room and indicated she used a wheelchair. The assessment did not clearly identify how often or how far R25 was able to ambulate, nor did it address R25's inconsistent implementation of the plan of care for ambulation. The plan of care dated 7/6/12, identified R25 as being able to ambulate with a front wheeled walker in room and for short distance in the hallway. It indicated R25 had a history of refusing to ambulate but was to work with restorative services 3-5 times per week. The plan of care did not direct the staff as to how far R25 was to ambulate. The plan of care was revised on 8/29/13, and directed the staff to transfer R25 with a standing lift when R25 expressed increased weakness. However, there was no assessment of R25's condition indicating the need for a mechanical lift. On 9/10/13, at 2:40 p.m. nursing assistant (NA)-B stated R25 was no longer able to ambulate and	F 310	reasons rehab not provided. One activity aide was trained to nursing rehab and is scheduled for rehab 2-3 hours/day 2-3 days a week. The activity aide focuses providing ROM exercises. R25 is offered to ambulate to meals. All residents capable of ambulation will be offered to ambulate to meals. Upon initial notation of decline in a resident's abilities/functionality, a comprehensive assessment will be performed by an RN. All residents will receive annual PT screenings and more frequently if needed and care plans will be updated/revised with recommendations. All care plans will be reviewed to determine if a PT/OT evaluation is needed and if so, an order will be obtained by the physician. All resident plans of care will be reviewed at quarterly care conferences and updated with any changes each care conference and more frequently if needed.	

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F 310	Continued From page 26 walked half the length of the hallway (greater than 75 feet) in the past, but due to the increased pain, staff were unable to walk R25 and used the standing lift. NA-A stated R25 did not consistently participate in the restorative program because she may refuse or the facility may not have a nursing assistant designated to restorative therapy. On 9/11/13, at 12:20 p.m. NA-D and registered nurse (RN)-C assisted R25 into a standing positioning. R25 used a four wheeled walker and was able to ambulate six feet with extensive assistance of both staff. R25 stated had pain in the right hip and the left knee when ambulating. The resident stated, "I just can not walk like I used to." The Rehab Flow Sheet directed the staff to ambulate R25 with a four wheeled walker 100-150 feet as tolerated. The rehab sheet did not direct staff how frequently R25 received assistance nor did the sheet indicate how far R25 ambulated. Review of the Rehab Flow Sheets identified the following information related to R25's ambulation. -9/1/13 through 9/11/13, R25 was offered and refused to ambulate one time. -August 2013, R25 ambulated seven times, but the documentation did not indicate how far. -July 2013, R25 ambulated 14 times, but the documentation did not indicate how far. On 9/11/13, at 11:30 a.m. RN-C stated staff were to attempt to transfer R25 with a walker and were only to use the standing lift if the resident was weak. RN-C stated had reviewed R25 during the MDS assessment period in August 2013, and	F 310		

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F 310	Continued From page 27 R25 was able to transfer with the walker at the time. RN-C stated received oral reports from the nursing assistants when a resident did not ambulate. When asked what was done with those reports, RN-C stated, "I have not been trained." RN-C stated was not aware of any new concerns related to R25, and the physician was not contacted nor had R25 been re-evaluated by physical therapy. RN-C confirmed the plan of care did not clearly direct staff how far to ambulate R25. On 9/11/13, at 12:05 p.m. the director of nursing (DON) stated the nursing assistants who worked with restorative were to report any changes to RN-C or RN-A depending on which part of the building the residents resided. The DON stated the restorative nursing documentation was not currently being monitored by any of the nursing staff. The DON explained she was new in the position and it had been missed. The DON started working at the facility in March of 2013, and at that time R25 had the ability to ambulate half the length of the hallway (approximately 75 feet). The DON confirmed since then, R25 had not been evaluated by physical therapy. The implementation of the standing lift had occurred in July of 2013, but it was to be used only when R25 was weak. The DON was unaware staff were routinely utilizing the standing lift. On 9/11/13, at 12:10 p.m. the DON confirmed the facility was experiencing nursing staff shortages and when this occurred the aide assigned to perform restorative nursing was reassigned to complete personal cares. The DON stated it occurred one to two times a week. The Rehabilitative Nursing Care policy dated	F 310		

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F 310	Continued From page 28 8/7/13, directed staff to perform rehabilitative services three to five times a week for those residents who required such services. The policy also explained the physical therapist was to develop the goals for rehabilitative nursing cares and the goals were to be reinforced by the therapy services (restorative nursing assistants). On 9/12/13, at 1:51 p.m. RN-A confirmed was aware of the lack of implementation of rehab services and stated did not have an answer as to why the concern was not brought forth to the QA committee. In addition, RN-A stated all staff were aware of the inconsistent implementation of the rehab services. On 9/12/13, at 1:55 p.m. the administrator stated was aware of the lack of implementation of the rehab services and verified it was due to insufficient staffing.	F 310		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with ambulation for 2 of 6 residents (R29, R43) dependent on staff for ambulation. Findings include:	F 311	R29 was admitted to the hospital on 9/11/13 and deceased on 9/23/13 with no return to Viking Manor Nursing Home. R43's care plan has been updated to include an intervention related to nursing rehab/ambulation. Resident is offered nursing rehab/ ambulation 3-5 times a week. All ambulatory residents are offered to ambulate to meals daily. Any resident currently	

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F 311	Continued From page 29 R29 did not receive assistance with ambulation according to the plan of care. R29's diagnoses included dementia, depression and Parkinson's disease. On 9/10/13, at 2:00 p.m. R29 was assisted onto a Nustep (exercise machine) in the restorative therapy room by nursing assistant (NA)-B. R29 was not able to keep balanced during the transfer and physical therapy assistant (PTA)-A joined NA-B to assist R29 onto the machine. On 9/10/13, at 3:40 p.m. NA-B stated R29 was not able to ambulate as well as she had in the past. NA-B stated if a resident was unable to participate in the restorative program as directed, would report the concern to the registered nurse (RN). NA-B explained several times a month, residents did not receive their restorative programs because the NA assigned to complete the restorative program was reassigned to assist with general nursing assistant duties (direct resident care). NA-B stated if the resident did not receive rehabilitation services, the documentation sheets would be blank. On 9/11/13, at 8:50 a.m. NA-A assisted R29 with morning cares. At 9:00 a.m. NA-A assisted R29 into a sitting position on the edge of the bed. R29 was not able to hold herself up while sitting on the bed. NA-A held R29 steady as trained medication aide (TMA)-A entered the room to assist with the transfer. A transfer belt was applied and a walker was placed in front of R29. R29 did not reach for the walker as the two staff assisted her to stand. R29 cried out as she stood, took two steps with extensive assistance of the two staff and sat in a wheelchair.	F 311	receiving ambulation/nursing rehab services will have their care plan reviewed and updated to include ambulation and any other nursing rehab the resident is receiving. Care plans of all ambulatory residents will be reviewed to determine if there is a need for a PT evaluation and if so, an order will be obtained from the physician. Any resident being added to an ambulation/ nursing rehab program will have a related intervention added to their care plan. To ensure R43 and all other residents are receiving services as per plan of care, Viking Manor Nursing Home has implemented staff schedule changes. One activity aide was trained to nursing rehab and is scheduled for rehab 2-3 hours/day 2-3 days a week. The activity aide focuses providing ROM/ambulation exercises. Viking Manor Nursing Home will continue to schedule a rehab aide Monday-Friday. One additional activity aide is enrolled in Certified Nursing Assistant (CNA)	

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	245559	A. BUILDING ____ B. WING ____	09/12/2013

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 311	Continued From page 30 On 9/11/13, at 9:20 a.m. NA-A stated R29 usually did not complain of pain with cares or transfers. NA-A stated there had to be something wrong with R29. NA-A stated in the past R29 had the ability to ambulate from the bed to the bathroom several times a day, but she had not been able to do that for a couple of months. NA-A could not recall the last time R29 had the ability to ambulate in her room. The quarterly Minimum Data Set (MDS) dated 7/11/13, indicated R29 had severe cognitive impairments and required extensive assistance with ambulation in the room but did not ambulate in the hallway. The activities of daily living Care Area Assessment (CAA) dated 4/10/13, indicated R29 required extensive assistance with ambulation. The CAA explained R29 was not able to ambulate far but could walk back and forth to the bathroom in her room. The assessment directed the staff to ensure R29 participated in ambulation to prevent a decline. The plan of care dated 6/6/12, directed the staff to assist R29 with ambulation using a walker and one to two staff members. The plan of care also indicated R29 received nursing rehabilitation services. The Rehab Flow sheets directed the staff to "ambulate." The sheets did not direct the staff as to what type of devices were to be used while ambulating, how many staff members were to assist, how far the resident was to ambulate or the frequency of which the services were to be provided.	F 311	classes and will also be trained to rehab upon completion of CNA classes. One additional RRA (registered resident assistant) has also been trained to nursing rehab and will be scheduled 1-2 days biweekly. All residents will receive annual PT screenings and more frequently if needed and care plans will be updated/revised with recommendations. All staff will complete education of new nursing rehab staffing by 10/30/13 plus an educational in-service "Restorative Care/ ROM" was assigned to all nursing staff to complete in the month of October so that in the absence of a rehab aide on the schedule other staff are knowledgeable to nursing rehab program and can perform assigned exercises. The physical therapy department will also be hosting an educational in-service for staff 10/30/13 focused on ROM and transferring. RNs for both wings and/or DON will be	

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F 311	Continued From page 31 Review of the Rehab Flow Sheets revealed the following information related to ambulation for R29. -9/1/13 through 9/11/13, R29 had not ambulated. -August 2013, R29 had ambulated four times, but there was no indication of how far. -July 2013, R29 had ambulated five times, but there was no indication of how far. The Physical Therapy Daily Treatment Notes dated 9/6/12, indicated R29 had ambulated 55 feet three different times during the therapy session. There was no indication of a discharge summary and plan from therapy, and R29 was not currently receiving physical therapy for ambulation services. Review of the Nurses Notes from 1/1/13- 9/11/13, lacked documentation related to R29's ability to ambulate. An Interdisciplinary Note dated 7/3/12, stated R29, "will walk with one aide and a walker at time." An Interdisciplinary Note dated 4/17/13, for R29 read, "assist of 1-2 with walker, and gaitbelt from bed to bathroom and back. Has nursing rehab 3-5 x (times) per week." The clinical record lacked documentation related to how R29 tolerated or the frequency of which R29 participated with the restorative ambulation program. On 9/11/13, at 11:50 a.m. RN-C stated R29's family was contacted regarding behavior during morning cares. RN-C stated R29's family was taking her to the clinic for an evaluation. RN-C stated R29 was last assisted to ambulate on 8/15/13, according to the restorative flow sheets.	F 311	auditing nursing rehab flow sheets weekly. All audit findings will be presented to the QA committee and the QA committee will determine how long to continue audits.	10/30/13

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F 311	Continued From page 32	F 311		

RN-C confirmed the distance R29 ambulated at that time had not been identified. RN-C reviewed the therapy notes and confirmed R29 had received therapy services in 9/2012, for ambulation but a formal discharge program and goals related to ambulation were not in the record. RN-C stated received oral reports from the nursing assistants when a resident did not ambulate. When asked what was done with those reports, RN-C stated, "I have not been trained." RN-C confirmed the plan of care did not clearly direct the staff on how to ambulate R29 or the distance she was to ambulate.

On 9/11/13, at 12:00 p.m. NA-D stated R29 had been walking two to three times a week to and from the bathroom. NA-D stated R29 had not been able to walk "for a long time" and refused to participate in the past month. NA-D stated while working as the restorative NA, R29 had not ambulated in the past month. If NA-D had noticed any concerns with R29, she would report to RN-C.

On 9/11/13, at 12:05 p.m. the director of nursing (DON) stated the nursing assistants who worked with restorative were to report any changes to RN-C or RN-A depending on which part of the building residents resided. DON stated the restorative nursing documentation was not currently being monitored by any of the nursing staff. The DON explained was new in her position and it had been missed. DON stated R29 still had the ability to ambulate to her knowledge but confirmed the nursing assistant assigned to perform restorative nursing services was frequently reassigned to complete general nursing cares.

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R43 did not receive assistance with ambulation.

R43 had diagnoses which included dementia, osteoarthrosis, and lumbosacral spondylosis. An annual MDS dated 6/25/13, identified R43 was severely cognitively impaired and required extensive assist from staff for mobility, transfers, and activities of daily living (ADL's).

R43's plan of care included a focus area of Mobility with an intervention to ambulate with assist of 1-2 using a gait belt and walker, and to encourage ambulation. The plan of care also included a focus area of Falls with an intervention for staff to encourage participation in activities which would promote exercise and physical activity. The plan of care did not indicate R43 was on a restorative nursing program (RNP).

During observation on 9/10/13 at 11:50 a.m., R43 ambulated in the hallway with one staff assist using a gait belt and wheeled walker, approximately 52 feet. Staff provided encouragement and verbal cueing.

A Physical Therapy Discharge Summary dated 2/4/13 included a Discharge Recommendation to continue ambulation program with nursing staff and to encourage/assist with ambulation. In addition, a Physical Therapy Discharge Summary dated 10/26/12 included a Discharge Recommendation of RNP with close supervision.

A nurse note dated 9/6/13, indicated R43

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received nursing rehabilitation, with direction to see the rehabilitation flow sheet for details of frequency and exercise.

Review of the Nursing Rehab Flowsheets from 8/1/13 to 9/11/13, revealed R43 was ambulated by nursing staff one time in the month of September and eight times in the month of August. No distance was included.

A Quarterly Care Conference note dated 7/9/13, revealed R43's spouse and daughter had complaints regarding him not being walked enough and they had requested staff ambulate him "more throughout the day."

During interview on 9/10/13, at 2:14 p.m., NA-B stated R43 was sometimes able to walk up to 100 feet in the hallway but she stated, "he doesn't get walked because the restorative aide is pulled to work on the floor" due to being short staffed.

During interview on 9/11/13, at 12:33 p.m., NA-F explained she knew she was supposed to assist R43 with walking in the hallway on a daily basis but she stated, "Walking does not always get done because we don't have time."

During interview on 9/11/13, at 1:00 p.m., RN-A confirmed R43 was on a restorative nursing program for ambulation but she stated staff did not have time to consistently assist R43 with ambulation. RN-A stated she was not aware of who was responsible to oversee the RNP.

During interview on 9/12/13, at 11:00 a.m., the DON confirmed staffing was a problem and she confirmed nursing staff did not always have time to ambulate residents routinely.

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

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F 311	Continued From page 35 The Rehabilitative Nursing Care policy dated 8/7/13, directed the staff to perform rehabilitative services three to five times a week for those residents who required such services. The policy also explained the physical therapist was to develop the goals for rehabilitative nursing cares and the goals were to be reinforced by the therapy services (restorative nursing assistants).	F 311		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide range of motion services to prevent further decrease in range of motion (ROM) for 8 of 8 residents (R25, R29, R23 R27, R34, R13, R22, R26) who had physical limitations. Findings include: R25 was identified with physical limitations had did not receive consistent restorative nursing services to maintain or prevent further decreased ROM. R25's diagnoses included anxiety, depression, and cognitive impairment.	F 318	R29 was hospitalized on 9/11/13 and deceased 9/23/13 with no return to Viking Manor Nursing Home between those dates. R25, R23, R27, R34, R13, R22, and R26 are each being offered ROM 3-5 times weekly. To ensure R25, R23, R27, R34, R13, R22, R26 and all other residents are receiving services as per plan of care, Viking Manor Nursing Home has implemented staff schedule changes. One activity aide was trained to nursing rehab and is scheduled for rehab 2-3 hours/day 2-3 days a week. The activity aide focuses on providing ROM exercises. Viking Manor Nursing Home will continue to schedule a rehab aide	

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F 318	Continued From page 37 restorative therapy. On 9/11/13, at 12:20 a.m. NA-D and RN-C assisted R25 into a standing positioning. R25 used a four wheeled walker and was able to ambulate six feet with extensive assistance of both staff. R25 stated had pain in the right hip and the left knee when ambulated. R25 stated, "I just can not walk like I used to." The annual Minimum Data Set (MDS) dated 8/14/13, identified R25 with severe cognitive impairment and required extensive assistance with all activities of daily living (ADLs). The ADL Care Area Assessment (CAA) dated 8/18/13, did not identify R25's functional ability related to range of motion. The plan of care dated 7/6/12, identified R25 as having limitation in mobility, and directed the staff to ambulate R25 three to five times a week. The plan of care did not include directions related to a range of motion program. The Rehab Flow Sheets directed the staff to provide R25 with lower extremity exercises in a supine (in bed on back) position for abduction and ad adduction exercises (moving the legs away from the center of the body) and heel slide, ankle pumps, knee squeezes and SAQ's (2 sets of 10). Review of the Rehab Flow Sheets identified the following information: --In September 1-11, 2013, the documentation was blank -August 2013, the documentation was blank -July 2013, the documentation was blank. On 9/11/13, at 11:30 a.m. RN-C stated staff were to provide R25 with range of motion to the lower	F 318	to nursing rehab program and can perform assigned exercises. The physical therapy department will also be hosting an educational in-service for staff 10/30/13 focused on ROM and transferring. RNs for both wings and/or DON will be auditing nursing rehab flow sheets weekly to monitor that ROM is being offered and to monitor for need for changes to the plan of care. All audit findings will be presented to the QA committee and the QA committee will determine how long to continue audits.	10/30/13

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F 318	Continued From page 36 On 9/10/13, at 2:40 p.m. nursing assistant (NA)-B stated R25 occasionally refused to participate with the restorative program. NA-B stated if a resident was unable to participate in the restorative program as directed, they would report the concern to the registered nurse (RN). NA-B explained several times a month, the residents were not able to receive their restorative programs because the NA assigned to complete the restorative program would need to be reassigned to assist with general NA duties (direct resident care). NA-B stated if a resident did not receive rehabilitation services, the documention sheets would be blank. The most current Occupational Therapy (OT) Discharge Summary dated 4/16/13, indicated R25 refused therapy and thus services had been discontinued. The OT daily treatment note dated 4/12/13, indicated R25 had been evaluated for transfers. The therapist had not addressed R25's upper body ROM. On 9/11/13, at 6:55 a.m. R25 was observed sitting on the toilet receiving assistance with cares from NA-A. R25 was connected to a standing mechanical lift while cares were completed. R25 was transferred out of the bathroom and positioned in a wheelchair via the standing lift. R25 was able to hold onto the standing lift with both hands and was able to release the lift when directed. R25's legs were fully extended while in the lift. At 11:25 a.m. NA-A stated R25 had not changed in ability to perform cares. NA-A had not noticed a change in R25's ability to complete ROM. NA-A stated R25 did not consistently participate in the restorative program because would refuse or the facility might not have a nursing assistant designated to	F 318	Monday-Friday. One additional activity aide is enrolled in Certified Nursing Assistant (CNA) classes and will also be trained to rehab upon completion of CNA classes. One additional RRA (registered resident assistant) has also been trained to nursing rehab and will be scheduled 1-2 days biweekly. Care plans will be reviewed for all residents receiving ROM to determine if a PT evaluation is needed and order will be obtained from the physician. All residents will receive annual PT screenings and more frequently if needed and care plans will be updated/ revised with recommendations. All staff will complete education of new nursing rehab staffing by 10/30/13 plus an educational in-service "Restorative Care/ROM" was assigned to all nursing staff to complete in the month of October so that in the absence of a rehab aide on the schedule other staff are knowledgeable	

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extremities according to the rehab flow sheets. RN-C stated had reviewed R25 during the MDS assessment period in August 2013, and was unaware R25 was not receiving range of motion exercises. RN-C stated received oral reports from the NAs when a resident did not participate with the rehab program. When asked what was done with the reports RN-C stated, "I have not been trained." RN-C stated had not been made aware of any new concerns related to R25. RN-C confirmed the plan of care did not clearly direct staff regarding the lower extremity range of motion program.

On 9/11/13, at 12:05 p.m. the director of nursing (DON) stated the NAs who worked with restorative were to report any changes to RN-C or RN-A depending on which part of the building residents resided. The DON stated the restorative nursing documentation was not currently being monitored by any of the nursing staff. The DON stated was new in her position and it had been missed. At 12:10 p.m. the DON confirmed the facility had been experiencing nursing staff shortages and when it occurred the aide assigned to perform restorative nursing was reassigned to complete personal cares. The DON stated the reassigning of the restorative NA occurred one to two times a week.

R29 identified with physical limitations had not received consistent restorative nursing services.

On 9/10/13, at 3:40 p.m. NA-B explained several times a month residents did not receive their restorative programs because the NA assigned to complete the restorative program would be reassigned to assist with general NA duties

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F 318	Continued From page 39 (direct resident care). NA-B stated if a resident did not receive rehabilitation services, the documention sheets would be blank. NA-B stated if a resident was unable to participate in the restorative program as directed, she report the concern to the registered nurse (RN). On 9/11/13, at 8:50 a.m. NA-A assisted R29 with morning cares. R29 was able to open both hands, and moved both arms with complaints of pain. NA-A moved R29's legs to donn pants and R29 winced with pain. At 9:00 a.m. NA-A assisted R29 into a sitting position on the edge of the bed. R29 was not able to hold herself up while sitting on the bed. NA-A held R29 steady as TMA-A entered the room to assist with the transfer. A transfer belt was applied and a walker was placed in front of R29. R29 did not reach for the walker as the two staff assisted her to stand. R29 cried out as she stood, took two steps with extensive assistance of the two staff and sat in a wheelchair. Once in the chair, NA-A assisted R29 to donn a shirt. R29 made facial grimaces when arms were moved. An interview conducted on 9/11/13, at 9:20 a.m. NA-A stated R29 usually did not complain of pain with cares or transfers. NA-A stated there had to be something wrong with R29. R29's diagnoses included dementia, depression and Parkinson's disease. The quarterly MDS dated 7/11/13, identified R29 with severe cognitive impairment and required extensive assistance with all ADLs. The ADL CAA dated 4/10/13, indicated R29 required extensive assistance with all ADLs. The CAA identified R29 with general "physical limitations: weakness, limited range of motion and poor coordination."	F 318		

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The CAA did not explain the exact area R29 had limitations. The CAA directed staff to ensure R29 participated in therapeutic exercise to prevent a decline.

The plan of care dated 6/6/12, indicated R29 participated in restorative nursing but it did not indicate what R29 was able to do or how staff helped R29 with restorative nursing.

The Rehab Flow sheets directed the staff to provide a "Nu-Step, sink standing activity (cones, pegs or arch)" and gave the staff a list of four exercises to choose from including "red theraband exercise, a two pound wand exercise over the head, side to side, chest in and out, pulleys or arm bike." The restorative flow sheets did not direct the staff as to the frequency the activities were performed or the length of time the exercises were provided. Review of the Rehab Flow Sheets revealed the following information:
-September 1-11. 2013, R29 had completed the Nu step on two occasion, and the pulleys one once.
-August 2013, R29 had completed the Nu-step on five occasions and had completed the pulleys twice.
-July 2013, R29 had competed the Nu-Step 12 times and had worked with the pulleys six times.

The Restorative Care Program dated 9/7/12, by the occupational therapy assistant (OTA) directed the staff to allow R29 to choose between the red theraband exercise, a two pound wand exercise including over the head, sided to side and chest in and out, over the head pulleys and an arm bike while seated. R29 was to perform the exercise ten times then rest and repeated it three times for a total of 30 repetitions.

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The clinical record contained a Physical Therapy Discharge Summary dated 3/1/13, R29 was evaluated by therapy due to complaints of shoulder pain. R29 was to continue with the previously established restorative program.

Review of the Nurses Notes from 1/1/13- 9/11/13, lacked documentation related to R29's ability to participate in the restorative program. .

The Interdisciplinary Note dated 4/17/13, read "Has nursing rehab 3-5 x (times) per week."

The clinical record lacked documentation related to how R29 tolerated or the frequency R29 participated with the restorative program.

On 9/11/13, at 11:50 a.m. RN-C stated R29's family was contacted regarding complaints of pain during morning cares. RN-C stated R29 usually did not have complaints during cares. RN-C explained R29 was to work with the restorative program but was not sure of the frequency. RN-C reviewed the restorative flow sheets and confirmed R29 was not consistently being offered restorative therapy. RN-C confirmed the clinical record was lacking a comprehensive review of the restorative program. RN-C stated had received oral reports from the nursing assistants when a resident did not participate with the program. When asked what was done with those reports, RN-C stated, "I have not been trained." RN-C confirmed the plan of care did not clearly direct the staff regarding the exercise program.

On 9/11/13, at 12:00 p.m. NA-D stated if had noticed any concerns with R29 would report to

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F 318	Continued From page 42 RN-C. On 9/11/13, at 12:05 p.m. the DON stated the NAs who worked with restorative were to report any changes to RN-C or RN-A depending on which part of the building a resident resided. The DON stated the restorative nursing documentation was not currently being monitored by any of the nursing staff. The DON stated she was new to her position and it had been missed. The DON also stated R29 had not sustained declines in range of motion to her knowledge but confirmed the nursing assistant assigned to perform restorative nursing services was frequently reassigned to complete general nursing cares. On 9/12/13, at 9:00 a.m. RN-C reported R29 was seen at the clinic on 9/11/12, and had been admitted into the hospital for an acute illness. R23 did not receive ROM as directed by physical therapy. R23 had diagnoses which included Alzheimer's Disease, hypertension, and depressive disorder. A quarterly MDS dated 8/27/13, revealed R23 was severely cognitively impaired and required extensive assist from staff for mobility, transfers, and ADLs. During an observation on 9/11/13, at 6:55 a.m., NA-F provided morning cares for R23, which consisted of dressing, toileting, peri-care, and transferring R23 to and from the toilet, and to her wheelchair. R23 was able to participate by the	F 318		

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use of her arms when given direction from NA-F, first by using her left elbow to slowly sit herself up on the bedside while NA-F assisted by guiding and turning R23's body to a sitting position on the side of the bed. R23 hung on around NA-F's neck with her right arm, as directed by NA-F. R23 straightened her arms one at a time into her shirt sleeves, with the shirt being guided by NA-F, each step was explained by NA-F while she continued to provide encouragement and verbal cueing. NA-F then directed R23 to grab onto the grab bars of the mechanical lift and pointed to the grab bars. R23 then reached with both hands toward the handles, lightly grasping with both hands. Upon coming to a standing position, NA-F continued to direct R23 to keep hanging on with both hands and to keep both feet on the foot rest to stand up. R23 followed directions well.

R23's plan of care included a focus of Mobility with several interventions which included two staff assist for transfers, as resident was no longer safe to ambulate. The plan of care did not include ROM.

A Physical Therapy Discharge note dated 10/26/12 revealed Discharge Recommendations: "RNP (restorative nursing program) with close supervision." A Restorative Care Program form dated 2/8/13 from a Physical Therapist included the following: Approach/Recommendations: play catch with ball, pegs and foam board, overhead pulleys, incline board, arm bike, and knee extension with 23 pounds, three sets of 10 each leg.

A Rehabilitation Flow Sheet included direction to provide ROM to all extremities. The Flow Sheet for September indicated ROM was provided for

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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R23 one day out of the month. The Flow Sheet for August indicated ROM was provided eight days out of the month.

A Quarterly Care Conference note dated 6/11/13, revealed R23 was no longer able to ambulate. However, the note lacked documentation regarding ROM services for R23.

A nursing note dated 9/2/13, indicated resident had nursing rehab and directed to seek flowsheet for the type of exercises and how often R23 was receiving them. The note also indicated R23 transferred with 1-2 staff and a mechanical Pal lift and resident was not able to ambulate.

During an interview on 9/10/13, at 2:14 p.m., NA-B stated she worked as a restorative aide but often would get pulled from restorative to work on the floor due to short staffing. NA-B stated R23 had declined such that she now "needs a Pal [mechanical lift] for transfers." NA-B confirmed R23 was supposed to be receiving ROM 3-5 times/week but this was not getting done due to the restorative aide being pulled from restorative to work on the floor.

During interview on 9/11/13, at 7:22 a.m., NA-F stated she often worked short staffed which made her feel rushed on most days and she stated the rehabilitation aide was directed to work on the floor instead of performing rehab duties. NA-F confirmed ROM does not consistently get done for R23 and she stated this would occur 2-3 times/week out of 5 days of scheduled rehabilitation.

During an interview on 9/11/13, at 8:38 a.m., a contracted physical therapy assistant stated R23

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was not currently receiving skilled services but was receiving a RNP. He stated as far as he knew, the nursing staff were following the therapy recommendations for ROM but he was unsure of who was responsible to manage or oversee the RNP.

During interview on 9/11/13, at 11:20 a.m., RN-A stated the restorative aide often gets pulled to help out on the floor, due to being short staffed. She confirmed ROM was not consistently being provided for the residents and she verified the lack of documentation in R23's restorative monthly schedule for September and August. RN-A further stated she was not sure who was responsible to oversee the restorative program.

During interview on 9/12/13, at 11:00 a.m., the DON confirmed staffing was a problem and she confirmed the staff did not always have time to provide ROM for R23, as directed.

R27 did not receive ROM services as directed by physical therapy.

R27 had diagnoses which included Parkinson's Disease, paralysis agitans, and congestive heart failure (CHF). An annual MDS dated 7/2/13 identified a completely intact cognitive status and also identified R27 required extensive assist from staff for mobility, transfers, and all ADL's.

During observations on 9/11/13 at 7:12 a.m., R27 was sitting in her wheelchair next to the nurses station. She stated she had a bath. R27's arms were laying in her lap and her fingers were curled into her palms. She was able to slowly lift her hand and arm up toward the surveyor but not able to move her fingers when prompted. Both knees

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F 318	Continued From page 46 were bent and her right ankle was slightly extended downwards. She was wearing tennis shoes. R27's plan of care included a focus of Parkinson's, initiated 6/5/12, with interventions which included: encourage gentle ROM as tolerated with daily care, and encourage her to wear her tennis shoes during the day for more support for her feet. Also, a focus of Mobility, revised 7/16/13, with interventions which included: assist of 2 staff using Pal lift (mechanical lift) to transfer, currently working with nursing rehab 3-5 days a week, no longer ambulating due to Parkinson's; and ADL's extensive assist. Physician orders dated 9/10/10: ankle brace to right foot prn (as needed) and 9/25/12: hand splints on at HS (bedtime) and off in the morning. A physician progress note dated 7/18/13, "patient has developed a bit of a drop foot. She sits in her chair all day. OT [occupational therapy] consult for appropriate wheelchair." An OT evaluation dated 7/24/13, for wheelchair positioning indicated a trial was implemented for foot rests to provide support to both feet. In addition, OT documented, "MD to assess for AFO (foot brace), or night splint." The last physical therapy evaluation was completed on 3/8/12 and recommended ROM and "Establish FMP [functional maintenance program] 3-5 times/week." A Rehabilitation Flow Sheet identified exercise goals: to maintain ability to transfer and ambulate	F 318		

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with assist, and aid in assist with ADL's. The Rehabiliation Flow Sheet for September revealed R27 received ROM exercises one day out of the month. The Rehabilitation Flow Sheet for August revealed R27 received ROM exercises nine days out of the month. The Rehabilitation Flow Sheet for July revealed R27 received ROM exercises nine days out of the month.

A quarterly care conference note dated 7/16/13, indicated discussion took place regarding a foot brace but R27 and her family declined. It was decided R27 would wear her tennis shoes during the day for support.

During a family interview on 9/10/13, at 10:33 a.m. family (F)-A stated he would visit R27 on a daily basis. F-A stated he was concerned because R27 was supposed to be getting exercises and ROM, but staff were not providing this. F-A also stated R27 was no longer getting walked at all and hadn't been walked for approximately 3 months. F-A stated staff quit walking R27 because it required 2-3 staff and "they have a staffing shortage." F-A further stated ROM is not provided because therapy staff gets pulled from therapy to work on the floor.

During an interview on 9/10/13 at 2:14 p.m., NA-B stated she worked as a restorative aide and nursing assistant. NA-B stated R27's fingers have gotten "a little tighter" and "I had to make her new pulleys to fit her hands because her fingers are very tight." Further, NA-B explained staffing was a problem and she would often get pulled from restorative to work on the floor, and she stated this would happen 2-3 times/week.

During interview on 9/11/13, at 8:04 a.m. NA-F

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F 318	Continued From page 48 indicated R27 did not have braces for her feet but had rolls for her hands. NA-F stated, "She's supposed to wear [rolls in hands] all day but they are so tight we can't open her hands." NA-F further stated, "She's had a decline, her Parkinson's." During an interview on 9/11/13, at 8:38 a.m. the contracted physical therapy assistant confirmed R27 was not currently receiving PT or OT services but was on a maintenance program with nursing. During an interview on 9/11/13, at 9:57 a.m. R27 stated she was able to lift her arms up to her head to remove her curlers. She then demonstrated she could do this by slowly lifting her arms up toward the top of her head and she grasped a curler using her right pointer finger and thumb. Three fingers on both hands were curled in toward her palms. R27 further stated she had exercises on Mondays, Wednesdays, and Fridays down in the therapy room. During interview on 9/11/13, at 11:32 a.m. NA-D stated she recently started working in therapy rehab twice weekly and prior to this week was only working in therapy twice per month. NA-D stated she was directed to provide hand soaks for R27, then assist with pulleys to both arms, and provide ROM to upper and lower extremities. NA-D further stated, "I am pulled from restorative to work on the floor and lately it's happen a lot." She confirmed when this happens, ROM does not get done for R27. During an interview on 9/11/13, at 1:12 p.m., RN-A pointed out in a nurse note dated 6/18/13, 6/20/13, and 6/27/13, which indicated discussion	F 318		

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had taken place regarding decline in ability to ambulate, discussion of foot braces, and disease progression. A nurse note dated 7/27/13, indicated R27 did not want braces for her feet and did not want foot supports at bedtime because her feet get too warm.

During interview on 9/12/13, at 11:00 a.m., the DON confirmed staffing was a problem and she confirmed the staff did not always have time to provide ROM for R27 as directed.

R34 was identified with functional limitations and had not received consistent range of motion services.

R34 diagnoses included left hemispheric stroke, depression, and dementia. The quarterly MDS dated 8/27/13, revealed R34 with severe cognitive impairment and required extensive assistance to total dependence with all ADLs. Further, the MDS identified R34 did not walk and has limitations in range of motion to both upper and lower extremities.

R34's current plan of care dated 5/26/13, identified R34 as had limitations in mobility, and ADL performance. However, the care plan lacked interventions related to therapeutic exercises or restorative nursing program.

Review of physician progress note dated 2/26/13, R34's family member revealed and reported R34 had been fairly sedentary, the facility really has not been working with him with respect to any kind of mobility or gait.

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F 318	Continued From page 50 Review of nursing notes from 7/10/13 to 9/4/13, revealed a note dated 7/10/13, indicated R34 had rehab therapy for range of motion, and used standing table with assistance of the rehab aid. Another note dated 8/6/13, indicated R34 routinely received nursing rehab services and further more a note dated 9/4/13, indicated R34 received rehab nursing services The Occupational Therapy Evaluation dated 7/1/13, indicated occupational therapy recommended to continue range of motion with restorative nursing program, and continue positioning program in place. The goal for R34's restorative program was to maintain flexibility and ROM to participate in ADL's. The program included: Nu-step x 5-10 minutes, patient needs occasional assist to hold/stabilize right foot it does not go flat, two person pivot transfer on Nu-step, ROM to upper and lower extremities, pulleys, arm bike, massage right arm, wands exercises 1) side to side 2) over head 3) chest out, and standing table. The Physical Therapy Evaluation dated 7/2/13, indicated physical therapy recommended to continue with restorative nursing program. The goal for R34's restorative program was to maintain flexibility and ROM to participate in ADLs. The program included: Nu-step x 5-10 minutes, patient needs occasional assist to hold/stabilize right foot it does not go flat, two person pivot transfer on Nu-step, ROM to upper and lower extremities, pulleys, arm bike, massage right arm, wands exercises 1) side to side 2) over head 3) chest out, and standing table.	F 318		

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F 318	Continued From page 51 On 9/11/13 at 8:59 a.m. NA-G was observed assisting R34 to sit up on edge of bed by manually lifting R34 to a sitting position. NA-F then assisted R34 to put his shirt on by lifting up R34's arms and inserting both arms into the sleeves of the shirt, and then NA-F proceeded to button shirt up. At 9:05 a.m. NA-G and NA-F assisted R34 into a a standing lift. R34 was able to grab onto the handles of the standing lift after NA-G and NA-F assisted R34 by lifting his hands onto the handle of the standing lift. R34 was lifted to a standing positioning with the use of a standing lift and NA-G then performed peri cares, and applied a new incontinent product for R34. R34 was then transferred to his recliner by NA-G and NA-F. During observation R34 provided no assistance with ADLs, except to loosely hold onto the standing lift handles and he was assisted by NA-G and NA-F. The Rehab Flow Sheet directed staff to provide and maintain flexibility and range of motion to participate in ADL's included: Nu-step x 5-10 minutes, patient needs occasional assist to hold/stabilize right foot it does not go flat, two person pivot transfer on Nu-step, ROM to upper and lower extremities, pulleys, arm bike, massage right arm, wands exercises 1) side to side 2) over head 3) chest out, and standing table. Review of the Rehab Flow Sheets identified the following information: For the month of September 1st-11th, 2013, R34 received services for only one day during the month, and for the month of August 1st-31st, 2013, R34 received services for six days during the month, and furthermore the month of July	F 318		

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F 318	Continued From page 52 1st-31st, 2013, R34 received services for thirteen days during the month. However, R34 only received services for 20 days out of a total of 73 days. On 9/11/13 at 1:55 p.m. NA-D indicated R34 does receive range of motion services from restorative nursing, However, she confirmed that R34 is not receiving services consistently. R13 was identified with functional limitations and had not receive consistent range of motion services. R13's diagnoses included cerebrovascular accident, depression, and dementia. The quarterly Minimum Data Set (MDS) dated 7/16/13, revealed R13 with severe cognitive impairment and required extensive assistance to total dependence with all activities of daily living (ADL). Further, the MDS identified R13 did not walk and limitations in range of motion to both upper and lower extremities. R13's current plan of care dated 6/18/13, identified R13 as having limitations in mobility, and ADL performance. However the care plan lacked interventions related to R13's therapeutic exercises or restorative nursing program for range of motion 3-5 days a week. Review of nursing notes from 6/12/13 to 8/7/13 revealed a note dated 6/12/13 indicated R13 receives nursing rehab services for range of motion exercises. Note dated 7/10/13 revealed	F 318		

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F 318	Continued From page 53 R13 receives ROM services routinely and further more a note dated 8/7/13 indicated R13 received nursing rehab services for ROM exercises. On 9/11/13 at 7:26 a.m. NA-J was observed assisting R13 to wash her face, NA-J manually lifted one arm at a time to remove R13's night shirt. NA-J then manually lifted one arm at a time to wash R13's underarms, then dried R13's underarms, applied deodorant in same manner and then put R13's undershirt on by lifting one arm at a time to insert it into the sleeve of the shirt. At 7:32 a.m. NA-J performed peri cares on R13, applied new incontinent product by manually turning R13 side to side. NA-J then applied lotion to lower extremities and feet of R13, applied socks by lifting one leg at time, then applied pants and shoes in same manner. NA-J then proceeded to apply R13 shirt by manually lifting one arm at a time and inserting both arms into the sleeves of the shirt. At 7:46 a.m. NA-J and NA-D assisted R13 using a hoyer lift to manually lift R13 from her bed to a sitting position in her wheelchair and then NA-J proceeded to comb R13's hair, and perform oral hygiene, R13 was then wheeled out to the hallway by NA-J. During observation R13 provided no assistance with ADL's. The Rehab Flow Sheet directed staff to provide and maintain strength with transfers/mobility included: passive range of motion to lower extremities with focus on knee extension all notions 10-20 reps, ROM to upper extremities (straighten elbow), and position patient in supine with abductor pillow between knees and pillows under heel area (float heels, allow patient to lie this way approximate one hour to promote knee extension and abduction.	F 318		

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F 318	Continued From page 54 Review of the Rehab Flow Sheets identified the following information: For the month of September 1st-11th, 2013 R13 received services for only one day during the month, and for the month of August 1st-31st, 2013 R13 received services for eight days during the month, and furthermore the month of July 1st-31st, 2013 R13 received services for seventeen days during the month. However R13 only received services for 26 days out of a total of 73 days. On 9/10/13 at 2:15 p.m. NA-B confirmed R13 receives range of motion services from restorative nursing, and stated "we stretch out her legs and do range of motion, she is a little tighter and confirmed that R13 is not receiving services consistently. On 9/11/13 at 12:28 p.m. physical therapist (PT) confirmed R13 does receive range of motion services from restorative nursing but has not received Tor occupational therapy (OT) since last survey. On 9/11/13 at 1:55 p.m. NA-D confirmed R13 does receive range of motion services from restorative nursing and however she indicated that R13 is not receiving services consistently. R22 was identified with functional limitations and had not received consistent range of motion	F 318		

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

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	245559	A. BUILDING ______ B. WING ______	09/12/2013

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F 318	Continued From page 55 services. R22 diagnoses included cerebrovascular accident, depression, and dementia. The annual Minimum Data Set (MDS) dated 8/6/13, identified R22 with severe cognitive impairment and required extensive assistance with all activities of daily living (ADL). The MDS further identified R22 has limitations in range of motion to both upper and lower extremities. R22's current plan of care dated 5/26/13, identified R22 as having limitations in mobility, and ADL performance. However the care plan lacked interventions related to R22's therapeutic exercises or restorative nursing program for range of motion 3-5 days a week. Review of nursing notes from 7/8/13 to 9/3/13 revealed a note dated 7/8/13 indicated R22 receives nursing rehab services for range of motion exercises. Note dated 8/5/13 revealed R22 receives nursing rehab services and further more a note dated 9/3/13 indicated R22 received nursing rehab services for ROM exercises. The Occupational Therapy Discharge Summary dated 7/5/13, indicated occupational therapy recommended to continue ROM with restorative nursing program for upper body exercises and standing frame. The goal for R22 restorative program was to increase and maintain endurance and functional mobility. The program included: Nu-step 10 minutes #5 or 6, ambulate as tolerated with front wheeled walker with assist of two, sit to stand five times, pulleys/gentle stretch, arm bike, standing frame 10 minutes can do pegs/nuts or bolts while standing, wand exercises	F 318		

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F 318	Continued From page 56 hand over hand, a forward and back stretches and trunk flexion, reaching activities-forward and flexed (use cones or other items), and legs kicks #2 (limited assist needed with right). The most current Physical Therapy Evaluation dated 6/18/13, indicated physical therapy recommended to continue with restorative nursing program. Discharge summary on 7/5/13 indicated restorative program developed and patient will continue with restorative care. The goal for R 22 restorative program was to increase and maintain endurance and functional mobility. The program included: Gnu-step 10 minutes #5 or 6, ambulate as tolerated with front wheeled walker with assist of two, sit to stand five times, pulleys/gentle stretch, arm bike, standing frame 10 minutes can do pegs/nuts or bolts while standing, wand exercises hand over hand, a forward and back stretches and trunk flexion, reaching activities-forward and flexed (use cones or other items), and legs kicks #2 (limited assist needed with right). On 9/11/13 at 6:57 a.m. NA-F was observed assisting R22 to a standing position from the toilet. R22 was able to grab onto the grab bar next to the toilet with verbal cueing only from NA-F. Then NA-F assisted R22 with peri cares and pulled R22's pants up and proceeded to assist R22 to turn, pivot and guided him to sit in his wheel chair. NA-F then wheeled R22 out into the hallway by the nurses station. At 7:22 a.m. R22 is observed wheeling self down hallway towards dining room by peddling with his feet and using his hands to propel the wheelchair. At 8:14 a.m. R22 is observed eating independently in the dining room. During observation R22 was noted	F 318		

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F 318	Continued From page 57	F 318		

to provide minimal assistance with ADL's. and required extensive assistance with all ADL's.

The Rehab Flow Sheet directed staff to increase/maintain endurance and functional mobility included: Gnu-step 10 minutes #5 or 6, ambulate as tolerated with front wheeled walker with assist of two, sit to stand five times, pulleys/gentle stretch, arm bike, standing frame 10 minutes can do pegs/nuts or bolts while standing, wand exercises hand over hand, a forward and back stretches and trunk flexion, reaching activities-forward and flexed (use cones or other items), and legs kicks #2 (limited assist needed with right).

Review of the Rehab Flow Sheets identified the following information:

For the month of September 1st-11, 2013 R 22 received services for only two days during the month, and for the month of August 1st-31st, 2013 R 22 received services for nine days during the month, and furthermore the month of July 1st-31st, 2013 R 22 received services for thirteen days during the month. However R 22 only received services for 24 days out of a total of 73 days.

On 9/11/13 at 7:08 a.m. NA-F confirmed R 22 does receive therapy from the restorative nursing program and stated "If they do not have the nursing rehab during the day they try to work with R 22 walking if they have time". NA-F indicated that R 22 had not received services consistently..

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F 318	Continued From page 58 On 9/11/13 at 1:04 p.m. NA-D confirmed R 22 does receive range of motion services from restorative nursing, and indicated that R22 needs alot of encouragement as R22 forgets what he should be doing and needs constant reminders. NA-D also indicated that R22 had not received services consistently. R26 did not consistently receive range of motion (ROM) three times a week as directed on her plan of care (POC). R26's diagnoses included diabetes, heart failure (decrease in heart function to pump blood), hypertension (high blood pressure), osteoporosis,	F 318		

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F 318	Continued From page 59 dementia, depression and anxiety. R26's quarterly Minimum Data Set (MDS) dated 8/7/13, indicated severe cognitively impairment and R26 was totally dependent on staff for activities of daily living (ADL), transferring, dressing, eating, toileting and personal hygiene. On 9/11/13, at 2:21 p.m. nursing assistant (NA)-D confirmed R26 was to receive ROM exercises three to five times a week. NA-D completed 15 repetitions of ROM exercises on R26's upper and lower extremities. R26's arms were tightly clutched to her chest and NA-D was able to reach ¾'s extension of R26's arms and fully extended R26's fingers. NA-D extended R26's lower extremities and reached full extension and flexion. NA-D revealed R26's left leg appeared stiffer to bend at the start of the exercises. R26's POC dated 9/19/12, revealed she had rehabilitation nursing three times a week. R26's Rehab Flow Sheet directed nursing rehabilitation staff to conduct ROM on R26's upper and lower extremities. Review of R26's Rehab Flow Sheet revealed the following: Week of 9/1/13, had the opportunity for three nursing rehabilitation sessions and received one. Week of 8/25/13, had the opportunity for three nursing rehabilitation sessions and received zero. Week of 7/28/13, had the opportunity for three nursing rehabilitation sessions and received two. Week of 7/7/13, had the opportunity for three nursing rehabilitation sessions and received two. The Rehabilitative Nursing Care policy dated 8/7/13, directed the staff to perform rehabilitative	F 318		

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F 318	Continued From page 60 services three to five times a week for those resident who required such services. The policy also explained the physical or occupational therapist was to develop the goals for rehabilitative nursing cares and the goals were to be reinforced by the therapy services (restorative nursing assistants).	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to thoroughly investigate causative factors of falls and failed to implement fall interventions related to the use of a personal alarm to minimize the risk of further falls/accidents for 1 of 3 residents (R43) reviewed with a history of falls. Findings include: R43 had diagnoses which included dementia, history of compression fractures of the lumbar vertebra and osteoarthrosis. An annual Minimum Data Set (MDS) dated 6/25/13, identified R43 had severe cognitive impairment and required extensive assist from staff for activities of daily living, which included mobility and transfers. The Care Area Assessment (CAA) dated 6/30/13, identified R43 had dementia, was not able to	F 323	R43's tabs unit was discontinued on 9/16/13. A chair alarm was initiated in place of the tabs unit. This alarm type is sensitive to R43's weight and will alarm when R43's weight is removed from the pad. R43's care plan has been updated to include the chair alarm as an intervention for fall prevention. Staff were educated initially via communication book when alarm changed and all staff will receive education by 10/30/13. R43 continues to have a laser alarm when in bed. Nursing staff are to sign off each shift that alarms have been checked and are on/clipped to residents. Each resident with an alarm or history of falls will have a care plan review to ensure accuracy of current plan of care. Resident falls are reviewed at ITD and QA meetings to discuss	

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F 323	Continued From page 61 understand or would forget he could not care for self which could result in falls. Further, The CAA identified R43 had problems with balance, transferring, and had fallen since the previous assessment. The CAA identified R43 was a risk for falls and the plan included use of a low bed, laser alarm while in bed, and a Tabs unit in the wheelchair. R43's plan of care last revised 7/10/13, included a focus area for risk of falls. The plan of care indicated R43 was not aware of safety needs and listed various interventions which directed staff to utilize a Tabs alarm at all times when up in wheelchair and utilize a laser alarm when in bed. During observations on 9/9/13, from 5:58 p.m. to 6:54 p.m., R43 was seated in a wheelchair in the dining room of the facility. A white alarm box was attached to the back of the wheelchair with a metal clip attached to an orange string, which hung down behind the backside of the wheelchair. The metal clip had not been attached to R43. At 6:55 p.m., RN-A confirmed the clip was not attached and she then attached the clip to R43's shirt. During observations on 9/11/13, from 6:55 a.m. to 7:20 a.m., R43 was seated in a wheelchair near the nurses station with the white alarm box attached to the back of the wheelchair. The metal clip had not been attached to R43 and the orange string was hanging down the backside of the wheelchair. At 7:20 a.m., the director of nursing (DON) approached R43 and attached the metal clip of the Tabs alarm to the back of R43's shirt. The DON then confirmed the clip was not attached to R43's back as it should have been.	F 323	interventions and care plan. All resident care plans will be updated to reflect changes in care and all staff will be informed and educated as needed to ensure ability to carry out the care plan. DON or designee will be performing random audits to ensure alarms are in place and turned on. Audit findings will be discussed at IDT meetings and QA meetings and IDT/QA will determine when to stop audits.	10/30/13

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F 323	Continued From page 62 A Falls Investigation Worksheet dated 8/15/13, indicated R43 had an unwitnessed fall in his room. R43 had stated he crawled from the bed to the wheelchair. The worksheet did not indicate any investigation of the unwitnessed fall or intervention implemented after the fall. A Falls Investigation Worksheet dated 8/25/13, indicated R43 fell asleep in the wheelchair, leaned forward, and tipped onto the floor. Post fall, R43 was encouraged to ask for assistance to lay down when feeling tired. Review of R43's nursing notes from 7/3/13 to 9/10/13, revealed on 7/18/13, R43 was attempting to transfer self from the wheelchair to the bed, alarm on. On 8/15/13, the notes revealed R43 was found out of bed in roommate's recliner. R43 indicated he had crawled out of bed. The notes identified the laser alarm had not been on and the fall was reported to the office of health facility complaints. On 8/25/13, the nursing notes revealed R43 had stood up by himself 3 times and was taken to the bathroom or bed. On 9/5/13, the notes revealed R43 was at high risk for falls due to moving fast and did not use the call light. An interview conducted on 9/11/13, at 12:33 p.m., nursing assistant (NA)-F stated R43 was usually content in the wheelchair but occasionally would become restless or anxious. NA-F stated R43 had a laser alarm on his bed and a Tabs alarm to be on at all times while up in the wheelchair. During an interview on 9/12/13, at 9:11 a.m., registered nurse (RN)-A indicated R43 had two falls in the recent past and RN-A confirmed she would expect the alarm to be clipped to his body while in the wheelchair.	F 323		

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F 323	Continued From page 63 During an interview on 9/12/13, at 11:00 a.m., the DON confirmed R43's current plan of care and verified she would expect all fall interventions to be implemented by nursing staff.	F 323		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to ensure sufficient qualified nursing staff were available to meet residents' needs for nursing care in a consistent manner for 10 of 45 residents R21, R25, R29, R43, R13, R22, R23, R26, R27, R34, in the sample.	F 353	Upon survey it was determined that Viking Manor Nursing Home was not in substantial compliance with staffing as evidenced by failure to meet residents' needs for R21, R25, R29, R43, R13,.. R21's care plan has been updated to include a bruising focus and interventions. R21's interventions and outcomes are discussed at IDT and QA meetings. R29 was admitted to the hospital on 9/11/13 and deceased 9/23/13 without return to Viking Manor Nursing Home. R25 and R43 are being offered ambulation via nursing rehab aide 3-5 times a week as is care planned. R13, R22, R23, R25, R26, R27, and R34 are being offered ROM via nursing rehab 3-5 times a week as is care planned. Viking Manor Nursing Home has since altered staffing to be able to provide nursing care in a consistent manor. To	

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Findings include:

The facility failed to provide necessary care and services for 1 of 2 residents (R21) reviewed who developed frequent bruising. See F309.

The facility failed to provide ambulation services to prevent loss of function for 1 of 6 residents (R25) who required physical assistance with ambulation. R25 was not provided assistance with ambulation, and was not re-assessed upon a decline in ambulation. R25's decline in ability to ambulate resulted in actual harm. See F310.
The facility failed to provide assistance with ambulation for 2 of 6 residents (R29, R43) in who were dependent on staff for ambulation. See F311.
The facility failed to provide range of motion services to prevent further decrease in range of motion (ROM) for 8 of 8 residents (R13, R22, R23, R25, R26, R27, R29, R34) who had limitations in range of motion. See F318.
During the survey conducted on 9/9/13, from 4:00 p.m. until 8:00 p.m. and 9/10/13, from 8:00 a.m. until 4:30 p.m., 9/11/13, from 7:00 a.m. until 4:30 p.m. and on 9/12/13, from 8:00 a.m. until 2:30 p.m., respectively staff were observed amd were not be able to consistently provide services for the residents as directed by their plans of care based on a comprehensive assessment of their needs.

On 9/11/13, at 12:23 p.m. the DON stated the nursing normal staffing patterns were as follows:
Day shift
1 RN working 8:00 a.m. to 4:30 p.m.
1 LPN who worked from 6:00 a.m. to 6:30 p.m. (12 hour shift)

F 353 (Provider's Plan of Correction)

ensure nursing rehab is offered consistently, Viking Manor Nursing Home has trained 1 activity aide to nursing rehab. The activity aide will perform nursing rehab services 2-3 hours/day for 2-3 days/week. One additional activity aide is enrolled in Certified Nursing Assistant (CNA) classes and will also be trained to rehab upon completion of CNA classes. One additional RRA (registered resident assistant) has also been trained to nursing rehab and will be scheduled 1-2 days biweekly. All residents on a nursing rehab program are offered rehab 3-5 times a week. All staff will complete education of new nursing rehab staffing by 10/30/13 plus an educational in-service "Restorative Care/ROM" was assigned to all nursing staff to complete in the month of October so that in the absence of a rehab aide on the schedule other staff are knowledgeable to nursing rehab program and can

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F 353	Continued From page 65 1 TMA working an 8 hour shift 3 nursing assistants working 8 hour shift 1 nursing assistant working a 6 hour shift. 1 nursing assistant assigned to work 8 hours as a bath aide 1 nursing assist assigned to work 8 hours as a restorative aide. Evening shift: 2 nursing assistants who worked from 11:45 a.m. to 9:15 p.m. 1 TMA working an 8 hour shift 1 nursing assistant who worked from 2:00 p.m. to 10:30 p.m. 1 nursing assistant who worked from 4:00 p.m. to 8:00 p.m. 2 nursing assistants who worked from 6:10 p.m. to 6:45 a.m. (12 hour shift) 1 RN who worked from 6:00 p.m. to 6:00 a.m. (12 hour shift) The night shift included the 2 NAs and 1 RN who started their shifts on the evening shift and worked through until the next morning. The staffing report for August 2013, identified 31 days of which 15 days were without shortages and 16 days (8/1/13, 8/2/13, 8/4/13, 8/5/13, 8/7/13, 8/8/13, 8/9/13, 8/16/13, 8/18/13, 8/19/13, 8/22/13, 8/26/13, 8/27/13, 8/29/13, 8/30/13, and 8/31/13) nursing assistant staff had shortages of one to two staff members. In September from 9/1/13 through 9/12/13, the facility had seven days (9/1/13, 9/3/13, 9/4/13, 9/5/13, 9/6/13, 9/7/13, and 9/12/13), of staffing shortages of one to two staff. Of the projected nursing schedule from 9/13/13 through 9/25/13, the facility daily staffing shortages (one to two) staff. The resident council minutes dated 9/3/13, indicated residents (unidentified) had questioned	F 353	perform assigned exercises. The physical therapy department will also be hosting an educational in-service for staff 10/30/13 focusing on ROM and transferring. Viking Manor Nursing Home has also hired 1 full time PM shift RRA and 1 full time LPN. Viking Manor Nursing Home continues to advertise for RRA positions and will hire qualified candidates as able. RNs for each wing will be auditing nursing rehab program to ensure all residents are receiving nursing rehab as is in plan of care for each resident. Nursing rehab program and staffing will be reviewed at quarterly QA meetings.	10/30/13

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F 353	Continued From page 66	F 353		

the staff if the facility was short of nursing staff. The staff had responded by informing the residents, "We are hiring and will fill positions as able." No further discussion regarding the nurse staffing was given to the residents.

On 9/9/13, at 5:12 p.m. R27 (alert resident) stated had to wait over 30 minutes before the call light was answered. R27 explained she had experienced incontinent episodes because of having to wait so long.

On 9/9/13, at 5:30 p.m. R31 (alert resident) stated she had to wait a long time for the call lights to be answered. R31 stated felt it was do to poor staffing.

On 9/10/13, at 10:10 a.m. R1 (alert resident) stated the facility did not have enough staff, but would not explain why they felt this way.

On 9/10/13, at 9:00 a.m. R16 (alert resident) stated while sitting on the toilet had turned on the call light and had to wait between 15-20 minutes for the light to be answered.

On 9/10/13, at 2:30 p.m. NA-B stated the facility was frequently short staffed. Because of the staffing, NA-B explained the NA assigned to complete the restorative program, frequently was reassigned to provide direct care for the residents. NA-B stated when it happened, the restorative program was not completed. NA-B explained the nursing shortage occurred one to two days a week, if not more.

On 9/11/13, at 7:45 a.m. NA-I stated was currently working as the bath aide and would be rescheduled to perform direct cares one to tow

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	245559	A. BUILDING ______ B. WING ______	09/12/2013

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days a week. NA-I stated when it happened, each NA was responsible for assisting the residents with baths. NA-I stated it was hard, but the staff were usually able to get their job done.

On 9/11/13, at 8:00 a.m. registered nurse (RN)-C stated at times the RN staff were pulled from their duties to assist the NA's on the unit. RN-C confirmed the facility did not consistently have enough staff to provide cares for the residents.

9/11/13, at 8:01 a.m. on 9/11/13, RN-C stated when working occasionally had to help out on the unit. RN-C stated would pull the restorative aide and the RN's would help out on the unit as needed. RN-C stated on the weekends she was not passing medications, and was extra in the facility as the supervisor. RN-C stated the bath aide was not pulled, but occasionally the restorative aide was pulled. RN-C stated, "I know that does not sound good but we do what we can." RN-C stated was able to help out on the unit as needed.

On 9/11/13, at 12:30 p.m. the director of nursing (DON) stated was aware the facility had not been able to be consistently full staffed because of staff taking other jobs or illness. The DON stated the facility had attempted to advertise in the local paper and had contacted the local school The DON confirmed was aware the facility was routinely pulling the NA from restorative duties to provide care for the residents, but had not established a system to ensure the restorative duties were completed.

On 9/11/13, at 2:15 a.m. the administrator confirmed was aware of the nurse staffing shortage. The administrator stated was aware

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F 353	Continued From page 68 the restorative NA was reassigned to assist with resident cares. The facility was working on the problem, but had not found a system to resolve the issue. On 9/12/13, at 8:20 a.m. NA-A and TMA-A confirmed the facility did not have a nursing assistant assigned to provide restorative nursing duties. The Staffing policy dated 2/16/10, indicated, "Viking Manor maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services." "Certified Nursing assistants are available on each shift to provide the needs care and services of each resident as outlined on the resident's comprehensive care plan."	F 353		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	Effective 9/17/13, housekeeping staff were not allowed access to medication rooms without the presence of an RN/LPN/TMA. Housekeeping will change from cleaning medication rooms daily to cleaning them 2-3 times a week. New locks/keys were installed for both medication rooms on 10/17/13. RNs, LPNs, and TMAs are the only staff that will have access to the medication rooms. All	

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F 431	Continued From page 69 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper medication storage in the medication refrigerators and failed to ensure only authorized personnel had access to the medication rooms for 1 of 2 medication storage rooms. Findings include: On 9/12/13, at 8:20 a.m. housekeeper-A was overheard asking trained medical assistant (TMA)-A to open the door to the medication room nearest to the main entrance to the facility. TMA-A opened the door with a key, and allowed housekeeper-A into the medication room an walked away. At 8:22 a.m. housekeeper (HSK)-A pulled a cleaning cart on wheels into the medication room doorway. No nursing staff members were present while HSK-A was in the	F 431	other staff will only have access to the medication rooms in the presence of an RN/LPN/TMA. All staff have received education on this process and education will be complete by 10/30/13. Medications in each medication room refrigerator have been separated from food items. In the west medication room, all supplements have been removed from the refrigerator. Supplements are now stored in the refrigerator in the day dining room. Medications only are stored in the west medication room refrigerator. In the east medication room refrigerator, all medications have been moved to the top shelf, with supplements being placed on lower shelves. All staff have been educated on this process. Education will be complete by 10/30/13. Random audits will be performed by the DON or her designee. Audit findings will be presented at QA	

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F 431	Continued From page 70 medication room. At 8:30 a.m. HSK-A moved the cleaning cart out of the doorway and exited the medication room. At no time were nursing staff members present while HSK-A was in the medication room. An interview conducted on 9/12/13, at 8:33 a.m. HSK-A stated each day she entered the medication storage room and cleaned the sinks, wiped off the counters if needed, replaced the paper towels, removed trash and mopped the floor. HSK-A confirmed medication administration staff were not present in the medication room while she completed these tasks. On 9/12/13, at 1:30 p.m. the medication storage room was reviewed with the director of nurses (DON).The DON opened the medication room with a key.The room contained multiple cupboards which were not locked.The cupboards contained resident overflow medications. Some of the prescription medications included carafate (a medication to treat excessive gastric acid), Cipro (an antibiotic) Alaprxolam (a blood pressure medication), vitamin B-12 injection form, and prescription eye drops.The cupboards had several over the counter medications also including but not limited to Tylenol, cranberry tablets, vitamin D, Lotrimin foot powered, Maalox, Robitussin, and a random bottle of liquid tears. At 1:35 p.m. the DON stated the medication cupboard also contained a narcotic box. The DON picked up a set of keys off the counter, opened two doors and removed four vials of morphine injections.The DON confirmed the keys were kept on the cupboard at all times. At 1:36 p.m. the DON opened the unlocked the three shelf medication refrigerator.The first shelf	F 431	meetings until QA deems auditing is no longer needed.	10/30/13

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continued nutritional supplements.The second shelf contained a large bottle of glucosamine (a supplement that supports the structure and function of joints), loroprazole power kits, medicated nasal spray all of which had been prescription labels on it. Also on the shelf was a box of suppositories, a basket of injectable medications such as insulin and hepatitis B vaccinations, tuberculin and an individual packet of strawberry jelly. The second shelf also contained a bottle of wine, and additional nutritional supplements. The third shelf contained nutritional supplements.

An interview was conducted on 9/12/13, at 1:41 p.m. the DON stated the only staff members who were allowed in the medication rooms were the licensed nursing staff and the trained medication aides.The DON confirmed all other staff including the housekeeping staff were to be accompanied by a nursing staff member. The DON also confirmed the medications in the refrigerator were to be stored separately from the edible items to ensure the food items did not contaminate the medications.

The Storage of Medication policy revised on 1/22/2010, stated, "The nursing staff shall be responsible for maintaining medication storage AND preparation area in clean, safe and sanitary manner." "Medication requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately from food and must be labeled accordingly." and "Only person authorized to prepare and administer medication shall have access to the medication room, including any keys."

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F 441	Continued From page 72	F 441		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	Viking Manor Nursing Home has implemented an employee infection control log effective 9/17/13. The infection control log is maintained by the DON or her designee. The log includes the date missed, the infection/illness type, the date returned to work, and if the MD was consulted. The staff infection control log is compared to the resident infection control log for comparison of transmission of infections between groups. The DON or her designee will audit the staff infection control log weekly to ensure it is current. The findings will be discussed at the QA meetings. Staff were educated on the new process for tracking and trending employee infections/illnesses/ diseases. Staff education will be complete by 10/30/13.	10/30/13

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F 441	Continued From page 73 This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop, implement, and maintain an infection prevention and control program related to the surveillance, investigation, and analysis of staff diseases/infections in order to prevent, recognize and control, to the extent possible, the onset and spread of infection within the facility. This practice had the potential to affect all 43 residents who resided in the facility. Findings include: Review of the facility infection control surveillance logs revealed the lack of employee illness/disease tracking and trending. On 9/12/13, at 11:03 a.m. the director of nursing (DON), infection control lead, verified the facility did not track, trend or analyze employee illness as required.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide housekeeping and maintenance services necessary to maintain	F 465	In resident bathrooms R13, R14, R34, R28, R36, R27, R2, R45, R33, R32, R43, and R15 the plastic foam tubing that was taped to the metal piping has been removed. All resident bathrooms have been reviewed to ensure free from plastic foam tubing. Training has been provided to staff that this practice is	

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F 465	Continued From page 74 sanitary conditions related to uncleanable surfaces for 12 of 43 resident bathrooms (R13, R14, R34, R28, R36, R27, R2, R45, R33, R32, R43, R15). Findings include: The facility failed to maintain sanitary conditions related to uncleanable surfaces on residents' toilets in bathrooms for R13, R14, R34, R28, R36, R27, R2, R45, R33, R32, R43, and R15. An environmental tour was conducted on 9/12/13, at 8:31 a.m. with the maintenance supervisor (MS) present during the tour. A long plastic, porous, foam tubing duck taped in various areas covered the metal piping running from the base of the toilet seat. The foam material covered approximately three feet of the metal pipe running up the wall from the toilet bowl. The foam material had areas that were brown stained, with pieces of the plastic foam missing. the foam material attached to the back of the toilets were observed in R13, R14, R34, R28, R36, R27, R2, R45, R33, R32 R43, R15's bathrooms. On 9/12/13, at 8:31 a.m. MS confirmed the above findings and stated, "The nurses put the foam on the back of the toilets." On 9/12/13, at 1:13 p.m. registered nurse (RN)-A confirmed the above findings and stated the facility routinely utilized foam material and duck tape to cover the metal pipes of the toilet. On 9/12/13, at 1:17 p.m. housekeeper (HSK)-A confirmed several residents had these long multi-colored plastic, porous foam tubing duck taped to the metal piping on the back of their	F 465	not allowed. The Head Housekeeper will be performing routine inspections to ensure this will not happen again. Audit finds will be presented to QA meetings until the QA committee determines audits are no longer needed.	10/30/13

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F 465	Continued From page 75 toilets. HSK-A stated she had not routinely cleaned the surfaces of of the foam and duck tape and indicated she was not sure if the cleaning products used would damage the materials. HSK-A stated "I have no idea if it is a cleanable surface." On 9/12/13, at 2:05 p.m. the DON confirmed the facility utilized long multi-colored plastic, porous foam tubing duck taped to the metal piping on the back of toilets. The DON confirmed the material was porous and confirmed the foam was not a cleanable surface. On 9/12/13, at 2:29 p.m. the housekeeping supervisor confirmed the facility utilized long multi-colored plastic, porous foam tubing duck taped to the metal piping on the back of toilets. The housekeeping supervisor stated the foam and duck tape was not washable or cleanable surface and stated, "It's porous." The undated policy titled, Cleaning Bedside Mats, specified bedside mats were cleaned and disinfected each time the floor was cleaned in a residents room or sooner if needed. The undated policy titled, Cleaning Toilet Bowls, specified to wipe down all pipes, valves, fittings and exterior bowl surfaces.	F 465		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520	Upon survey, it was found that Viking Manor Nursing Home had not identified the need to address the nursing rehabilitation program at the QA (quality assurance) meetings.	

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F 520	Continued From page 76 facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility Quality Assessment and Assurance (QA&A) committee failed to develop and implement appropriate action plans for previously identified areas of concern related the lack of implementation and documentation of rehabilitative nursing services that included ambulation and range of motion cares as directed by physical and occupational therapy. This practice had the potential to affect all residents who recieved restorative services residing in the facility. Findings include: Refer to F310, F312, F318, and F353.	F 520	The Viking Manor Nursing Home QA committee discussed the nursing rehab program at its QA meeting on 10/10/2013 and the action plan implemented for correcting the nursing rehab program. Nursing rehab will be continually discussed at QA until the QA committee determines it no longer needs to be addressed. The QA committee meets 1-2 times each quarter. All staff have been educated on QA committee and how to bring forth concerns to the QA committee. This education will be completed by all departments by 10/30/13. The QA committee will also dedicate time during meetings for open discussion related to concerns identified by staff and/or committee members.	10/30/13

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F 520	Continued From page 77 On 9/12/13, at approximately 11:00 a.m. the director of nursing (DON) verified nursing rehabilitation (rehab) services needed improvement related to monitoring and implementation. Additionally, the DON stated the identified concerns had not been brought forth to the QA (quality assurance) committee in order to develop an action plan and could have been. On 9/12/13, at 1:51 p.m. registered nurse (RN)-A, a member of the QA committee, confirmed was aware of the lack of the implementation of rehab services and stated did not have an answer as to why the concern was not brought forth to the QA committee. In addition, RN-A stated all staff were aware of the inconsistent implementation of the rehab services. On 9/12/13, at 1:55 p.m. the administrator, a member of the QA committee, stated was aware of the lack of implementation of the rehab services and verified it was due to insufficient staffing. In addition, the administrator confirmed the concern was not brought forth to the QA committee for review and the development of an action plan.	F 520		

Viking Manor of Ulen

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9/12/13

F241 E

Based on observation and interview, the facility failed to ensure that each resident's dignity was maintained during meal observations in the main dining room. Staff was observed to scrape off dirty plates when residents were eating which had the potential to affect 40 of 43 residents who ate their meal in the main dining room.

F252 E

Based on observation, interview, and document review, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary conditions related to un-cleanable surfaces for 12 of 43 resident bathrooms (R13, R14, R34, R28, R36, R27, R2, R45, R33, R32, R43, R15) and odor-free environment for a resident room for 1 of 1 resident (R1) in the sample with a strong urine odor in the room.

F279 E

Based on observation, interview, and document review, the facility failed to develop the care plan to include identified interventions for 1 of 6 residents (R43) reviewed for ambulation; for 2 of 6 (R23, R34) for ROM; and for 2 of 2 (R39, R21) for bruising, in the sample.

F280 D

Based on observation, interview, and document review, the facility failed to revise the plan of care to include identified interventions related to ambulation and ROM for 2 of 6 residents (R29, R25) in the sample.

F282 E

Based on observation, interview, and document review, the facility failed to provide services in accordance with the resident's written plan of care for 1 of 3 residents (R43) related to fall interventions and for 4 of 8 (R27, R26, R22, R13) requiring ROM.

F309 D

Based on observation, interview, and record review, the facility failed to provide necessary care and services for 1 of 2 residents (R21) reviewed who developed frequent bruising.

F310 G

Based on observation, document review, and interview, the facility failed to provide ambulation services to prevent loss of function for 1 of 6 residents (R25) in the sample who required physical assistance with

ambulation. R25 was not provided assistance with ambulation, and was not re-assessed upon a decline in ambulation. The resident's decline in ability to ambulate resulted in actual harm.

F312 D

Based on observation, interview, and document review, the facility failed to provide assistance with ambulation for 2 of 6 residents (R43, R29) in the sample who were dependent on staff for ambulation.

F318 E

Based on observation, interview, and document review, the facility failed to provide range of motion services to prevent further decrease in range of motion (ROM) for of 4 residents (R13, R22, R23, R25, R26, R27, R29, R34) in the sample who had limitations in range of motion. Findings include:

F323 D

Based on observation, interview, and document review, the facility failed to ensure consistent implementation of fall interventions had been implemented to minimize the risk of further falls/accidents for 1 of 3 residents (R43) reviewed who were identified at risk for falls.

F353 E

Based on observation and interview, the facility failed to ensure that sufficient qualified nursing staff was available to meet the residents' needs for nursing care in a manner which promotes each resident's physical, mental and psychosocial well-being, thus enhancing their quality of life. This practice had the potential to affect all __ residents residing in the facility.

F431 E

Based on observation, interview, and document review, the facility failed to ensure proper medication storage in the medication refrigerators and failed to ensure only authorized personnel had access to the medication rooms for 2 of 2 medication storage rooms.

F441 E

Based on observation, interview, and document review, the facility staff failed to develop and implement an surveillance program for employees and residents this practice had the potential to affect all 43 residents residing in the facility.

F520 E

Based on interview and document review the facility did not ensure the Quality Assessment and Assurance (QA&A) committee developed and implemented appropriate plans of action to correct identified quality deficiencies, related to restorative nursing. This had the potential to affect all 43 residents who resided in the facility.

PRINTED: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

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

F5559022

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	09/18/2013

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 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 substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 St. Paul, MN 55101	K 000	POC ok TS 11-21-13 RECEIVED NOV 20 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc 10-22-13
Exit: 9/18/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] | TITLE: Administrator | (X6) DATE: 10/31/2013

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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	245559	A. BUILDING **01 - 1965 BUILDING 01** B. WING	09/18/2013

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	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 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 2003 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.	K 000		

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	245559	A. BUILDING 01 - 1965 BUILDING 01 B. WING	09/18/2013

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	Continued From page 2 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 1999 edition. 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" 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 45 beds and had a census of 40 at the time of the survey. The facility was surveyed as two buildings. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	A door closure has been installed on the south wing storage room corridor door. We have replaced the door handle on the soiled linen room corridor so that it properly latches. To assist maintenance in Identifying any items that are in need of repair we	

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	245559	A. BUILDING **01 - 1965 BUILDING 01** B. WING ______	09/18/2013

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 029	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations it was determined that two of ten hazardous area corridor doors tested are not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 18.3.2.1. This deficient practice could allow the products of combustion to travel from this hazardous area into the corridor system if a fire occurs within the room, which could negatively impact all 45 of the residents, the staff and any visitors of the facility. Findings include: Observations during the facility tour on September 18, 2013, between 1:00 pm and 2:45 pm, by surveyor 03006, revealed that: 1) The south wing storage room corridor door was not self-closing, and 2) The soiled linen room corridor door did not latch. The Maintenance Man verified this finding during the facility tour and at the exit conference.	K 029	have a repair tracking sheet at the east nurses' station where anyone can write down items that need repair. This is reviewed daily by maintenance and then initialed when repaired. In addition we have added a check of doors on our monthly maintenance checklist.	10/22/13
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded	K 050	I have a grid I use to show when fire drills are conducted. The Administrator will ensure that fire drills are conducted at varying times. Fire drills since the survey were held at 2:00 p.m. for the day shift and 5:30 a.m. for the night shift	10/22/13

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K 050	Continued From page 4 announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on a review of fire drill records, it was determined that the facility staff have not conducted fire exit drills in accordance with National Fire Protection Association (NFPA) 101 "The Life Safety Code" (LSC) 2000 edition section 19.7.1.2. Not conducting fire exit drills could allow confusion and delay in the staff response, which would negatively impact all 45 of the residents and any visitors in a fire emergency. Findings include: A review of the fire exit drill records for Viking Manor Nursing Home for 2012 and 2013, prior to the facility tour on September 18, 2013, at approximately 12:45 pm, by surveyor 03006, revealed that fire exit drills are not being conducted at varying times and situations. All four fire drills for the day shifts have been conducted between 10:30 am and 11:00 am, and 3 of 4 of the evening shift drills were conducted between 7:50 pm and 9:00 pm The Maintenance Man verified this finding during the facility tour and at the exit conference.	K 050		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in	K 056	Repair of the sprinkler system was completed on September 26, 2013.The ceiling tiles that had been removed to work on the sprinkler system was replaced.	10/22/13

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K 056	Continued From page 5 accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and an interview with staff it was determined that the automatic fire sprinkler system is not operational in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems and NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.5. This deficient practice could allow a fire to progress throughout the building and negatively effect all 45 of the residents, all staff and any visitors of the facility. Findings include: Observations and an interview with the Maintenance Man during the facility tour on September 18, 2013, 1:00 pm and 2:45 pm, by surveyor 03006, revealed that: 1) The automatic sprinkler system is shut off due the the replacement of the dry pipe system in the 1981 building. It has been shut down since Monday 9-16-2013 from approximately 9:00 am, and 2) Ceiling tiles are missing in the west nurse's lounge.	K 056		

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K 056	Continued From page 6 The Maintenance Man verified this finding during the facility tour and at the exit conference and with the Administrator by telephone.	K 056		
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on a review of facility documentation, it was determined that the automatic sprinkler system may not have been serviced in in accordance with NFPA 25 The Standard for Inspection, Maintenance of Water Based Suppression Systems (1999 edition). Failure to properly maintain the automatic fire sprinkler system could affect all 45 of the residents, all staff and any visitors, if the sprinkler system fails to function properly in a fire emergency. Findings include: A review of the fire system testing records for Viking Manor Nursing Home by Allied Sprinkler Company, prior to the facility tour on September 18, 2013, at approximately 12:55 pm, by surveyor 03006, revealed that the documentation of the last sprinkler system test was not available (the tag on the system indicated 12-18-12). The Maintenance Man verified this finding during the facility tour and at the exit conference.	K 062	The sprinkler system has been tested and tagged. The tag is attached to the sprinkler valve in the mechanical room.	10/22/13
K 147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD	K 147	The extension cord that was run through the plaster ceiling	

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

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K 147	Continued From page 7 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations it was determined that an extension cord was run thorugh the plaster ciling and used as a substitute for permanent wiring and is not in accordance with NFPA 70 "The National Electrical Code" (NEC) 1999 edition. This deficient practice could cause over heating of the device causing a fire that will negatively impact the residents, staff and any visitors in the area of the cord. Findings include: Observationsa and an interview with the Maintenance Man during the facility tour on September 18, 2013, between 1:00pm and 2:45 pm, by surveyor 03006, revealed that a flexible extension cord was extending through the plaster ceiling in the janitors closet by the main entrance, serving a condication pump. The Maintenance Man verified this finding during the facility tour and at the exit conference	K 147	has been removed. The hole that it went through has been fire caulked and painted.	10/22/13
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1	K 154	On September 18, 2013 at 2:30 p.m. a fire watch for the entire building was put in place. This fire watch continued until Thursday September 19,2013 at 1:45 p.m. at which time the sprinkler system was up and working. The sprinkler system was then shut down again	

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K 154	Continued From page 8 This STANDARD is not met as evidenced by: Based on a review of documentation and an interview with staff it was determined that the facility staff is not following the facility's written out of service policy for the automatic sprinkler system in accordance with NFPA 101 (LSC) 2000 edition sections 19.3.4.5.1 and 9.7.6.1. This deficient practice could negatively impact all 45 residents, the staff and any visitors if the system is out of service and no alternative method of containing a fire is provided. Findings include: A review of the Viking Manor Nursing Home Fire Watch Policy, an interview with the facility staff and an interview with the Advance sprinkler installers, during the facility tour on September 18, 2013, between 1:00 pm and 2;45 pm, by surveyor 03006, revealed that the facility's automatic fire sprinkler system was shut off due to the project to replace the leaking dry pipe system in the 1981 building. The sprinkler system has been shut off since Monday September 16, 2013 at approximately 9:00 am, drained and will not be operational until Thursday September 19, 2013 at noon. An interview with facility staff revealed that the facility staff were not doing a fire watch as per facility policy and NFPA 101 section 9.7.6.1. (Facility staff started a fire watch for the entire building by the end of the survey). The Maintenance Man verified this finding during the facility tour and at the exit conference and with the Administrator by telephone.	K 154	on Tuesday September 24, 2013 at 12:30 p.m. at which time a fire watch was again put into effect. On Thursday September 26, 2013 at 10:45 the sprinkler system was activated so we discontinued the fire watch at that time. All sprinkler repairs have been completed. A log was kept which indicates who conducted the fire watch, at which times, their observations, and signature. The Administrator will ensure that if the sprinkler system is out of service for more than 4 hours in a 24 hour period that our fire watch plan is put in place.	10/22/13

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F5559022

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245559	A. BUILDING 03 - BUILDING 0202 B. WING ______	09/18/2013

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 02 PT Addition 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 02 PT Addition was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. 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 St. Paul, MN 55101	K 000	POC ok TS 11-21-13 RECEIVED NOV 20 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	10/31/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245559	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 0202 B. WING	(X3) DATE SURVEY COMPLETED 09/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1	K 000		

Or by e-mail to:
Marian.Whitney@state.mn.us and
Barbara.Lundberg@state.mn.us

Fax Number 651-215-0525

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 2003 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.

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

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K 000	Continued From page 2 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 1999 edition. 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" 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 45 beds and had a census of 40 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 as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2	K 050	I have a grid I use to show when fire drills are conducted. The Administrator will ensure that fire drills are conducted at varying times. Fire drills since the survey were held at 2:00 p.m. for the day shift and 5:30 a.m. for the night shift.	10/22/13

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	245559	A. BUILDING 03 - BUILDING 0202 B. WING	09/18/2013

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K 050	Continued From page 3 This STANDARD is not met as evidenced by: Based on a review of fire drill records, it was determined that the facility staff have not conducted fire exit drills in accordance with National Fire Protection Association (NFPA) 101 "The Life Safety Code" (LSC) 2000 edition section 19.7.1.2. Not conducting fire exit drills could allow confusion and delay in the staff response, which would negatively impact all 45 of the residents and any visitors in a fire emergency. Findings include: A review of the fire exit drill records for Viking Manor Nursing Home for 2012 and 2013, prior to the facility tour on September 18, 2013, at approximately 12:45 pm, by surveyor 03006, revealed that fire exit drills are not being conducted at varying times and situations. All four fire drills for the day shifts have been conducted between 10:30 am and 11:00 am, and 3 of 4 of the evening shift drills were conducted between 7:50 pm and 9:00 pm The Maintenance Man verified this finding during the facility tour and at the exit conference.	K 050		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection	K 056	Repair of the sprinkler System was completed on September 26, 2013. The ceiling tiles that had been removed to work on the sprinkler system was replaced.	10/22/13

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K 056	Continued From page 4 Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This STANDARD is not met as evidenced by: Based on observations and an interview with staff it was determined that the automatic fire sprinkler system is not operational in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems and NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.5. This deficient practice could allow a fire to progress throughout the building and negatively effect all 45 of the residents, all staff and any visitors of the facility. Findings include: Observations and an interview with the Maintenance Man during the facility tour on September 18, 2013, 1:00 pm and 2:45 pm, by surveyor 03006, revealed that: 1) The automatic sprinkler system is shut off due the the replacement of the dry pipe system in the 1981 building. It has been shut down since Monday 9-16-2013 from approximately 9:00 am, and 2) Ceiling tiles are missing in the west nurse's lounge. The Maintenance Man verified this finding during the facility tour and at the exit conference and	K 056		

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K 056	Continued From page 5 with the Administrator by telephone.	K 056		
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on a review of facility documentation, it was determined that the automatic sprinkler system may not have been serviced in in accordance with NFPA 25 The Standard for Inspection, Maintenance of Water Based Suppression Systems (1999 edition). Failure to properly maintain the automatic fire sprinkler system could affect all 45 of the residents, all staff and any visitors, if the sprinkler system fails to function properly in a fire emergency. Findings include: A review of the fire system testing records for Viking Manor Nursing Home by Allied Sprinkler Company, prior to the facility tour on September 18, 2013, at approximately 12:55 pm, by surveyor 03006, revealed that the documentation of the last sprinkler system test was not available (the tag on the system indicated 12-18-12). The Maintenance Man verified this finding during the facility tour and at the exit conference.	K 062	The sprinkler system has been tested and tagged. The tag is attached to the sprinkler valve in the mechanical room.	10/22/13
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour	K 154	On September 18, 2013 at 2:30 p.m. a fire watch for the entire building was put in place. This	

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K 154	Continued From page 6 period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a review of documentation and an interview with staff it was determined that the facility staff is not following the facility's written out of service policy for the automatic sprinkler system in accordance with NFPA 101 (LSC) 2000 edition sections 19.3.4.5.1 and 9.7.6.1. This deficient practice could negatively impact all 45 residents, the staff and any visitors if the system is out of service and no alternative method of containing a fire is provided. Findings include: A review of the Viking Manor Nursing Home Fire Watch Policy, an interview with the facility staff and an interview with the Advance sprinkler installers, during the facility tour on September 18, 2013, between 1:00 pm and 2;45 pm, by surveyor 03006, revealed that the facility's automatic fire sprinkler system was shut off due to the project to replace the leaking dry pipe system in the 1981 building. The sprinkler system has been shut off since Monday September 16, 2013 at approximately 9:00 am, drained and will not be operational until Thursday September 19, 2013 at noon. An interview with facility staff revealed that the facility staff were not doing a fire watch as per facility policy and NFPA 101 section 9.7.6.1. (Facility staff started a fire watch for the entire building by the end of the survey).	K 154	fire watch continued until Thursday September 19,2013 at 1:45 p.m. at which time the sprinkler system was up and working. The sprinkler system was then shut down again on Tuesday September 24, 2013 at 12:30 p.m. at which time a fire watch was again put into effect. On Thursday September 26, 2013 at 10:45 the sprinkler system was activated so we discontinued the fire watch at that time. All sprinkler repairs have been completed. A log was kept which indicates who conducted the fire watch, at which times, their observations, and signature. The Administrator will ensure that if the sprinkler system is out of service for more than 4 hours in a 24 hour period that our fire watch plan is put in place.	10/22/13

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K 154	Continued From page 7 The Maintenance Man verified this finding during the facility tour and at the exit conference and with the Administrator by telephone.	K 154		