DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL E SURVEY AGENCY	ID: M6T7 Facility ID: 00075
MEDICARE/MEDICAID PROVIDER NO. (L1) 245559 STATE VENDOR OR MEDICAID NO. (L2) 734040100 S. EFFECTIVE DATE CHANGE OF OWN (L9)		3. NAME AND ADI (L3) VIKING MA (L4) 317 FIRST S' (L5) ULEN, MN 7. PROVIDER/SUF	NOR NURSING TREET NORTHV	HOME WEST	(L6) 56585 <u>02</u> (L7) 13 PTIP 22 CLIA	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
6. DATE OF SURVEY 11/21/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2013 (L34) (L10)	01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/IID 12 RHC	14 CORF	FISCAL YEAR ENDING DATE: (L35) 09/30
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	45 (L18) 45 (L17)	B. Not in Com	ce With quirements		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 45 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARKS See Attached Remarks 17. SURVEYOR SIGNATURE	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):		18. STATE SURVEY AGENCY AP	PROVAL Date:
Denise Erickson, HF			02/26/2014	(L19)		(L20)
19. DETERMINATION OF ELIGIBILITY _X1. Facility is Eligible to Partia 2. Facility is not Eligible		20. COM	D BY HCFA RE			ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 06/01/1991 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEMI BEGINNING I (L41) 27. ALTERNATIVI A. Suspension o	DATE E SANCTIONS	 LTC AGREEME ENDING DATE (L25) 		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety
(L27)	B. Rescind Sus		(L44) (L45)			00-Active
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C 03001	ARRIER NO.	(L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION (11/26/2013	DF APPROVAL DAT	Е (L33)	DETERMINATION APPRO	VAL

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

CCN: 24-5559

C&T REMARKS - CMS 1539 FORM

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.

STATE AGENCY REMARKS

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))

Viking Manor Nursing Home November 21, 2013 Page 2

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.

Viking Manor Nursing Home November 21, 2013 Page 3

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

Viking Manor Nursing Home November 21, 2013 Page 4

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

Enclosure

cc: Licensing and Certification File

5559r1_70DayNotice.rtf

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 245559	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/7/2013
Name	e of Facility		Street Address, City, State, Zip Code	
VI	KING 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	(Y4)	Item		(Y5)	Date	(Y4)	ltem	1	(Y5)	Date
	F0241 483.15(a)		Correction Completed 10/30/2013		ID Prefix Reg. # LSC	F0252 483.15(h)(1)		Correction Completed 10/30/2013		ID Prefix Reg. # LSC	F0279 483.20(d), 483.2	20(k)(1)	Correction Completed 10/30/2013
	F0280 483.20(d)(3), 4		Correction Completed 10/30/2013		•	F0282 483.20(k)(3)(ii)		Correction Completed 10/30/2013		•	F0309 483.25		Correction Completed 10/30/2013
	F0310 483.25(a)(1)		Correction Completed 10/30/2013		ID Prefix Reg. # LSC	F0311 483.25(a)(2)		Correction Completed 10/30/2013			F0318 483.25(e)(2)		Correction Completed 10/30/2013
	F0323 483.25(h)		Correction Completed 10/30/2013		ID Prefix Reg. # LSC	F0353 483.30(a)		Correction Completed 10/30/2013		ID Prefix Reg. # LSC	F0431 483.60(b), (d), (d	9)	Correction Completed 10/30/2013
	F0441 483.65		Correction Completed 10/30/2013			F0465 483.70(h)		Correction Completed 11/30/2013			F0520 483.75(o)(1)		Correction Completed 10/30/2013
Reviewed B	у	Reviewed I	•	Dat		Signature of	Surve	-	-			Date:	- 10 0 1 0
State Agence Reviewed B	-	MM/G.		11/2 Dat	21/201:		S	3125	6			11/0 Date:	7/2013
CMS RO	у	Reviewed I	Бу		.e.	Signature of	Surve	yui:				Date:	
Followup to	Survey Compl 9/12	eted on: /2013		-			-				a Summary of 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 245559	(Y2) Multiple Constru A. Building B. Wing	BUILDING 01	(Y3) Date of Revisit 11/21/2013
Name	of Facility		Street Address, City, State, Zip Code	
VIK	KING 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	(Y4)	ltem		(Y5)	Date	(Y4)	ltem		(Y5)	Date
				Correction					Correction					Correction
				Completed					Completed					Completed
IL) Prefix			10/22/2013		ID Prefix			10/22/2013		ID Prefix			10/22/2013
	•	NFPA 101				-	NFPA 101				•	NFPA 101		
	Lac	K0029				190	K0050				L3C	K0056		
				Correction					Correction					Correction
				Completed					Completed					Completed
10) Prefix			10/22/2013		ID Prefix			10/22/2013		ID Prefix			10/22/2013
	-	NFPA 101				-	NFPA 101				-	NFPA 101		
	LSC	K0062				LSC	K0147				LSC	K0154		
				Correction					Correction					Correction
				Completed					Completed					Completed
10	O Prefix					ID Prefix			-		ID Prefix			
	Reg. #					Reg. #					Reg. #			
	LSC					LSC					LSC			
				Correction					Correction					Correction
10	D Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
	Reg. #			•		Reg. #			-		Reg. #			
	LSC					LSC					LSC			
				Correction					Correction					Correction
10	D Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
	Reg. #					Reg. #								
	LSC										LSC			
Revi	ewed By		Reviewed E	-	Da		-	ture of Surve	-				Date:	
State	Agency	1	MM/PS	3	02	/26/201	.4	03	006				11/2	21/2014
Revi	ewed By	·	Reviewed E	Зу	Da	te:	Signa	ture of Surve	yor:				Date:	
CMS	RO													
Follo	owup to	Survey Comp	leted on:				c	-				a Summary of		
		9/18	/2013					Uncorrecte	d Deficiencie	s (CM	S-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 245559	(Y2) Multiple Constru A. Building B. Wing	DING 0202	(Y3) Date of Revisit 11/21/2013
Name	of Facility		Street Address, City, State, Zip Code	
VIF	KING 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	(Y4)	ltem	(Y5)	Date	(Y	4) Item	1	(Y5) I	Date
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			10/22/2013		ID Prefix		10/22/2013		ID Prefix			10/22/2013
•	NFPA 101				Reg. #	NFPA 101	_		Reg. #	NFPA 101		_
LSC	K0050				LSC	K0056	-		LSC	K0062		_
			Correction				Correction					Correction
ID Prefix			Completed 10/22/2013		ID Brofiv		Completed		ID Brofiv			Completed
			10/22/2013				-					_
•	NFPA 101				Reg. #		-		Reg. #			_
	K0154			<u> </u>	LSC		-					_
			o "				0 "					o "
			Correction				Correction					Correction
ID Prefix			Completed		ID Prefix		Completed		ID Prefix			Completed
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LSC					LSC		-		LSC			_
							-	-				
			Correction				Correction					Correction
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ID Prefix					ID Prefix		-		ID Prefix			_
Reg. #	. <u></u>				Reg. #		-		Reg. #			_
LSC				ļ	LSC		-		LSC			-
Reviewed By		ewed B	-	Da		Signature of Surve	•				Date:	
State Agency	, М	M/P	S	02	/26/20	14	030	06			11/2	1/2013
Reviewed By	Revie	ewed B	у	Da	te:	Signature of Surve	eyor:				Date:	
CMS RO												
Followup to	Survey Completed of			_		-				a Summary of to the Facility?		
	9/18/2013					Cheoneete		0,0			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:

Viking Manor Nursing Home February 26, 2014 Page 2

• 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

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

DEPARIMENT OF HEALTH A							DICAKE & MEDI	CAID SERVICES
		ARE/MEDICAI TO BE COMPI						ID: M6T7 Facility ID: 00075
1. MEDICARE/MEDICAID PROVIDER N		3. NAME AND AI			IE SURVEI A	GENCI	4. TYPE OF ACT	
(L1) 245559		(L3) VIKING MA			E		1. Initial	2. Recertification
2.STATE VENDOR OR MEDICAID NO.		(L4) 317 FIRST S	STREET NOR	THWEST	-		3. Termination	4. CHOW
(L2) 734040100		(L5) ULEN, MN			(L6) 50	6585	5. Validation 7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF OWN	NERSHIP	7. PROVIDER/SU	PPLIER CATEG	ORY	<u>02</u> (L7)			
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA	8. Full Survey Aft	er Compraint
)13 (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF	10 NF	14 CORF		FISCAL YEAR ENI	DING DATE: (L35)
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L10)	03 SNF/NF/Distillet 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/III 12 RHC	D 15 ASC 16 HOSPICE		09/30	
2 AOA 3 Other								
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia					The Following Require	
To (b):			equirements e Based On:		2. Techni 3. 24 Hou	ical Personnel	6. Scope of S 7. Medical D	
12.Total Facility Beds	45 (L18)		cceptable POC			RN (Rural SN		
					5. Life Sa	afety Code	9. Beds/Roo	m
13.Total Certified Beds	45 (L17)	X B. Not in Con Requirement	pliance with Prog ents and/or Applie	ram ed Waivers:	* Code: B	*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY ME	ETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1	861 (j) (1):	(L15)	
45								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	KS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	EY AGENCY	APPROVAL	Date:
Rebecca Haberle HFE	Nursing E	val. II 1	1/21/2013	(L19)	Kato Joh	ston En	Sorcement Spec	<u>cialis</u> t 11/26/2013 (L20)
PART	II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR	SINGLE S	FATE AGENCY	
19. DETERMINATION OF ELIGIBILITY		20. COM	IPLIANCE WITH	I CIVIL	21. 1. Sta	tement of Finar	ncial Solvency (HCFA-22	572)
X 1. Facility is Eligible to Partic	ipate	RIGH	ITS ACT:			nership/Contro th of the Above	l Interest Disclosure Stn	nt (HCFA-1513)
2. Facility is not Eligible	-				5. 50			
	(L21)							
22. ORIGINAL DATE 23	3. LTC AGREE	MENT 24	4. LTC AGREEM	IENT	26. TERMINATI	ION ACTION:		(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DAT	ſΈ	VOLUNTARY	00	INVOLU	JNTARY
06/01/1991					01-Merger, Closur			o Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction			o Meet Agreement
25. LTC EXTENSION DATE: 27	. ALTERNATI	VE SANCTIONS			03-Risk of Involunt		OTHER	
	A. Suspension	n of Admissions:	<i>a</i> . 145		04-Other Reason fo	or withdrawai	07-Provi 00-Activ	ider Status Change
(L27)	B. Rescind Su	spension Date:	(L44)				00-Activ	C .
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)	05001		(L31)				
				. /				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)			(L33)	DETERMINA	TION APPF	ROVAL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES	CENTERS FOR MEDICARE & MEDI	CAID SERVICES
MEDICARE/MEDICAID CERTIFICATION AN	D TRANSMITTAL	ID: M6T7
PART I - TO BE COMPLETED BY THE STATE	SURVEY AGENCY	Facility ID: 00075

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS
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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

Viking Manor Nursing Home October 29, 2013 Page 4

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

Viking Manor Nursing Home October 29, 2013 Page 5

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 Viking Manor Nursing Home October 29, 2013 Page 6

Feel free to contact me if you have questions.

Sincerely,

Katol moton

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

TATEMENT	RS FOR MEDICARI	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING)	COMPLETED
		245559	B. WING		09/12/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST	
VIKING	MANOR NURSING HO	DME	1.	ULEN, MN 56585	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETIO
F 000	INITIAL COMMEN	TS	F 000		14:13
	as your allegation of Department's accept	of correction (POC) will serve of compliance upon the ptance. Your signature at the bage of the CMS-2567 form will ion of compliance.			'Sa
	revisit of your facilit validate that substa regulations has bee your verification.	acceptable POC an on-site y may be conducted to initial compliance with the en attained in accordance with			
	483.15(a) DIGNITY INDIVIDUALITY	AND RESPECT OF	F 241	and implemented to assure	dignified
	manner and in an e enhances each resi	omote care for residents in a invironment that maintains or ident's dignity and respect in is or her individuality.		clearing of tables with the ex of breakfast due to the open breakfast. 1) Tables will not begin to be	
	by: Based on observat failed to ensure eac maintained during n dining room. Staff w dirty plates when 10	NT is not met as evidenced ion, and interview, the facility th residents' dignity was neal observations in the main vere observed to scrape off 0 of 21 residents (R3, R24, 2, R23, R29, R30, R1) were		cleared until 20 minutes after last plate has been dished u 2) Staff will bring dishes to a outside the soiled dishwasher 3) Dirty dishes will be scrape a garbage can and liquids w placed into a soiled liquid pa	r the p. rea er room. ed into ill be
	Findings include:	-		4) Dirty dishes placed into co that when full will be transfer	
	evening meal in the conducted. The dini resident tables at wi their meals, and incl	m. observations of the facility dining room were ng room contained 12 nich 29 residents received luded an attached "sun room "		soil dishwasher room. 5) Dishes will be placed into dishwasher for cleaning. 6) When clearing tables after	r meal
DRATORY	DIRECTORS OF FROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGNA	Rdu.	in at at	

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: 00075

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

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

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		E & MEDICAID SERVICES		a second and a second		0.0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 B. B.			TE SURVEY
		245559	B. WING		09	/12/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VIKING	MANOR NURSING HO	DME		317 FIRST STREET NORTHWEST ULEN, MN 56585	,	
(X4) ID Prefix Tag	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 241	area with 4 tables f meals. At 6:33 p.m completed their me themselves out of t (DA)-B wheeled a b kitchen. The cart h contained a green top shelf. In additio DA-B was observed (approximately 33 g she wheeled out at DA-B wheeled the b picked up the dirty j the food debris into poured the left over juice) into the green silverware into the t level of the cart. DA the next table. As D dishware and food observed still eating tables. At 6:36 p.m (approximately) 10 eating as DA-B clea again scraping food garbage can, pourir placing the dishes c DA-B wheeled the b dining room and into 17 residents remain sun room. DA-B co around the dining ro from plates and rem tables. At 6:47 p.m. can directly next to b tablemates handed cleared. At 6:47 p.m.	age 1 or 12 residents to eat their . a few of the residents had bal and began wheeling he dining room. Dietary aide ous cart out of the main lad three shelves, and bail and large plastic tub on the n to wheeling out the bus cart, d to have a large garbage can gallon can) on wheels which the same time. At 6:35 p.m. bus cart to a unoccupied table, plates and used a fork to push the garbage can. DA-B fluids (coffee milk, and/or n pail and placed the cups and ub and the plates onto the first -B then wheeled the cart to DA-B removed the dirty debris, 21 residents were their meals at the adjoining . DA-B wheeled the cart within inches of R12. R12 was ared the table behind him, i items into the uncovered ng the liquids into a pail and onto the cart. At 6:38 p.m. bus cart across the main o the Sun room. At 6:47 p.m. led in the dining room and the nutinued to move the bus cart boying dirty dishware from the . DA-B wheeled the garbage R25. R25 continued to eat as DA-B their dishes to be 1. 17 residents in the main oom were still eating their eared all of the other residents	F 241	convice, no toblo will be do	ng at er will or 2 er will dit t QA will	10/31/1

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY
		245559	B. WING		09/	12/2013
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	511 14 OABOLO (514	
/IKING I	MANOR NURSING HO	ME		317 FIRST STREET NORTHWEST ULEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I D BE	(X6) COMPLETION DATE
F 241	clothing protectors of cart. At 7:05 p.m. a completed their mea sipping on coffee. I dirty dishware, food	ge 2 he other residents' solled on the bottom shelf of the bus II of the residents had als except R1 who was still DA-B had cleared all of the debris and beverage while eating in the dining room.	F 24	1	9 18. 18.	
	from 12:35 p.m. to 1 observed pushing a used to place dirty p from table to table ir scraped off left over garbage bin, and pla and utensils on the o	of the lunch meal on 9/11/13, 2:42 p.m., DA-A was large garbage bin and cart lates, glasses and utensils the main dining room. DA-A food on the plates into the ced the dirty plates, glasses part. During this time there ill in the main dining room eal.	•		a.	
10	(DON) observed DA dishes from the dinir continued to finish er was not a dignified d					
	confirmed busing tak garbage bin while re-	p.m. the dietary manager bles and pushing along the sidents continued to eat their fied dining experience.		e		•
F 252 SS=E	dignified dining was 1 483.15(h)(1)	regarding clearing tables and requested but not provided. FORTABLE/HOMELIKE	F 252	Resident R1 and other resident Viking Manor will be providen odor free, safe, clean, comfo	d an	
	The facility must prov comfortable and hom	vide a safe, clean, nelike environment, allowing		and homelike environment. Regarding R1, to combat the	•	

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

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VENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	. 0938-03
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245559	B. WING		09	12/2013
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) Completic Date
	the resident to use h to the extent possib This REQUIREMEN by: Based on observati review, the facility fa environment for 1 of urine odor in the roo Findings include: The facility falled to p clean environment for R1 had diagnoses w osteoporosis. The qu dated 6/23/13, identi cognitive impairment assistance from staff living. During observation of 8:40 a.m. a strong un the hallway outside of urine odor was stron- contained the resided floor mats. During observation of pungent odor of urine room and adjoining h On 9/12/13 at 9:06 a. supervisor confirmed urine smell that perm	his or her personal belongings le. IT is not met as evidenced on, interview, and document tiled to provide an odor free in resident (R1) with a strong im. provide an odor free and or R1. thich include arthritis and uarterly Minimum Data Set, fied R1 had moderate t and required extensive f with all activities of daily of R1's room on 9/11/13, at rine odor permeated out into of R1's room. The pungent gest in R1's room which nt's bed, a cloth recliner and in 9/12/13, at 9:04 a.m., a e was again noted in R1's	F 25	² CNA's are to change her line every other day, her Hoyer is to be hand-washed night machine washed weekly are often if needed. Her wheel to be cleaned daily, deodor drops have been purchase in her catheter bag daily, clemats daily and swap them a week, clean her recliner a chair pad weekly. Also, a venot working during the surv has now been fixed. Training be provided to staff response implement this plan. The De designee will be auditing the interventions randomly to end are being completed. Our H Housekeeping will monitor a of Viking Manor to ensure a free and clean environment for our residents. Audit find will be presented at QA mee The QA committee will dete how long to continue audits.	bucket dy and nd more chair is izer d to put ean out twice and clue ent was ey and ng will sible to ON or ese nsure the lead all areas n odor exists ings eting. rmine	

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Facility ID: 00075

If continuation sheet Page 4 of 78

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		. 0938-03 E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:	1.		CON	IPLETED
		245559	B. WING		09/	12/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
VIKING N	MANOR NURSING HO	ME		317 FIRST STREET NORTHWEST ULEN, MN 56585		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5) COMPLETIC
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		DATE
F 252	Continued From pa	ge 4	F 25	2		
	are the mats and re	Wales (0.2)				
			1.11			
		7 a.m. the administrator				
		g urine smell was present in e hallway of the facility.				
			23	202 34		
		a.m. registered nurse (RN)-A n had a strong urine odor and				
		hat since admission and the				
	smell is urine."					
	0.04040314440	and the second second				
		p.m. the contracted d the ventilation system in the	6			
	facility was functioni	ing properly and stated, "The		ale -		
	smell would come fi	rom the source or cause of it."				
	On 9/12/13 at 1:58	p.m. director of nursing				
	(DON) confirmed th	e presence of strong urine				
1	smell in R1's room t	hat permeated into the				
	of her equipment an	tated, "I expect good cleaning				
	483.20(d), 483.20(k		F 27	R21's care plan has bee	n updated	
	COMPRÉHENSIVE			to include a focus on bru		
	A facility must use th	ne results of the assessment		Additional interventions	-	
		nd revise the resident's		added to reduce the nun		
	comprehensive plan	of care.			ACCESSION OF THE STATE OF THE S	
	The facility must dev	velop a comprehensive care		bruises R21 sustains, inc		
		nt that includes measurable		not limited to derma slee		
		ables to meet a resident's		bilateral arms and skin n	and a set of the set of	
	medical, nursing, an needs that are ident	d mental and psychosocial ified in the comprehensive		BID. R21's physician ord	1. Sec. 1. Sec	
	assessment.			work and will also be mo	-	
				R21's skin status. All RN	S	
		describe the services that are tain or maintain the resident's		have received education	and	
	highest practicable p			instruction on on adding	bruising	

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

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CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 09						. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COM	e survey Ipleted
		245559	B. WING			09/	12/2013
	PROVIDER OR SUPPLIEF			3	STREET ADDRESS, CITY, STATE, ZIP CODE 117 FIRST STREET NORTHWEST JLEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORHECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) Completic Date
	psychosocial well- §483.25; and any s be required under due to the resident §483.10, including under §483.10(b)(4 This REQUIREME by: Based on observa review, the facility it to include identified reviewed for bruisin reviewed for bruisin reviewed for ambu (R34) reviewed for Findings include: R21's plan of care interventions to min On 9/10/13, at 10:5 wearing a short sle in his room. R21's from the finger tips bruises ranged in c yellow/green. (R21' appearance which paper). On 9/11/13, at 9:50 was observed to as NA-A washed the u R21 bruised so eas on after R21 was of entered the room a from the bed to a re	being as required under services that would otherwise §483.25 but are not provided I's exercise of rights under the right to refuse treatment	F 2		focus to care plans for any res receiving anticoagulant medica and/or steroids. Staff were initi informed of need to wear geri-sleeves on 9/16/13.All sta have received education regar bruising interventions by 10/30 The DON or her designee will perform random audits to ensu- implementation of interventions Findings will be presented to G committee and QA committee determine how long audits nee be continued. R43's care plan has been upda to include an intervention relate nursing rehab/ambulation. Res is offered nursing rehab/ambul 3-5 times a week. All ambulato residents are offered to ambula meals daily. Any resident curre receiving ambulation/nursing re services will have their care pla reviewed and updated to include ambulation and any other nursi rehab the resident is receiving. resident being added to an ambulation/nursing rehab program	ations ally ff will ding i/13. ire s. DA will d to ated ed to ident ation ry ate to ntly shab in le ng Any	

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Facility ID: 00075

If continuation sheet Page 6 of 78

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245559	B. WING	·····	00/	12/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		LILOIO
VIKING	MANOR NURSING HO	DME		317 FIRST STREET NORTHWEST ULEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SG IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	On 9/12/13, at 11:0 administration alde new open area on t filled out an inciden into the nurse. TMA TMA-A stated R21 f to protect arms from On 9/12/13, at 11:44 (RN)-C reviewed th the plan of care did bruising or intervent further bruising. The Reporting of Br directed the staff to complete an inciden prone to bruising tha (used to prevent hea clots in veins and ar Prednisone (anti-infl care planned for." On 9/12/13, at 12:12 (DON) confirmed the consistently attempts minimize R21's risk concern had not bee	0 a.m. the trained medication (TMA)-A stated R21 had a he elbow. TMA-A stated had t report and turned the report A-A stated R21 bruised easily. was to wear long sleeve shirts n bruising. 0 a.m. registered nurse e plan of care and confirmed not include R21's frequent ions to minimize the risk for ulses Policy dated 8/11/10, document new bruises and t report. "Residents that are at are wanders, on Coumadin art attacks, strokes, and blood teries), ASA [Aspirin] or ammatory medication) will be	F 27	will have a related interven added to their care plan. Al will receive education regar comprehensive care plans 10/30/13. The DON or her will perform random audits plans to ensure the care pla current. RNs for each wing auditing nursing rehab flow weekly to ensure all resider are receiving ambulation as planned. Care plans will con be reviewed quarterly and F Audit findings will be preser QA committee and QA com will determine how long aud to be continued. R 23 and R34's care plan ha updated to include an interv ROM. R23 and R34 are offer nursing rehab/ROM 3-5 time week. Additional staff availa assistance in providing ROM exercises. Any resident curr receiving ROM/nursing reha services will have their care reviewed and updated to inc ROM and any other nursing the resident is receiving. Am	I staff rding by designee of care ans are will be sheets nts care ntinue to PRN. ited to mittee its need as been ention for red es a ble for 1 ently b plan lude rehab	

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		AND HUMAN SERVICES	•		FORM	D: 10/21/20 MAPPROVE D. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DA CO	TE SURVEY MPLETED
		245559	B. WING_		. 09	/12/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
VIKING I	MANOR NURSING HO	ME		317 FIRST STREET NORTHWEST ULEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	. ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
8	staff. A Physical Therapy 2/4/13, included a D continue ambulatior and to encourage/a: addition, a Physical dated 10/26/12, incl Recommendation o with close supervision During interview on registered nurse (RH nursing program was of care. During interview on director of nursing var responsible to keep and accurate. R23's plan of care d services (ROM), as of R23's plan of care, r focus of Mobility with included two staff as was no longer safe to did not include ROM	Discharge Summary dated Discharge Recommendation to a program with nursing staff ssist with ambulation. In Therapy Discharge Summary uded a Discharge f restorative nursing program on. 9/11/13, at 1:02 p.m., N)-A verified a restorative s not included on R43's plan 9/12/13, at 11:00 a.m., the erified nursing staff were resident care plans updated id not include range of motion directed by Physical Therapy. evised 9/5/13, identified a n several interventions which sist for transfers, as resident o ambulate. The plan of care	F 27	resident being added to nursing rehab program related intervention add their care plan. All staff education regarding co care plans by 10/30/13 her designee will perfor audits of care plans to care plans are current. wing will be auditing nu flow sheets weekly to e residents are receiving care planned. Care plan continue to be reviewed quarterly and PRN. Aud will be presented to QA and QA committee will o how long audits need to continued.	o a ROM/ will have a ded to f will receive mprehensive . The DON o rm random ensure the RNs for each rsing rehab nsure all ROM as ns will d dit findings . committee determine	r
	10/26/12 revealed D "RNP (restorative nu supervision." A Rest dated 2/8/13 from a l the following "Approa catch with ball, pegs pulleys, incline board	Discharge note dated ischarge Recommendations: rsing program) with close torative Care Program form Physical Therapist included ach/Recommendations: play and foam board, overhead I, arm bike, and knee unds, three sets of 10 each				

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		AND HUMAN SERVICES	1		©	FOR OMB NO	D: 10/21/2013 M APPROVED D. 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD				TE SURVEY
		245559	B. WING			09	9/12/2013
NAME OF	PROVIDER OR SUPPLIER			- 6	STREET ADDRESS, CITY, STATE, ZIP CODE		
VIKING	MANOR NURSING HO	ME		1.15	JLEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	Continued From pa leg."	ge 8	F 2	279			
		9/11/13 at 11:20 a.m., RN-A s not included on R23's plan			•		
	director of nursing v	9/12/13, at 11:00 a.m., the erified nursing staff were resident care plans updated					
	developed to mainta motion (ROM) to pa living (ADLs). On 9/11/13, at 8:59 needing extensive a assistant (NA)-F and bed, dressing, and p a.m. R34 was obser position, peri cares p were pulled up by N transferred by mech was able to grab ont mechanical lift with g from NA-G. On 9/11/13, at 9:25 a was receiving ROM nursing and stated, ' and he has not really On 9/11/13, at 1:55 p was receiving ROM nursing and stated, " nursing and stated, "	anical lift to the recliner. R34 o the handles of the guidance and verbal cueing a.m. NA-F confirmed R34 services from restorative R34 is dependent on staff,					
	On 9/11/13, at 2:30 p	.m. RN-A reviewed and					
	7/00.00) Dravious Varaione C				liby ID: 00075		

FORM CMS-2567(02-99) Previous Vers lete

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Event ID: M61711

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/21/2013 FORM APPROVED

	T OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION		. 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING		CON	IPLETED
		245559	B. WING		09/	12/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VIKING	MANOR NURSING HO	ME		317 FIRST STREET NORTHWEST ULEN, MN 56585		
(X4) ID Prefix Tag	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IÐ PRÉFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	confirmed the plan of ROM services to ma participate in ADLs. The facilities Goals policy dated 10/22/0 derived from the res	ge 9 of care did not include R34's aintain flexibility and ROM to and Objectives, Care Plan 99, revealed the POC was sident's comprehensive ovided goals and objectives	F 279			
F 280 SS=D	483.20(d)(3), 483.10 PARTICIPATE PLAN The resident has the incompetent or othe incapacitated under	NNING CARE-REVISE CP a right, unless adjudged rwise found to be the laws of the State, to ng care and treatment or	F 280	R25 and R29 were identified re to not receiving revision of pla care related to ambulation an R29 has was hospitalized on 9 and was deceased on 9/23/13 without return to facility.	an of d ROM.	
	within 7 days after the comprehensive asso- interdisciplinary team physician, a register for the resident, and disciplines as determ and, to the extent pro- the resident, the resi- legal representative;	re plan must be developed be completion of the essment; prepared by an n, that includes the attending ed nurse with responsibility other appropriate staff in nined by the resident's needs, acticable, the participation of dent's family or the resident's and periodically reviewed m of qualified persons after		R25 received a comprehensive assessment on 9/17/13. An ord for PT evaluation and treatment was obtained on 9/17/13. R25 ⁴ plan of care has been updated include current ambulation ab and recommendations from P evaluation. R25 is offered ambulation and ROM 3-5 time weekly. One activity aide was	der nt to illity T s	
	by: Based on observation review, the facility fai	T is not met as evidenced on, interview, and document led to revise the plan of care nterventions for 2 of 6		trained to nursing rehab and is scheduled for rehab 2-3 hours, 2-3 days a week. The activity al focuses on providing ROM exercises. R25 is offered to ambulate to meals. All resident	/day de	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MÚĽ A. BUILD	TIPLE CONSTRUCTION	(X3) D/ CC	ATE SURVEY
	202-19-54s	245559	B. WING			9/12/2013
	PROVIDER OR SUPPLIER	DME		STREET ADDRESS, CITY, ST. 317 FIRST STREET NORTH ULEN, MN 56585	ATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SG IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION FE ACTION SHOULD BE D TO THE APPROPRIATE GIENCY)	(X5) COMPLETIO DATE
	residents (R25, R2 ROM. Findings include: R25's plan of care (regarding ambulation R25's POC dated 7 to ambulate with a fi and for short distan R25 had a history of to work with restorat times per week. Til limitations in mobilit directions related to how far R25 was to On 9/11/13, at 6:55 sitting on the toilet re cares from NA-A. F standing mechanicat completed. R25 was bathroom and positi standing lift. R25's la during the transfer. On 9/11/13, at 12:20 nurse (RN)-C assist positioning. R25 us was able to ambulat assistance of both s the right hip and the The resident stated to."	 a) related to ambulation and b) related to ambulation and c) related to ambulation needs. c) rand range of motion needs. r) range of motion program or ambulate. a.m. R25 was observed ecciving assistance with R25 was connected to a an stransferred out of the oned in a wheelchair via the egs were fully extended r) a.m. NA-D and registered ed R25 into a standing ed a four wheeled walker and e six feet with extensive taff. R25 stated had pain in left knee when ambulating. r) just can not walk like I used c) Flow Sheets identified the 	F 24	80 capable of ambul offered to ambula All residents will r PT screenings an frequently if need plans will be upda with recommenda resident plans of reviewed at quart conferences and any changes each conference and m if needed. Change will be communicat communication bo All staff will receiv be completed by t to revision of care The DON or her d performing randor audits to ensure re occurring as need findings will be rev and QA meetings committee will det when to stop audit	ate to meals. receive annual ad more ed and care ated/revised ations. All care will be erly care updated with n care nore frequently es to care plans ated to staff via pok and/or orally. e education to 10/30/13 related plans. esignee will be n care plan evisions are ed. Audit viewed at IDT and QA ermine	10/30/13

Facility ID: 00075

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

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
	245559	B, WING	·····	09	/12/2013
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, 317 FIRST STREET NOP ULEN, MN 56585	STATE, ZIP CODE	34 14
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
and refused to am - In August 2013, I The documentatio resident ambulate - In July 2013, R2 The documentatio resident ambulate Review of the Reh following informati - In September 1-1 was blank - In August 2013, the R29's plan of care revised regarding a needs. R29's plan of care to assist ambulatio members. The pla informed the staff I restorative nursing to what R29 was d On 9/10/13, at 2:00 assisted onto a Nu restorative therapy (NA)-B. R29 was r her balance during	 11, 2013, R25 had been offered bulate one time. R25 had ambulated 7 times. n did not indicate how far the d. 5 had ambulated 14 times. n did not indicate how far the d. ab Flow Sheets identified the on for range of motion: 11, 2013, the documentation he documentation was blank. documentation was blank. documentation was blank. had not been revised to been ambulation and range of motion dated 6/6/12, directed the staff n using a walker and 1-2 staff an also directed the staff R29 was participating with but it did not direct the staff as oing with restorative nursing 0 p.m. R29 was observed to be step (exercise machine) in the room by nursing assistant not observed to be able to hold the transfer and physical PTA)-A joined NA-B to assist 	F 2			
assisted R29 with r	a.m. nursing assistant (NA)-A norning cares. At 9:00 a.m. into a sitting position on the				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		TE SURVEY
		DENTI DATON NOMOLI.	A. BUILDING			
•		245559	B. WING			/12/2013
	PROVIDER OR SUPPLIER	ME	317	REET ADDRESS, CITY, STATE, ZI FIRST STREET NORTHWEST EN, MN 56585		
(X4) ID Prefix Tag	 (EACH DEFICIENCY 	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 280	edge of the bed. R up while sitting on t as trained medication room to assist with	29 was not able to hold herself he bed. NA-A held her steady on aide (TMA)-A entered the the transfer. A transfer belt	F 280		•	
	R29. R29 did not re staff assisted her to stood, took two step the two staff and sa the chair, NA-A assi	valker was placed in front of each for the walker as the two stand. R29 cried out as she as with extensive assistance of t in a wheelchair. Once in sted R29 to donn her shirt. maces when her arms were		-	4 24 3	
	did not complain of She stated there ha R29. She stated in ambulate from the b	a.m. NA-A stated R29 usually pain with cares or transfers. s to be something wrong with the past R29 had the ability to red to the bathroom several had not been able to do that hs.		*	a l	
	"ambulate." The she to what type of devic ambulating, how ma assist, how far the re	eets directed the staff to eets did not direct the staff as ees were to be used while ny staff members were to esident was to ambulate or ch the services were to be		34. ¹⁷ 3	- *	
	Review of the Rehat revealed the followin	p Flow Sheets for ambulation g information:				
	ambulated. - In August 2013, R2 The distance to whic not identified.	2013, R29 had not 9 had ambulated 4 times. h R29 had ambulated was ad ambulated five times.	•			t

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245559	B. WING		09	/12/2013
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, S 317 FIRST STREET NOR ULEN, MN 56585	STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE IED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE
F 280	provide a "Nu-Step, pegs or arch)" and	eets directed the staff to sink standing activity (cones, gave the staff a list of four	F 2	80	-	
	exercise to choose exercise, a two pou head, side to side, o arm bike." The rest directed the staff as were to be performed	from including "red theraband nd wand exercise over the chest in and out, pulleys or orative flow sheets did not to the frequency the activities ad or the length of time in were to be provided.			14 14	
		b Flow Sheets for range of following information:	E.	2 2		
	the Nu step on two	. 2013, R29 had completed occasion, and the pulleys one time spent on each activity d.				
	on five occasions ar	29 had completed the Nu-step id had completed the pulleys time spent on each exercise d.				
	times and had worke	nad competed the Nu-Step 12 ed with the pulleys six times. each exercise was not			5	
e.	(DON) confirmed the	p.m. the director of nursing plans of care had not been 5's and R29's current e of motion needs.				
	dated 10/22/09, direc	ctives, Care Plan policy cted the staff to review and ares quarterly and with any		5		

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		OI	MB NO. 093	8-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245559		(X1) PROVIDER/SUPPLIER/CLIA (X2)		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245559	B. WING	N	09/12/2013		
NAME OF PROVIDER OR SUPPLIER VIKING MANOR NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COM	(X5) Pletion Date	
F 282 SS=E SS=E	483.20(k) (3) (ii) SEF PERSONS/PER CA The services provided must be provided by accordance with eac care. This REQUIREMEN by: Based on observati review, the facility fa accordance with the care for 1 of 3 resid personal alarm for fa (R27, R13, R22, R20 services. Findings include: R43's plan of care (for the use of a pers n the wheelchair. R43's plan of care la occus area for risk of ndicated R43 was n isted various interve utilize a Tabs alarm a wheelchair.	Presidents' condition. VICES BY QUALIFIED RE PLAN ed or arranged by the facility y qualified persons in ch resident's written plan of IT is not met as evidenced on, interview, and document iled to provide services in resident's written plan of ents (R43) who utilized a all prevention, and for 4 of 8 b) requiring range of motion POC) had not been followed onal alarm (Tabs) unit while st revised 7/10/13, included a falls. The plan of care ot aware of safety needs and ntions which directed staff to at all times when up in on 9/9/13, from 5:58 p.m. to seated in a wheelchair in the cility. A white alarm box was of the wheelchair with a o an orange string, which	F 280 F 282		iated alarm ht and s care ide ion for cated k raff /13. alarm to have ed to hs yes med sure h. ming s are		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00075

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

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STATEMENT OF DEPICIENCIES AND PLAND OF CORRECTION (M) IDENTIFICATION NUMBER: (A) MULTIPLE CONSTRUCTION A. BUILDING (A) DEPICIPUE 24559 24559 IS WING (B) WING (B) WING VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, 2JP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56595 (B) WING (B) WING PROVIDER VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, 2JP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56595 (B) WING (B) WING PROVIDER STATE SUMMARY STATEMENT OF DEFICIENCIES TAG (B) WING (B) WING (B) WING (B) WING PROVIDER STATE SUMMARY STATEMENT OF DEFICIENCIES TAG (B) WING (CENTERS FOR MEDICARE & MEDICAID SERVICES					OWB NO	MB NO. 0938-0391		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE VIKING MANOR NURSING HOME STRESTADRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY		
VIKING MANOR NURSING HOME 317 FIRST STREET NORTHWEST ULEN, MN 56535 VIKING MANOR NURSING HOME 317 FIRST STREET NORTHWEST ULEN, MN 56535 VIKING MANOR NURSING HOME ID			245559	B. WING			09/12/2013		
VIKING MANOR NURSING HOME ULEN, MN 56585 CM102 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUST DE PRECEDED BY PULL PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH DOPICATIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 000000000000000000000000000000000000					200				
PREFIX TAG(EACH CORRENCE ACTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY)COMMENT DEFICIENCYF 282Continued From page 15 was not attached and she then attached the clip to R43's shift.F 282IDT/QA will determine when to stop audits.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 of the Tabs alarm to the back of P43's shift. The DON then confirmed freq Edg was not attached to R43's back as it should have been.F 282IDT/QA will determine when to stop audits. R27, R13, R22, and R26's care plans have each been updated to include ROM/nursing rehab thervention. R27, R13, R22 and R26 are each offered ROM/nursing rehab exercises 3-5During an interview conducted on 9/11/13, at 12:39 p.m. nursing assistant (NA)-F stated R43 and the obd and a TABs alarm on at all times while up in the wheelchair.F 282IDT/QA will determine when to stop audits. R27. R13, R22, and R26 are plans have each been updated to include ROM/nursing rehab exercises 3-5During 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 Afs would expect the alarm to be clipped to his body while in the wheelchair.F 282During 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 282During 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 nu					1.37	ULEN, MN 56585			
 both the property of the state of t	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETION DATE	
additional RRA (registered resident assistant) has also been trained to		was not attached at to R43's shirt. During observations 7:20 a.m., R43 was the nurses station v attached to the bac clip had not been at string was hanging wheelchair. At 7:20 (DON) approached clip of the Tabs alar The DON then conf attached to R43's b During an interview 12:33 p.m. nursing was usually content occasionally would NA-F stated R43 ha and a TABs alarm of wheelchair. During an interview registered nurse (RI falls in the recent pa expect the alarm to the wheelchair. During an interview DON confirmed R43 verified she would e be implemented by R27's POC interven motion (ROM) exerci	nd she then attached the clip s on 9/11/13, from 6:55 a.m. to s seated in a wheelchair near with the white alarm box k of the wheelchair. The metal ttached to R43 and the orange down the backside of the 0 a.m., the director of nursing R43 and attached the metal m to the back of R43's shirt. firmed the clip was not ack as it should have been. conducted on 9/11/13, at assistant (NA)-F stated R43 t in the wheelchair but become restless or anxious. ad a laser alarm on the bed on at all times while up in the on 9/12/13, at 9:11 a.m., N)-A indicated R43 had two ast and confirmed she would be clipped to his body while in on 9/12/13, at 11:00 a.m., the B's current plan of care and expect all fall interventions to nursing staff.	F2		stop audits. R27, R13, R22, and R26's caplans have each been updat include ROM/nursing rehab intervention. R27, R13, R22 R26 are each offered ROM/nursing rehab exercise times a week. To ensure R27 R22, and R26 and all other residents are receiving service per plan of care, Viking Mano Nursing Home has implement staff schedule changes. One activity aide was trained to nursing rehab and is schedul rehab 2-3 hours/day 2-3 days The activity aide focuses prov ROM exercises. Viking Mano Nursing Home will continue to schedule a rehab aide Monda Friday. One additional activity is enrolled in Certified Nursing Assistant (CNA) classes and will also be trained to rehab up completion of CNA classes. On additional RRA (registered res	are ed to and s 3-5 7, R13, ces as or ited ed for a week iding y- aide y- aide y- aide	ς.	

FORM CMS-2567(02-99) Previous Versions Obsolete

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Event ID:M6T711

Facility ID: 00075

If continuation sheet Page 16 of 78

STATEMEN	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	of connection	IDENTI IDATION NOMBER.	. A. Building			
		245559	B. WING		09/12/2013	
NAME OF	PROVIDER OR SUPPLIER	•:		STREET ADDRESS, CITY, STATE, ZIP CODE		
VIKING	MANOR NURSING HO	DME		117 FIRST STREET NORTHWEST JLEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETH ATE DATE	
F 282	Initiated 6/5/12, with encourage gentle F care; and encourage during the day for m Also, a focus of Moi interventions which using Pal lift (mecha working with nursing longer ambulating of activities of daily livi During a family inter a.m., family (F)-A st daily basis. F-A stat because R27 was s exercises and ROM this. F-A also stated walked at all and ha approximately 3 mo walking R27 because "they have a staffing ROM is not provided pulled from therapy During an interview stated she worked a nursing assistant. S problem and she wo	n interventions which included: ROM as tolerated with daily te her to wear her tennis shoes hore support for her feet. bility, revised 7/16/13, with included: assist of 2 staff anical lift) to transfer, currently g rehab 3-5 days a week, no lue to Parkinson's, and ng (ADL's) extensive assist. rview on 9/10/13 at 10:33 ated he would visit R27 on a ted he was concerned upposed to be getting but staff were not providing d R27 was no longer getting dn't been walked for nths. F-A stated staff quit se it required 2-3 staff and g shortage." F-A further stated d because therapy staff gets	<u>.</u>	nursing rehab and will be schee	s will and care ith sing an tive ned an	
2	not provided for R27 During interview on s stated, "I am pulled t the floor and lately it confirmed when this	mes/week and ROM was then 9/11/13, at 11:32 a.m., NA-D from restorative to work on 's happen a lot." She happens, ROM does not get other resident who was on		rehab flow sheets weekly. All au findings will be presented to the QA committee and the QA committee will determine how lo to continue audits.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00075

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

PRINTED: 10/21/2013 FORM APPROVED

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION		TE SURVEY MPLETED
		245559	B. WING			/12/2013
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE 317 FIRST STREET NORTHW ULEN, MN 56585	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETIO DATE
F 282	During interview on DON confirmed sta confirmed the staff provide ROM for R2 confirmed R27's cu	9/12/13, at 11:00 a.m., the ffing was a problem and she did not always have time to 27, as directed. The DON rrent plan of care and d expect ROM interventions to	F 2	282		ŧ
4	a week as directed R13's POC dated 6/ receive rehabilitation five times a week. R13's Rehab Flow S rehabilitation staff to upper and lower ext Review of R13's Re following: September 1-11, 20 services on one day August 1-31, 2013 services on 8 days of	18/12, directed she was to n nursing for ROM three to Sheet directed nursing assist with ROM on R13's remities. hab Flow Sheet revealed the 13R13 had received ROM of the month. R13 had received ROM			э Э	
1	17 days of the mont On 9/11/13, at 1:55 had not received rar routinely from restor rehab aide had beer	h. p.m. NA-C confirmed R13 nge of motion services ative nursing. She stated the n consistently reassigned to ed the rehab aid duties "it's	20		• •	
	three times a week a R22's POC dated 9/ recieve rehabilitation five times a week.	ROM exercises consistently as directed by his POC. 11/12, directed he was to a nursing for ROM three to theet directed nursing				

		AND HUMAN SERVICES			FORM	D: 10/21/2013 MAPPROVED D: 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION	(X3) DA CO	TE SURVEY MPLETED
		245559	B. WING	l	09	/12/2013
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CO 317 FIRST STREET NORTHWEST ULEN, MN 56585	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefi Tag		SHOULD BE	(X6) COMPLETION DATE
F 282	rehabilitation staff to such as: ambulation nu-step 10 minutes, pulleys/gentle streto frame 10 minutes. Review of the Reha following information For the month of Se received services fo month, and for the r 2013 R 22 received the month, and furth 1st-31st, 2013 R 22 days during the mor received services fo days. On 9/11/13, at 1:55 (had not received rar routinely from restor rehab aide had beer direct care and state not all getting done."	b conduct various exercises a with front wheeled walker, a sits to stand five times, b, leg kicks, and standing b Flow Sheets identified the n: ptember 1st-11, 2013 R 22 r only two days during the nonth of August 1st-31st, services for nine days during the month of August 1st-31st, services for nine days during the month of July received services for thirteen th. However R 22 only r 24 days out of a total of 73 p.m. NA-C confirmed R22 age of motion services ative nursing. She stated the n consistently reassigned to ad the rehab aid duties "it's ntly receive ROM three times	F 2	282		
	R26's POC dated 9/ rehabilitation nursing R26's Rehab Flow S rehabilitation staff to upper and lower extr	19/12, revealed she had three times a week. heet directed nursing conduct ROM on R26's				< .

		AND HUMAN SERVICES			FORM	: 11/01/201 APPROVE . 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION	(X3) DAT CON	E SURVEY
		245559	B. WING		09/12/2013	
NAME OF	PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CO	DE	
VIKING	Manor Nursing Ho	ME		317 FIRST STREET NORTHWEST ULEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3 GROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE
F 282	following: Week of 9/1/13, had nursing rehabilitatio Week of 8/25/13, had nursing rehabilitatio Week of 7/28/13, had nursing rehabilitatio Week of 7/7/13, had nursing rehabilitatio On 9/10/13, at 2:04 often pulled to the fi nursing rehabilitatio The facility's Rehabilitatio The facility's Rehabilitatio The facility's Rehabilitatio The facility's Goals a policy dated 10/22/2 derived from the res	d the opportunity for three n sessions and received one. ad the opportunity for three n sessions and received zero. ad the opportunity for three n sessions and received two. I the opportunity for three n sessions and received two. b.m. NA-B revealed she is oor when assigned to do n. litative Nursing Care policy ad rehabilitative nursing care ive times weekly for those	F 24	32		
F 309 SS=D	483.25 PROVIDE C. HIGHEST WELL BE Each resident must provide the necessa or maintain the high mental, and psychos accordance with the and plan of care. This REQUIREMENT by: Based on observation	receive and the facility must ry care and services to attain est practicable physical,	F 30	9 R21's care plan has bee include a focus on bruisin Additional interventions h added to reduce the num bruises R21 sustains, ind not limited to derma slee bilateral arms and skin m BID. R21's physician has consulted. Lab work has ordered and R21's physic be monitoring R21's skin Care plans of all resident	ng. have been ber of cluding but ves to nonitoring been been cian will status.	0

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

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA . IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245559	B. WING		09/	12/2013
	PROVIDER OR SUPPLIER	DME		STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56586		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) COMPLETIO DATE
-	of 2 residents (R21 Findings include: R21 bruised easily were not developed bruising. R21's dia stroke, history of ar to include a dysthry On 9/10/13, at 10:5 wearing a short slee in his room. R21's from the finger tips bruises ranged in co yellow/green. (R21's appearance which of paper). On 9/11/13, at 9:50 was observed to as NA-A washed the up R21 bruised so easi on after R21 was ou entered the room ar from the bed to a re NA-A dressed R21 i Physiclan's Orders of took medications the become frail and ea were Prednisone (a daily and aspirin 81 placed on hold 9/9/1 R21's Accident or In through 9/12/13, wei following information	and appropriate interventions to minimize the risk of gnoses included status post memia, and cardiac disorders mic disorder. 0 a.m. R21 was observed eved t-shirt sitting in a recliner arms had multiple bruises to the upper forearms. The polor from deep purple to s skin had a very thin could be compared to tissue a.m. nursing assistant (NA)-A sist R21 with morning cares. oper body and stated since ily would attempt to put a shirt it of bed. At 9:53 p.m. NA-C nd assisted transferring R21 cliner. Once in the recliner n a short sleeved t-shirt. dated 9/4/13, indicated R21 at may cause the skin to sily bruised. The medications steroid) 5 milligrams (mg) mg daily. The aspirin was 3. cident Reports from 8/10/13 re reviewed and revealed the n. 8/10/13, at 5:00 p.m. R21 neter) by 3 cm bruise on the	F 309	frequent bruising have been reviewed and updated. Resid bruises are reviewed at IDT a QA meetings to discuss interventions and current plan of care. All RNs have receive education and instruction on adding bruising focus to care plans for any residents receive anticoagulant medications an steroids. All staff will have rec education regarding bruising interventions by 10/30/13. Th DON or her designee will per random audits of ensure implementation of intervention Findings will be presented to committee and QA committee determine how long audits ne to be continued.	and d d d/or ceived form ns. QA e will ed	10/30/13

OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245559		LE CONSTRUCTION		TE SURVEY MPLETED
ANOR NURSING HO	245559	B. WING			
ANOR NURSING HO	1			09	/12/2013
			STREET ADDRESS, CITY, STATE, ZIF		
	OME		317 FIRST STREET NORTHWEST ULEN, MN 56585		201 - 14 M.S.
(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X6) COMPLETIO DATE
happened, R21 der -8/11/13, at 6:00 p.r	nbers asked if anything had nied harm. n. R21 had a bruised area on	F 309			
cm, three bruises o each measuring 1 c and 0 .5 cm x 0.5 cl irregular shaped are along the entire fore cm. The incident re hurt R218/14/13, across the top of the by 3 cm. R21 denie	orearm measuring 2 cm by 3 n the top of the right hand cm by 1 cm, 2 cm x 2.5 cm, m, There was also an ea with red "specks" running earm measuring 12 cm x 5 eport indicated nobody had at 9:00 a.m. R21 had a bruise e right hand measuring 2 cm ad being hurt by any person, indicated R21 bruised			ν	
-8/21/13, at 3:25 p.r on the right elbow, wheelchair when as occurred. The repo to minimize the risk -9/5/13, R21 had a p elbow that reopened cm) while being drea assistants. -9/6/13, at 10:00 a.n hand going up into t	previous skin tear on the right d, (measuring 1.3 cm by 0.4 ssed by the nursing n. R21 had a bruise on the left he left wrist. The bruise		2 2 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		5 540
Indicated R21 bruise aspirin. R21 denied -9/9/13, R21 had ner right arm bruise mea left arm had four ner by 2 cm, 3 cm by 2 c by 6 cm. Although t aspirin and Prednisc interventions to mini	ad easily and was currently on being hurt. w bruises on both arms. The asured 6 cm by 6 cm. The w bruises measuring 2.5 cm cm, 3 cm by 2 cm and 12 cm he report indicated R21 took one, It did not include mize the potential rlsk for		*		
hnina	and going up into t neasured 11.6 cm k ndicated R21 bruise spirin. R21 denied 9/9/13, R21 had nei ght arm bruise mea eft arm had four nei y 2 cm, 3 cm by 2 c y 6 cm. Although t spirin and Prednisc nterventions to mini urther bruises.	and going up into the left wrist. The bruise neasured 11.6 cm by 10 cm. The report ndicated R21 bruised easily and was currently on spirin. R21 denied being hurt. 9/9/13, R21 had new bruises on both arms. The ght arm bruise measured 6 cm by 6 cm. The eft arm had four new bruises measuring 2.5 cm y 2 cm, 3 cm by 2 cm, 3 cm by 2 cm and 12 cm y 6 cm. Although the report indicated R21 took spirin and Prednisone, it did not include nterventions to minimize the potential risk for urther bruises.	and going up into the left wrist. The bruise neasured 11.6 cm by 10 cm. The report ndicated R21 bruised easily and was currently on spirin. R21 denied being hurt. 9/9/13, R21 had new bruises on both arms. The ght arm bruise measured 6 cm by 6 cm. The eft arm had four new bruises measuring 2.5 cm y 2 cm, 3 cm by 2 cm, 3 cm by 2 cm and 12 cm y 6 cm. Although the report indicated R21 took spirin and Prednisone, It did not include nterventions to minimize the potential risk for urther bruises.	and going up into the left wrist. The bruise neasured 11.6 cm by 10 cm. The report ndicated R21 bruised easily and was currently on spirin. R21 denied being hurt. 9/9/13, R21 had new bruises on both arms. The ght arm bruise measured 6 cm by 6 cm. The eft arm had four new bruises measuring 2.5 cm y 2 cm, 3 cm by 2 cm, 3 cm by 2 cm and 12 cm y 6 cm. Although the report indicated R21 took spirin and Prednisone, It did not include nterventions to minimize the potential risk for urther bruises.	and going up into the left wrist. The bruise neasured 11.6 cm by 10 cm. The report ndicated R21 bruised easily and was currently on spirin. R21 denied being hurt. 9/9/13, R21 had new bruises on both arms. The ght arm bruise measured 6 cm by 6 cm. The eft arm had four new bruises measuring 2.5 cm y 2 cm, 3 cm by 2 cm, 3 cm by 2 cm and 12 cm y 6 cm. Although the report indicated R21 took spirin and Prednisone, It did not include interventions to minimize the potential risk for

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION		(X3) DAT	E SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NOWIDER:	A. BUILDIN	G		000	ricitio
	•	245559	B. WING			09/	12/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,			
VIKING I	MANOR NURSING HO	ME		317 FIRST STREET NOI ULEN, MN 56585	THWEST		÷
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECT TIVE ACTION SHOU CED TO THE APPRC EFICIENCY)	DBE	(X6) COMPLETIO DATE
F 309	Continued From pa	de 22	F 30	9		7 e	
		ight arm measuring 0.5 cm by			30		
1	R21's incident repor 9/12/13, did not incl the risk of bruising,	rts dated 8/10/13 through ude interventions to minimize or skin tears.				ł	
	7/17/13, identified R impairment and requ	um Data Set (MDS) dated 21 with severe cognitive ulring extensive assistance daily living. The MDS did not s with R21's skin.					
	R21's plan of care d any interventions to	ated 5/1/13, did not indicate minimize the risk for bruising.					
	administration aide (out an incident report new open area on the bruised easily and a laboratory staff placi draw blood. TMA-A	a.m. the trained medication (TMA)-A was observed filling rt. TMA-A stated R21 had a ne elbow. TMA-A stated R21 lso bruised from the ng tourniquets on the arms to stated R21 was to wear long act the arms from bruising.					
	(RN)-C stated had ta physician about the i stated residents curr aspirin bruise easier aspirin on hold. RN- assist R21 with care had made attempts to bruising by asking R clothes but had not a RN-C reviewed and did not include R21's	a.m. registered nurse alked to R21's primary frequent bruising. RN-C rently taking Prednisone and so the MD placed R21's C stated two staff were to s. RN-C stated the facility to decrease the risk of 21's family to bring in bigger asked for long sleeve shirts. confirmed the plan of care is frequent bruising or mize the risk for further			/4 18 ^{- 8} 1		

CENTE		AND HUMAN SERVICES	(X2) MULTIP	O PLE CONSTRUCTION	FORM APPROV MB NO. 0938-03 (X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		9	COMPLETED
	•	245559	B. WING		09/12/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
VIKING	MANOR NURSING HO	DME		317 FIRST STREET NORTHWEST ULEN, MN 56585	
(X4) ID Prefix Tag	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETI
F 309	Continued From pa	age 23	F 309		
	directed the staff to complete an incider prone to bruising th Coumadin (used to strokes, and blood ASA [Aspirin] or Pre medication) will be	ruises Policy dated 8/11/10, document new bruises and nt report. "Residents that are at are wanderers, on prevent heart attacks, clots in veins and arteries), ednisone (anti-inflammatory care planned for." 2 p.m. the director of nursing			
F 310 SS=G	(DON) reviewed R2 facility had not iden alternative intervent further bruising and care planned.	11's record and confirmed the tified or consistently attempted tions to minimize R21's risk for the concern had not been DO NOT DECLINE UNLESS	F 310	R25 received a comprehensiv assessment on 9/17/13. An or	
84 -	resident, the facility abilities in activities unless circumstance condition demonstra unavoidable. This in to bathe, dress, and ambulate; toilet; eat	rehensive assessment of a must ensure that a resident's of daily living do not diminish es of the individual's clinical ate that diminution was ncludes the resident's ability I groom; transfer and ; and use speech, language, ommunication systems.		for PT evaluation and treatme was obtained on 9/17/13. R25 plan of care has been updated to include current ambulation ability and recommendations from PT evaluation. R25 is offered ambulation and ROM	i's d
	by: Based on observati review, the facility fa services to prevent I residents (R25) who with ambulation. R2	IT is not met as evidenced on, interview and document iled to provide ambulation oss of function for 1 of 6 required physical assistance 5 was not provided outation, and was not		times weekly. The nursing reh flow sheets have been altered to include room for documenta of number of repetitions for RC and number of feet ambulated as well as a space for documentation of refusal or oth	ation DM ,

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Facility ID: 00075

If continuation sheet Page 24 of 78

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A, BUILDIN	PLE CONSTRUCTION (X3)	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		245559	B, WING		09/12/2013	
	Provider or supplier Manor Nursing Ho			STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585	0011212010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFIGIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETIO DATE	
F 310	the staff had been in lift for transfer. NA- anxious when ambu participating. NA-A unable to participate directed, they would registered nurse (RI times a month, resid their restorative pro- assigned to complet would be reassigned nursing assistant du NA-B stated if the re- rehabilitation service would be blank. The most current Oc Discharge Summary resident had refused ability and OT was d R25 was being trans assistance of one st ambulate to In her ro On 9/11/13, at 6:55 a sitting on the toilet re cares from NA-A. R standing mechanical completed. R25 was bathroom and positio standing lift. R25's le during the transfer. On 9/11/13, at 11:18 stated R25 had not b	nstructed to use the standing A stated R25 became very ilating and was no longer stated if a resident was a in the restorative program as report the concern to the N). NA-B explained several dents were not able to receive grams because the NA te the restorative program d to assist with general ties (direct resident care). esident did not receive as, the documentation sheets coupational Therapy (OT) d dated 4/16/13, indicated the therapy services for transfer iscontinued. At that time, offerred with minimal aff and she was able to	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 audi to ensure revisions are occurring a 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.		

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

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2 CONSTRUCTION	(3) DATE SURVEY COMPLETED
	£	245559	B. WING		09/12/2013
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 66585	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETI TE DATE
F 310	resident's decline in actual harm. Findings include: R25's diagnoses ind and cognitive Impair Minimum Data Set (identified R25 with r Impairment and as r of one staff to ambu 8/14/13, identified R impairment and as r of two staff to ambu living Care Area Ass 8/18/13, identified R ambulate in her roor wheelchair. The ass identify how often or ambulate, nor did it implementation of th The plan of care dat being able to ambula walker in room and th hallway. It indicated to ambulate but was services 3-5 times p did not direct the sta ambulate. The plan of care was directed the staff to th lift when R25 express However, there was condition indicating the On 9/10/13, at 2:40 p	decline in ambulation. The ability to ambulate resulted in cluded anxiety, depression, ment. The quarterly (MDS) dated 5/29/13,	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 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 physiciar All resident plans of care will be reviewed at quarterly care conferences and updated with any changes each care conferent and more frequently if needed.	'S 1.

STATEMEN AND PLAN (FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DA CO	TE SURVEY MPLETED	
		245559	B. WING		09	/12/2013	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X6) COMPLETIO DATE	
F 310	walked half the len 75 feet) In the past staff were unable to standing lift. NA-A participate in the re she may refuse or t	age 26 gth of the hallway (greater than , but due to the increased pain, o walk R25 and used the stated R25 did not consistently storative program because the facility may not have a esignated to restorative	F 310	•	16		
	nurse (RN)-C assis positioning. R25 us was able to ambula assistance of both the right hip and the	0 p.m. NA-D and registered ted R25 into a standing sed a four wheeled walker and te six feet with extensive staff. R25 stated had pain in e left knee when ambulating. , "I just can not walk like I					
	ambulate R25 with 100-150 feet as tole not direct staff how	neet directed the staff to a four wheeled walker erated. The rehab sheet did frequently R25 received he sheet indicate how far R25		8. 10. 11.			
	following Information -9/1/13 through 9/11 refused to ambulate -August 2013, R25 the documentation of	ambulated seven times, but did not Indicate how far. bulated 14 times, but the		* *			
	to attempt to transfe only to use the stand weak. RN-C stated	a.m. RN-C stated staff were r R25 with a walker and were ding lift if the resident was had reviewed R25 during the erlod in August 2013, and				÷ 	

TATEMENT OF DI ND PLAN OF COP		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONS	TRUCTION			(X3) DATE SURVEY COMPLETED	
		245559	B, WING				•	09	/12/2013
	er or supplier R NURSING HO		STREET ADDRESS, CITY, STATE, ZIP CO 317 FIRST STREET NORTHWEST ULEN, MN 56585						
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORR	ECTIVE ACT ENCED TO T DEFICIENC	ION SHOUL	D BE	(X5) COMPLETIO DATE
R25 time nurs amb repo RN relat cont phys care amb On 9 (DOI with RN-C build the r curre staff, posit starte and a half t feet), not b imple in Jul R25 were On 9, facilit and v perfo comp	RN-C stated ing assistants ulate. When as rts, RN-C state Stated was n ed to R25, and acted nor had ical therapy. F did not clearly ulate R25. /11/13, at 12:0) stated the n restorative wer or RN-A depond ing the residen setorative nurs ntly being mor The DON exp on and it had her ed working at the that time R20 n e length of the The DON con sen evaluated mentation of the y of 2013, but vas weak. The routinely utilizing () was experient then this occurs mentative occurs () was experient then this occurs	ansfer with the walker at the received oral reports from the when a resident did not sked what was done with those ed, "I have not been trained." ot aware of any new concerns the physician was not R25 been re-evaluated by RN-C confirmed the plan of direct staff how far to 5 p.m. the director of nursing ursing assistants who worked to report any changes to ending on which part of the its resided. The DON stated ing documentation was not bitored by any of the nursing clained she was new in the been missed. The DON he facility in March of 2013, 5 had the ability to ambulate e hallway (approximately 75 firmed since then, R25 had by physical therapy. The he standing lift had occurred it was to be used only when e DON was unaware staff ing the standing lift.	F 3	10					

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245559	B, WING		09/12/2013
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585	ula de destalación Vita
(X4) ID PREFIX ȚAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO
F 310	8/7/13, directed stat services three to fiv residents who requi also explained the p develop the goals for and the goals were	ge 28 if to perform rehabilitative e times a week for those red such services. The policy hysical therapist was to or rehabilitative nursing cares to be reinforced by the storative nursing assistants).	F 310	3	
	aware of the lack of services and stated why the concern wa committee. In additional aware of the inconsil rehab services. On 9/12/13, at 1:55 was aware of the lac rehab services and w	p.m. RN-A confirmed was implementation of rehab did not have an answer as to s not brought forth to the QA on, RN-A stated all staff were stent implementation of the o.m. the administrator stated k of implementation of the rerified it was due to		1	
F 311 / SS=D /	IMPROVE/MAINTAI	MENT/SERVICES TO	F 311	R29 was admitted to the hosp on 9/11/13 and deceased on 9/23/13 with no return to Vikin Manor Nursing Home. R43's care plan has been	
	by: Based on observation review, the facility fai	Γ is not met as evidenced on, Interview, and document led to provide assistance of 6 residents (R29, R43) or ambulation.		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	

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	X3) DATE	SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	09/12/2013	
	245559	B. WING			
NAME OF PROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP CODE		
VIKING MANOR NURSING H	OME		317 FIRST STREET NORTHWEST ULEN, MN 56585		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEF(CIENCY)	DBE	(X5) COMPLETIO DATE
according to the p included dementia disease. On 9/10/13, at 2:0 Nustep (exercise r therapy room by n was not able to ke and physical thera NA-B to assist R29 On 9/10/13, at 3:40 not able to ambula past. NA-B stated participate in the re would report the co (RN). NA-B expla residents did not re programs because the restorative prog with general nursin resident care). NA receive rehabilitatio sheets would be bi On 9/11/13, at 8:50 morning cares. At into a sitting positio was not able to hol bed. NA-A held R2 aide (TMA)-A enter transfer. A transfer was placed in front	e assistance with ambulation lan of care. R29's diagnoses , depression and Parkinson's 0 p.m. R29 was assisted onto a machine) in the restorative ursing assistant (NA)-B. R29 ep balanced during the transfer py assistant (PTA)-A joined 0 onto the machine. 0 p.m. NA-B stated R29 was te as well as she had in the if a resident was unable to estorative program as directed, oncern to the registered nurse ined several times a month, eceive their restorative the NA assigned to complete gram was reassigned to assist g assistant duties (direct -B stated if the resident did not on services, the documentation	F 311	receiving ambulation/nursing	r ated y lent e and d ent n/ ave to 3 and ing has to ed for a es ing	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: M8T711

Facility ID: 00075

If continuation sheet Page 30 of 78

		& MEDICAID SERVICES	1		OMB NO	APPROVE 0938-03	
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ASS/1 75	G	(X3) DAT CON	E SURVEY	
		245559	B, WING			09/12/2013	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
VIKING I	MANOR NURSING HC	DME		317 FIRST STREET NORTHWEST ULEN, MN 56585	*	9	
(X4) ID Prefix TAg	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETIO DATE	
F 311	Continued From pa	ge 30	F 311	classes and will also be trained			
		a.m. NA-A stated R29 usually		to rehab upon completion of			
		pain with cares or transfers. ad to be something wrong		CNA classes. One additiona	방상은 방법을 위하는 것		
		ted in the past R29 had the	147	(registered resident assistar			
2	ability to ambulate from the bed to the bathroom several times a day, but she had not been able to			has also been trained to nur			
do that for a couple of mon			rehab and will be scheduled	1-2			
	recall the last time F	R29 had the ability to ambulate		days biweekly. All residents	will		
	in her room.			receive annual PT screening	is and		
	The quarterly Minim	um Data Set (MDS) dated		more frequently if needed an	nd		
1	7/11/13, Indicated R	29 had severe cognitive		care plans will be updated/re	evised		
		quired extensive assistance ne room but did not ambulate		with recommendations. All s	taff		
	in the hallway.			will complete education of ne	ew		
· [The activities of dell	silv living Care Area		nursing rehab staffing by			
		of daily living Care Area (CAA) dated 4/10/13, indicated R29		10/30/13 plus an educationa	I		
	required extensive a	ssistance with ambulation.		in-service "Restorative Care	/	1.04	
		R29 was not able to ambulate ack and forth to the bathroom		ROM" was assigned to all			
		sessment directed the staff		nursing staff to complete in t	he		
		ipated in ambulation to		month of October so that in			
	prevent a decline.			the absence of a rehab aide	on		
	The plan of care dat	ed 6/6/12, directed the staff		the schedule other staff are			
		nbulation using a walker and holers. The plan of care also		knowledgeable to nursing			
		red nursing rehabilitation		rehab program and can			
	services.			perform assigned exercises.	1		
	The Rehab Flow she	eets directed the staff to		The physical therapy			
		eets did not direct the staff as		department will also be hosti	ng		
		es were to be used while ny staff members were to		an educational in-service for	5		
	assist, how far the re	sident was to ambulate or		staff 10/30/13 focused on RC	M		
		ch the services were to be		and transferring. RNs for bot			
	provided.			wings and/or DON will be			

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245559 B. WING 09/12/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST VIKING MANOR NURSING HOME **ULEN, MN 56585** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION ID PREFIX (X5) COMPLETION (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) auditing nursing rehab flow F 311 F 311 Continued From page 31 sheets weekly. All audit findings Review of the Rehab Flow Sheets revealed thefollowing information related to ambulation for will be presented to the QA R29. committee and the QA committee -9/1/13 through 9/11/13, R29 had not ambulated. -August 2013, R29 had ambulated four times, but will determine how long to continue there was no indication of how far. 10/30/13 audits. -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 galtbelt 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. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: M6T711 Facility ID: 00075 If continuation sheet Page 32 of 78

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/01/2013

FORM APPROVED

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A, BUILDING	CONSTRUCTION	(X3) DAT COM	TE SURVEY
		245559	B. WING		09	12/2013
	PROVIDER OR SUPPLIEF			REET ADDRESS, CITY, STATE, ZIP CODE 7 FIRST STREET NORTHWEST		
VIKING	MANOR NURSING H	OME		_EN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPI DEFIGIENCY)	OULD BE	(X6) COMPLETIO DATE
F 311	RN-C confirmed the that time had not be the therapy notes a received therapy s ambulation but a for goals related to an record. RN-C state the nursing assisted ambulate. When a reports, RN-C state RN-C confirmed the direct the staff on the distance she was to On 9/11/13, at 12:00	the distance R29 ambulated at been identified. RN-C reviewed and confirmed R29 had ervices in 9/2012, for formal discharge program and abulation were not in the direceived oral reports from ants when a resident did not sked what was done with those ed, "I have not been trained." e plan of care did not clearly now to ambulate R29 or the o ambulate. 0 p.m. NA-D stated R29 had	F 311		1. 1. 1.	
	from the bathroom. been able to walk " participate in the pa working as the rest ambulated in the pa	o three times a week to and NA-D stated R29 had not for a long time" and refused to ast month. NA-D stated while orative NA, R29 had not ast month. If NA-D had ns with R29, she would report		ž.	a P	
	(DON) stated the n with restorative wer RN-C or RN-A dependent building residents nor restorative nursing currently being mor staff. The DON exp position and it had be R29 still had the ab knowledge but conf assigned to perform	5 p.m. the director of nursing ursing assistants who worked e to report any changes to anding on which part of the esided. DON stated the documentation was not litored by any of the nursing plained was new in her been missed. DON stated lity to ambulate to her irmed the nursing assistant n restorative nursing services signed to complete general				ул 1.#

	(EACH DEFICIENC)	245559 DME ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		STREET ADDRESS, CITY, STATE 317 FIRST STREET NORTHW ULEN, MN 56585 PROVIDER'S PLAN C (EACH CORRECTIVE A	, ZIP CODE EST DF CORRECTION	12/2013
/IKING (X4) ID PREFIX TAG	MANOR NURSING HC SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	TEMENT OF DEFICIENCIES	ID PREFIX	317 FIRST STREET NORTHW ULEN, MN 56585 PROVIDER'S PLAN C (EACH CORRECTIVE A	, ZIP CODE EST DF CORRECTION	
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	TEMENT OF DEFICIENCIES	ID PREFIX	ULEN, MN 56585 PROVIDER'S PLAN C (EACH CORRECTIVE A	OF CORRECTION	
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE A		
F 311	Continued From pa			CROSS-REFERENCED TO DEFICIEI	O THE APPROPRIATE	(X5) COMPLETIO DATE
		ge 33	F 311	[
		× 3				
	R43 did not receive	assistance with ambulation.				
	osteoarthrosis, and annual MDS dated (severely cognitively	which included dementia, lumbosacral spondylosis. An 5/25/13, identified R43 was impalred and required m staff for mobility, transfers, y living (ADL's).			ан 11	
	Mobility with an Inter assist of 1-2 using a encourage ambulati- included a focus are for staff to encourag which would promot activity. The plan of	ncluded a focus area of rvention to ambulate with gait belt and walker, and to on. The plan of care also a of Falls with an intervention e participation in activities e exercise and physical care did not indicate R43 nursing program (RNP).	th.			74
		et. Staff provided				
	2/4/13 included a Dis continue ambulation and to encourage/as addition, a Physical 1 dated 10/26/12 include	Discharge Summary dated scharge Recommendation to program with nursing staff sist with ambulation. In Therapy Discharge Summary ded a Discharge RNP with close supervision.		ž "		

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	a state of the second state of the	E CONSTRUCTION		TE SURVEY
	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING			WFLETED
		245559	B. WING		09	/12/2013
	PROVIDER OR SUPPLIER	ME	31	TREET ADDRESS, CITY, STATE I7 FIRST STREET NORTHW LEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X6) COMPLETIC DATE
F 311		habilitation, with direction to n flow sheet for details of	F 311	5 8 - 2		
	8/1/13 to 9/11/13, re by nursing staff one	ng Rehab Flowsheets from ovealed R43 was ambulated time in the month of at times in the month of was included.		47 41	E	
	revealed R43's spot complaints regardin	onference note dated 7/9/13, use and daughter had g him not being walked d requested staff ambulate ut the day."				
	stated R43 was som feet in the hallway b walked because the	9/10/13, at 2:14 p.m., NA-B letimes able to walk up to 100 ut she stated, "he doesn't get restorative aide is pulled to le to being short staffed.		·		
	explained she knew R43 with walking in t	9/11/13, at 12:33 p.m., NA-F she was supposed to assist the hallway on a daily basis king does not always get on't have time."				
	confirmed R43 was of program for ambulat not have time to con ambulation. RN-A st	9/11/13, at 1:00 p.m., RN-A on a restorative nursing lon but she stated staff did sistently assist R43 with ated she was not aware of to oversee the RNP.				
	DON confirmed staff	0/12/13, at 11:00 a.m., the ing was a problem and she aff did not always have time s routinely.				

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		AND HUMAN SERVICES			INTED: 11/01/2013 FORM APPROVED IB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	X3) DATE SURVEY COMPLETED
	19 4 (245559	B. WING		09/12/2013
	PROVIDER OR SUPPLIER	, ME		STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585	7
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 311	Continued From pa	ge 35	F 311		
SS=E	8/7/13, directed the services three to fiv residents who requi- also explained the p develop the goals for and the goals were therapy services (re- 483.25(e)(2) INCRE IN RANGE OF MO Based on the comp resident, the facility with a limited range appropriate treatme	rehensive assessment of a must ensure that a resident of motion receives nt and services to increase l/or to prevent further	F 318	R29 was hospitalized on 9/11/1 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	2
с	by: Based on observative review, the facility far motion services to p range of motion (RC R29, R23 R27, R34 physical limitations.	IT is not met as evidenced on, interview, and document illed to provide range of revent further decrease in DM) for 8 of 8 residents (R25, R13, R22, R26) who had		R13, R22, R26 and all other residents are receiving services as per plan of care, Viking Man Nursing Home has implemente staff schedule changes. One activity aide was trained to nursing rehab and is scheduled	or d
	did not receive cons services to maintain	vith physical limitations had istent restorative nursing or prevent further decreased ses included anxiety, nitive impairment.		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	

FORM CMS-2667(02-99) Previous Versions Obsolete

Event ID: M6T711

Facility ID: 00076

If continuation sheet Page 36 of 78

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TATEMEN	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4.94 EX		X3) DATE SURVEY COMPLETED
		245559	B. WING		09/12/2013
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	3	STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST JLEN, MN 56585 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) E COMPLETIO
	restorative therapy. On 9/11/13, at 12:20 assisted R25 into a used a four wheeled ambulate six feet wi both staff. R25 stat and the left knee wh just can not walk like The annual Minimur 8/14/13, identified R impairment and requ with all activities of of Care Area Assessm not identify R25's fui range of motion. The plan of care dat having limitation in n to ambulate R25 thre plan of care did not I range of motion prog The Rehab Flow She provide R25 with low supine (in bed on ba and ad adduction exi away from the center ankle pumps, knee s of 10). Review of the dentified the followin September 1-11, 201 blank August 2013, the docur	D a.m. NA-D and RN-C standing positioning. R25 d walker and was able to th extensive assistance of ed had pain in the right hip ien ambulated. R25 stated, "I e I used to." In Data Set (MDS) dated 25 with severe cognitive uired extensive assistance taily living (ADLs). The ADL ent (CAA) dated 8/18/13, did inctional ability related to ed 7/6/12, identified R25 as nobility, and directed the staff set o five times a week. The include directions related to a gram. Sets directed the staff to er extremity exercises in a ck) position for abduction ercises (moving the legs of the body) and heel slide, queezes and SAQ's (2 sets a Rehab Flow Sheets	F 318	to nursing rehab program and can perform assigned exercises The physical therapy department will also be hosting an education 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 be to continue audits.	ent onal ing. N

PRINTED: 11/01/2013 FORM APPROVED OMB NO. 0938-0391

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

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	E Bures	IPLE CONSTRUCTION	(X3) DA CO	TE SURVEY MPLETED
•		245559	B. WING			/12/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
8	On 9/10/13, at 2:40 stated R25 occasion with the restorative p resident was unable restorative program the concern to the re explained several tir were not able to rec- programs because t the restorative progr reassigned to assist (direct resident care did not receive rehal documention sheets The most current Oc Discharge Summary R25 refused therapy discontinued. The C 4/12/13, indicated R2 transfers. The thera upper body ROM. On 9/11/13, at 6:55 a sitting on the tollet re cares from NA-A. R2 standing mechanical completed. R25 was bathroom and position standing lift. R25 was standing lift with both release the lift when a fully extended while in stated R25 had not c cares. NA-A had not ability to complete RC not consistently partic program because wo	p.m. nursing assistant (NA)-B hally refused to participate program. NA-B stated if a a to participate in the as directed, they would report egistered nurse (RN). NA-B mes a month, the residents elve their restorative he NA assigned to complete am would need to be with general NA duties). NA-B stated if a resident oillitation services, the would be blank. ecupational Therapy (OT) dated 4/16/13, indicated and thus services had been VT daily treatment note dated 25 had been evaluated for pist had not addressed R25's a.m. R25 was observed celving assistance with 25 was connected to a	F 31	Monday-Friday. One additi activity aide is enrolled in Certified Nursing Assistant (CNA) classes and will also trained to rehab upon completion of CNA classes One additional RRA (regist resident assistant) has also been trained to nursing reh and will be scheduled 1-2 of biweekly. Care plans will be reviewed for all residents receiving ROM to determine if a PT evaluation is needed and order will be obtained f the physician. All residents receive annual PT screenin and more frequently if need and care plans will be upda revised with recommendatio All staff will complete educa of new nursing rehab staffin 10/30/13 plus an educationa in-service "Restorative Care was assigned to all nursing to complete in the month of October so that in the abser of a rehab aide on the sched other staff are knowledgeab	o be ered ab lays e d rom will gs ed ted/ ons. tion g by al o/ROM" staff	

FTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X): DENTIFICATION NUMBER: DENTIFICATION NUMBER: 245559 (X): DENTIFICATION NUMBER: 255559 (X): DENTIFICATION NUMBER: 255559 (X): DENTIFICATION NUMBER: 2555550 (X): DENTIFICATION NUMBER: 2555550			AND HUMAN SERVICES			FORM	: 11/01/201 APPROVE . 0938-039
NAME OF PROWDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE VIKING MANOR NURSING HOME STREET ADDRESS, CITY, STATE, 2P CODE 040 ID SUMMARY STATEMENT OF DEFICIENCIES 040 ID SUMMARY STATEMENT OF DEFICIENCIES 1700 F318 Continued From page 38 PROVIDERS PLAN OF CORRECTION extremities according to the relab 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 had not been made aware of any new concerns related to R25, RN-C concerns related to R25, RN-C confirmed the pen of care did not clearly firered staff regarding the lower extremity range of motion program. On 9/11/13, at 12:05 p.m. the director of nursing (DO) 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 staff. The DON stated the restorative nursing staff. The DON stated the restorative nursing staff. The DON stated the restorative nursing was reassigned to complete personal cares. The DON stated the facility had been experiencing nursing staff. The DON stated the restorative nursing was reassigned to complete personal cares. The DON stated the restorative nursing was reassigned to complete personal cares. The DON stated the restorative nursing was reassigned to complete personal cares. The DON stated the restorative nursing services. On 9/10/13, at 3:00 p.m. NA-B explained several times a moth residents restorative nursing services. On 9/10/13, at 3:00 p.m. NA-B explained several times a moth residents id not receive their restorative progr						(X3) DAT CON	e survey Ipleted
VIKING MANOR NURSING HOME 317 FIRST STREET NORTHWEST ULEN, MN 56585 (M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ORDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION (EACH	*		245559	5 C-1	· ·	09/	12/2013
VIKING MANOR NURSING HOME ULEN, MN 56585 (%1) D TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BERECEDED BY FULL REDULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S FLAN OF CORRECTION (EACH DEFICIENCY MUST BE RECEDED BY FULL REDULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S FLAN OF CORRECTION (EACH DEFICIENCY) ID DEFICIENCY (EACH DEFICIENCY) F 318 Continued From page 38 extremilies according to the rehab flow sheets. RN-C stated had reviewed R26 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 dict 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 lifect 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 in period any or the nursing staff. The DON stated was new in her position and it had been mised. At 12:10 p.m. the DON confirmed the facility had been experiencing nursing staff shortages and when it occurred the alde assigned to perform restorative nursing was reassigned to complete period 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	NAME OF	PROVIDER OR SUPPLIER					
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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 regarcling 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 nurse to report any changes to RN-C ourrently 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 di don treeview their restorative purgrams because the NA assigned to	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X6) COMPLETION DATE
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 were iso 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	F 318	extremities accordin RN-C stated had re assessment period unaware R25 was n exercises. RN-C st from the NAs when	ng to the rehab flow sheets. viewed R25 during the MDS in August 2013, and was ot receiving range of motion ated received oral reports a resident did not participate	F 318			
(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		done with the report been trained." RN-0 aware of any new co confirmed the plan o staff regarding the lo	s RN-C stated, "I have not C stated had not been made oncerns related to R25, RN-C of care did not clearly direct				
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		(DON) stated the N/ restorative were to r or RN-A depending residents resided. T restorative nursing of currently being moni	As who worked with eport any changes to RN-C on which part of the building The DON stated the locumentation was not tored by any of the nursing				
Con 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		and it had been miss confirmed the facility nursing staff shortag aide assigned to per reassigned to compl DON stated the reas	sed. At 12:10 p.m. the DON had been experiencing es and when it occurred the form restorative nursing was ete personal cares. The signing of the restorative NA				1.0 40- 3.003
times a month residents did not receive their restorative programs because the NA assigned to		R29 Identified with p received consistent r	hysical limitations had not estorative nursing services.				17
reassigned to assist with general NA duties		times a month reside restorative programs complete the restora	nts did not receive their because the NA assigned to tive program would be		2 .		

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		AND HUMAN SERVICES					FORM): 11/01/20 1 APPROVI . 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		(X3) DAT COM	TE SURVEY APLETED
		245559	B. WING				09/	12/2013
NAME OF	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE,		1999 to -97	
VIKING	ANOR NURSING HO	ME		1229.1	FIRST STREET NORTHWI	287		
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	did not receive reha documention sheet stated if a resident the restorative prog the concern to the n On 9/11/13, at 8:50 morning cares. R29 hands, and moved k pain. NA-A moved I R29 winced with pai assisted R29 into a the bed. R29 was n while sitting on the b as TMA-A entered th transfer. A transfer was placed in front of the walker as the tw R29 oried out as she extensive assistance wheelchair. Once in R29 to donn a shirt. when arms were mo An interview conduc NA-A stated R29 ust with cares or transfe be something wrong R29's diagnoses incl and Parkinson's dise The quarterly MDS d with severe cognitive extensive assistance the dated 4/10/13, indica assistance with all Al with general "physica	 a). NA-B stated if a resident is would be blank. NA-B was unable to participate in ram as directed, she report egistered nurse (RN). a.m. NA-A assisted R29 with 9 was able to open both both arms with complaints of R29's legs to donn pants and in. At 9:00 a.m. NA-A sitting position on the edge of ot able to hold herself up bed. NA-A held R29 steady he room to assist with the belt was applied and a walker of R29. R29 did not reach for o staff assisted her to stand. a stood, took two steps with a of the two staff and sat in a in the chair, NA-A assisted R29 made facial grimaces wed. ted on 9/11/13, at 9:20 a.m. ually did not complain of pain rs. NA-A stated there had to with R29. buded dementia, depression 	FS	318				

		AND HUMAN SERVICES				M APPROVE D. 0938-039
TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION		ATE SURVEY
		245559	B. WING		0	9/12/2013
NAME OF	PROVIDER OR SUPPLIER	, a 110,000		REET ADDRESS, CITY, STATE, ZIP CODE		
VIKING I	MANOR NURSING HO	ME		7 FIRST STREET NORTHWEST LEN, MN 56585		
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F 318	The CAA did not ex limitations. The CA	ge 40 plain the exact area R29 had A directed staff to ensure R29 peutic exercise to prevent a	F 318	3		E
	participated in resto	ted 6/6/12, indicated R29 rative nursing but it did not vas able to do or how staff torative nursing.		2. 12		
	provide a "Nu-Step, pegs or arch)" and g exercises to choose theraband exercise, over the head, side pulleys or arm bike." did not direct the sta	a two pound wand exercise to side, chest in and out, ' The restorative flow sheets iff as to the frequency the		at de la constante de la consta En constante de la constante de En constante de la constante de		
	exercises were prov Flow Sheets reveale -September 1-11. 20 Nu step on two occa once. -August 2013, R29 h five occasions and h twice. -July 2013, R29 had	rmed or the length of time the ided. Review of the Rehab ad the following information: 013, R29 had completed the asion, and the pulleys one had completed the Nu-step on had completed the pulleys competed the Nu-Step 12 ed with the pulleys six times.		* (*) *	Ĩ	
•	The Restorative Car the occupational the the staff to allow R29 theraband exercise, including over the he in and out, over the he while seated. R29 w	e Program dated 9/7/12, by rapy assistant (OTA) directed 9 to choose between the red a two pound wand exercise ad, sided to side and chest head pulleys and an arm bike vas to perform the exercise nd repeated it three times for		•• • •		t) t:

	f of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		TE SURVEY	
	245559		B. WING		09	09/12/2013	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
VIKING	MANOR NURSING H	OME		17 FIRST STREET NORTHWEST			
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	Discharge Summa evaluated by theral shoulder pain. R29 previously establish Review of the Nurs lacked documentat participate in the re The Interdisciplinar "Has nursing rehab The clinical record to how R29 tolerate participated with the On 9/11/13, at 11:50 family was contacte pain during morning usually did not have RN-C explained R2 restorative program frequency. RN-C re sheets and confirm being offered restor confirmed the clinic comprehensive revi RN-C stated had re nursing assistants v	age 41 contained a Physical Therapy ry dated 3/1/13, R29 was py due to complaints of 9 was to continue with the hed restorative program. tes Notes from 1/1/13- 9/11/13, tion related to R29's ability to estorative program ry Note dated 4/17/13, read 0 3-5 x (times) per week." lacked documentation related do or the frequency R29 e restorative program. 0 a.m. RN-C stated R29's ed regarding complaints of g cares, RN-C stated R29 e complaints during cares. 29 was to work with the but was not sure of the eviewed the restorative flow ed R29 was not consistently rative therapy. RN-C al record was lacking a lew of the restorative program. ceived oral reports from the when a resident did not program. When asked what	F 318				
•	have not been train of care did not clear the exercise progra On 9/11/13, at 12:00	e reports, RN-C stated, "I ed." RN-C confirmed the plan ly direct the staff regarding m. 0 p.m. NA-D stated if had hs with R29 would report to			đ		

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES		, 	OMB NO.	
ND PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245559	B. WING		09/1	12/2013
NAME OF	PROVIDER OR SUPPLIER		192	TREET ADDRESS, CITY, STATE, ZIP CODE		
VIKING	MANOR NURSING HO	DME	1	I7 FIRST STREET NORTHWEST LEN, MN 56685	,	
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F 318	Continued From pa RN-C.	ge 42 .	F 318			
	NAs who worked w any changes to RN which part of the bu DON stated the res documentation was by any of the nursin was new to her pos The DON also state declines in range of confirmed the nursi perform restorative frequently reassigne nursing cares.	5 p.m. the DON stated the ith restorative were to report -C or RN-A depending on hilding a resident resided. The torative nursing not currently being monitored g staff. The DON stated she lition and it had been missed. ad R29 had not sustained motion to her knowledge but ng assistant assigned to nursing services was ad to complete general a.m. RN-C reported R29 was a 9/11/12, and had been spital for an acute illness.				
	R23 did not receive therapy.	ROM as directed by physical		940 940 940		24
	Disease, hypertensi A quarterly MDS dat was severely cognit	which included Alzheimer's on, and depressive disorder. ted 8/27/13, revealed R23 lvely impaired and required n staff for mobility, transfers,	-	а э		
	NA-F provided morr consisted of dressin transferring R23 to a	on on 9/11/13, at 6:55 a.m., hing cares for R23, which g, toileting, peri-care, and and from the toilet, and to her is able to participate by the		Ŧ		*

CENTE		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE C		FORMA	11/01/2013 PPROVED 0938-039 SURVEY
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD		COMPLETED			
		245559	B. WING	·		09/1	2/2013
NAME OF PROVIDER OR SUPPLIER VIKING MANOR NURSING HOME				317 F	ET ADDRESS, CITY, STATE, ZIP CODE IRST STREET NORTHWEST N, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) COMPLETION DATE
F 318	and a second	ge 43 en given direction from NA-F,	F३	318			
t2	first by using her lef on the bedside while and turning R23's b side of the bed. R2	t elbow to slowly sit herself up e NA-F assisted by gulding ody to a sitting position on the 3 hung on around NA-F's arm, as directed by NA-F.	÷				
	R23 straightened he shirt sleeves, with th each step was expla continued to provide cueing. NA-F then of grab bars of the me grab bars. R23 then toward the handles, hands. Upon comin continued to direct F both hands and to k	ar arms one at a time into her he shirt being guided by NA-F, ained by NA-F while she encouragement and verbal directed R23 to grab onto the chanical lift and pointed to the reached with both hands lightly grasping with both g to a standing position, NA-F 23 to keep hanging on with eep both feet on the foot rest lowed directions well.			بر (ه) پ		
	with several interver assist for transfers,	ncluded a focus of Mobility itions which included two staff as resident was no longer he plan of care did not	2.				÷
	10/26/12 revealed D "RNP (restorative nu supervision." A Res dated 2/8/13 from a the following: Approa catch with ball, pegs pulleys, incline board	Discharge note dated lischarge Recommendations: trising program) with close torative Care Program form Physical Therapist included ach/Recommendations: play and foam board, overhead d, arm bike, and knee unds, three sets of 10 each		3	्र 		
	provide ROM to all e	/ Sheet included direction to xtremities. The Flow Sheet ted ROM was provided for					

r dointy 10,00

OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 245559 09/12/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **317 FIRST STREET NORTHWEST** VIKING MANOR NURSING HOME **ULEN, MN 56585** PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 318 Continued From page 44 F 318 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 alde 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 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: M6T711 Facility ID: 00075 If continuation sheet Page 45 of 78

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/01/2013

FORM APPROVED

IDENTIFICATION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DA COI	TE SURVEY MPLETED
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		245559	B, WING			/12/2013
NAME OF I	PROVIDER OR SUPPLIER	÷		STREET ADDRESS, CITY, STATE, Z		
VIKING	MANOR NURSING HO	ME		JLEN, MN 56685		
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	was receiving a RN knew, the nursing s recommendations f who was responsibl RNP. During Interview on stated the restorativ help out on the floor She confirmed ROM provided for the resi lack of documentati monthly schedule for RN-A further stated responsible to overs During interview on DON confirmed staff confirmed the staff of provide ROM for R2 R27 did not receive physical therapy. R27 had diagnoses Disease, paralysis a failure (CHF). An an identified a complete also identified R27 m	ceiving.skilled services but P. He stated as far as he taff were following the therapy or ROM but he was unsure of e to manage or oversee the 9/11/13, at 11:20 a.m., RN-A re alde often gets pulled to r, due to being short staffed. A was not consistently being idents and she verified the on in R23's restorative or September and August. she was not sure who was see the restorative program. 9/12/13, at 11:00 a.m., the fing was a problem and she did not always have time to	F 318			
	was sitting in her wh station. She stated were laying in her la into her palms. She	on 9/11/13 at 7:12 a.m., R27 eelchair next to the nurses she had a bath. R27's arms p and her fingers were curled was able to slowly lift her ward the surveyor but not able				

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(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245559 B. WING 09/12/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **317 FIRST STREET NORTHWEST** VIKING MANOR NURSING HOME **ULEN, MN 56585** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 318 Continued From page 46 F 318 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

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

PRINTED: 11/01/2013 FORM APPROVED OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00076

If continuation sheet Page 47 of 78

TATEMENT OF DEFI ND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		245559	B, WING _		09	/12/2013
NAME OF PROVIDEN		ME		STREET ADDRESS, CITY, STATE, ZIP C 317 FIRST STREET NORTHWEST ULEN, MN 56585		
	CH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE
with as Rehab R27 re- month. reveale out of t for July nine da A quart indicate brace b decided the day During a.m. fai daily ba becaus exercis- this, F- walked approxi walking "they ha ROM is pulled fit During a stated s nursing have go her new fingers a staffing pulled fit	Illation Flow s ceived ROM The Rehabi d R27 received he month. T revealed R2 ys out of the erly care con ad discussion ut R27 and h for support. a family inter mily (F)-A stat e R27 would for support. a family inter mily (F)-A stat e R27 would for support. a family inter mily (F)-A stat e R27 was stated at all and have mately 3 mor R27 becaus twe a staffing not provided for therapy to he worked as assistant. N tten "a little ti pulleys to fit are very tight was a proble om restorative	In assist with ADL's, The Sheet for September revealed exercises one day out of the litation Flow Sheet for August red ROM exercises nine days he Rehabilitation Flow Sheet 7 received ROM exercises	F 31	8		
During i	nterview on 9	/11/13, at 8:04 a.m. NA-F				EP

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DAT CON	'E SURVEY IPLETED
		245559	B, WING					10040
NAME OF	PROVIDER OR SUPPLIE		0. 1110		REET ADDRESS, CITY, STAT	E, ZIP CODE	1 09/	12/2013
	MANOR NURSING H			. 317	FIRST STREET NORTHV EN, MN 56585			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED ' DEFICI	ACTION SHOUL	DBE	(X6) COMPLETIO DATE
F 318	Indicated R27 dld had rolls for her h supposed to wear are so tight we ca	age 48 not have braces for her feet but ands. NA-F stated, "She's [rolls in hands] all day but they n't open her hands." NA-F e's had a decline, her	F3	18	ik K	4		
	contracted physica R27 was not curre	w on 9/11/13, at 8:38 a.m. the al therapy assistant confirmed antly receiving PT or OT on a maintenance program with	ė		,			Q.
	stated she was ab head to remove he demonstrated she her arms up towar grasped a curler u thumb. Three fing in toward her palm	w on 9/11/13, at 9:57 a.m. R27 le to lift her arms up to her er curlers. She then could do this by slowly lifting d the top of her head and she sing her right pointer finger and ers on both hands were curled is. R27 further stated she had days, Wednesdays, and Fridays y room.	•		34 2 1	÷		
	stated she recently rehab twice weekly only working in the stated she was din R27, then assist w provide ROM to up NA-D further state to work on the floo	n 9/11/13, at 11:32 a.m. NA-D v started working in therapy v and prior to this week was rapy twice per month. NA-D ected to provide hand soaks for ith pulleys to both arms, and oper and lower extremities. d, "I am pulled from restorative r and lately it's happen a lot." en this happens, ROM does not			а Э			
1	RN-A pointed out li	/ on 9/11/13, at 1:12 p.m., n a nurse note dated 6/18/13, 13, which indicated discussion						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILI		(X3) DA	D. 0938-0391 TE SURVEY MPLETED		
		245559	B. WING	·		09	/12/2013
1001000000000	PROVIDER OR SUPPLIER	ME		31	REET ADDRESS, CITY, STATE, ZIP CODE 7 FIRST STREET.NORTHWEST LEN, MN 56585		5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 318	ambulate, discussio progression. A nurse indicated R27 did no and did not want foo because her feet ge During interview on DON confirmed staf	arding decline in ability to n of foot braces, and disease e note dated 7/27/13, ot want braces for her feet ot supports at bedtime t too warm. 9/12/13, at 11:00 a.m., the fing was a problem and she tid not always have time to	F	318			
	had not received cor services. R34 diagnoses inclu	/ith functional limitations and nsistent range of motion ded left hemispheric stroke, nentia. The guarterly MDS			94 285		
	dated 8/27/13, revea cognitive impairment assistance to total de Further, the MDS ide	led R34 with severe t and required extensive ependence with all ADLs. entified R34 did not walk and ge of motion to both upper					
	identified R34 as had ADL performance. H	f care dated 5/26/13, d limitations in mobility, and owever, the care plan lacked to therapeutic exercises or rogram.			ж. , Т		
	R34's family member had been fairly seder	progress note dated 2/26/13, r revealed and reported R34 ntary, the facility really has h him with respect to any					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DAT CON	TE SURVEY
		245559	B. WING		09	/12/2013
	PROVIDER OR SUPPLIER)ME	31	REET ADDRESS, CITY, STATE, ZIP 7 FIRST STREET NORTHWEST LEN, MN 56585	the second s	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
	Review of nursing r revealed a note dat rehab therapy for ra- standing table with Another note dated routinely received n further more a note received rehab nurs The Occupational T 7/1/13, indicated oc recommended to co restorative nursing positioning program ROM to participate included: Nu-step x occasional assist to does not go flat, two Nu-step, ROM to up pulleys, arm bike, m exercises 1) side to out, and standing ta The Physical Thera indicated physical th continue with restor goal for R34's resto maintain flexibility ai	notes from 7/10/13 to 9/4/13, ted 7/10/13; indicated R34 had ange of motion, and used assistance of the rehab aid. 8/6/13, indicated R34 iursing rehab services and dated 9/4/13, indicated R34 sing services Therapy Evaluation dated cupational therapy portinue range of motion with program, and continue in place. The goal for R34's was to maintain flexibility and in ADL's. The program 5-10 minutes, patient needs hold/stabilize right foot it oper and lower extremities, hassage right arm, wands side 2) over head 3) chest ble. py Evaluation dated 7/2/13, herapy recommended to ative nursing program. The rative program was to ind ROM to participate in included: Nu-step x 5-10	F 318			
	hold/stabilize right for person pivot transfe and lower extremities massage right arm,	eds occasional assist to bot it does not go flat, two r on Nu-step, ROM to upper es, pulleys, arm bike, wands exercises 1) side to chest out, and standing				

		AND HUMAN SERVICES		4		FORM	: 11/01/201: APPROVED , 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A, BUILE	TIPLE CONSTRUCT	ION	(X3) DA1	TE SURVEY
		245559	B. WING			09	12/2013
the states and its	PROVIDER OR SUPPLIER	, ME		State of the State	38, CITY, STATE, ZIP CODE EET NORTHWEST 585		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	PRO X (EACH	VIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
	assisting R34 to sit manually lifting R34 then assisted R34 to R34's arms and insi- sleeves of the shirt, button shirt up. At 9 assisted R34 into a to grab onto the har NA-G and NA-F ass onto the handle of th to a standing positions standing lift and NA- and applied a new in R34 was then transi and NA-F. During of assistance with ADL the standing lift hand NA-G and NA-F. The Rehab Flow Sh and maintain flexibil participate in ADL's minutes, patient nee- hold/stabilize right for person pivot transfer and lower extremitie	a.m. NA-G was observed up on edge of bed by to a sitting position. NA-F o put his shirt on by lifting up arting both arms into the and then NA-F proceeded to 05 a.m. NA-G and NA-F a standing lift. R34 was able idles of the standing lift after disted R34 by lifting his hands he standing lift. R34 was lifted ning with the use of a -G then performed peri cares, noontinent product for R34. Ferred to his recliner by NA-G oservation R34 provided no is, except to loosely hold onto dies and he was assisted by eet directed staff to provide ity and range of motion to included: Nu-step x 5-10 dos occasional assist to oot it does not go flat, two r on Nu-step, ROM to upper	F 3	118			
	table. Review of the Rehal following information For the month of Sej received services for	otember 1st-11th, 2013, R34 • only one day during the	-			e M	
	2013, R34 received	nonth of August 1st-31st, services for six days during ermore the month of July bosolete Event ID:M8T711		Facility ID: 00075	•		Page 52 of 78

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

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP ND PLAN OF CORRECTION IDENTIFICATION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G	(X3) DATE SURVEY COMPLETED	
•0		245559	B. WING		09/12/2013	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56586	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLET	
F 318	days during the m received services days. On 9/11/13 at 1:55	bage 52 34 received services for thirteen onth. However, R34 only for 20 days out of a total of 73 5 p.m. NA-D indicated R34 does notion services from restorative	F 31	3		
	receiving services	she confirmed that R34 is not consistently. I with functional limitations and onsistent range of motion				
	services. R13's diagnoses in accident, depressi quarterly Minimum 7/16/13, revealed impairment and re total dependence v (ADL). Further, the	ncluded cerebrovascular on, and dementia. The Data Set (MDS) dated R13 with severe cognitive quired extensive assistance to with all activities of daily living MDS identified R13 did not s in range of motion to both	4	4		
	Identified R13 as h and ADL performa lacked intervention	of care dated 6/18/13, aving limitations in mobility, nce. However the care plan is related to R13's therapeutic ative nursing program for 5 days a week.	÷	10	•	
	revealed a note da receives nursing re	notes from 6/12/13 to 8/7/13 ted 6/12/13 indicated R13 shab services for range of Note dated 7/10/13 revealed	41	** **		

		AND HUMAN SERVICES				FORM): 11/01/2013 1 APPROVED). 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. A. B		NSTRUCTION	(X3) DA COI	TE SURVEY MPLETED
		245559	B. WING			09	/12/2013
	PROVIDER OR SUPPLIER	ME		317 Fil	T ADDRESS, CITY, STATE, ZIP COD RST STREET NORTHWEST MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X6) COMPLETION DATE
	more a note dated & nursing rehab service On 9/11/13 at 7:26 a assisting R13 to wa lifted one arm at a ti shirt. NA-J then mai to wash R13's unde underarms, applied and then put R13's arm at a time to inse shirt. At 7:32 a.m. N R13, applied new in turning R13 side to to lower extremities socks by lifting one and shoes in same proceeded to apply one arm at a time at the sleeves of the sl NA-D assisted R13 lift R13 from her bed wheelchair and then R13's hair, and perfet then wheeled out to observation R13 pro ADL's.	services routinely and further 3/7/13 indicated R13 received ces for ROM exercises. a.m. NA-J was observed sh her face, NA-J manually me to remove R13's night nually lifted one arm at a time rarms, then dried R13's deodorant in same manner undershirt on by lifting one ert it into the sleeve of the A-J performed peri cares on continent product by manually side. NA-J then applied lotion and feet of R13, applied leg at time, then applied pants manner. NA-J then R13 shirt by manually lifting nd inserting both arms into nirt. At 7:46 a.m. NA-J and using a hoyer lift to manually I to a sitting position in her NA-J proceeded to comb orm oral hygiene, R13 was the hallway by NA-J. During vided no assistance with	. F 3	318			
	and maintain strengt included: passive rai extremities with focu notions 10-20 reps, l (straighten elbow), a with abductor pillow under heel area (floa	eet directed staff to provide th with transfers/mobility nge of motion to lower is on knee extension all ROM to upper extremities nd position patient in suplne between knees and pillows at heels, allow patient to lie to one hour to promote knee stion.			2) 12 12		
RM CMS-256	7(02-99) Previous Versions C	bsolete Event ID: M6T711		Facility ID; (00075 If contin	uation sheet P	age 54 of 78

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		AND HUMAN SERVICES					FORM	: 11/01/201 APPROVE . 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DAT COM	e survey IPleted
		245559	B. WING	÷			09/12/2013	
NAME OF I	PROVIDER OR SUPPLIER	I.,		0.00	TREET ADDRESS, CITY, STATE			
VIKING N	MANOR NURSING HO	ME		10.00	17 FIRST STREET NORTHWI	:ST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROP) BE	(X5) COMPLETIO DATE
F 318	Continued From pa	ge 54	F	318		4.01		
	Review of the Reha following informatio	b Flow Sheets identified the		s	21			
3	received services for month, and for the r 2013 R13 received the month, and furth 1st-31st, 2013 R13 seventeen days dur	eptember 1st-11th, 2013 R13 or only one day during the month of August 1st-31st, services for eight days during nermore the month of July received services for ing the month. However R13 res for 26 days out of a total of				,		÷.
	receives range of m restorative nursing, legs and do range of	p.m. NA-B confirmed R13 otion services from and stated "we stretch out her f motion, she is a little tighter R13 is not receiving services	12					•
	confirmed R13 does services from restor	p.m. physical therapist (PT) receive range of motion ative nursing but has not tional therapy (OT) since last						
	does receive range restorative nursing a	o.m. NA-D confirmed R13 of motion services from and however she indicated ving services consistently.			ie , is			
κ.	а." Э							
		vith functional limitations and sistent range of motion	ί¢.		et C. e.			

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		AND HUMAN SERVICES			FORM): 11/01/201 APPROVE 0. 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DA CO	TE SURVEY MPLETED
		245559	B, WING		09	/12/2013
	PROVIDER OR SUPPLIER	ME	3	STREET ADDRESS, CITY, STATE, ZIP COD 117 FIRST STREET NORTHWEST JLEN, MN 56585	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X6) COMPLETION DATE
F 318	Continued From pa services.	ge 66	F 318		ž	
	accident, depressio Minimum Data Set R22 with severe coo required extensive a daily living (ADL). T	uded cerebrovascular n, and dementia. The annual (MDS) dated 8/6/13, identified gnitive impairment and assistance with all activities of he MDS further identified R22 nge of motion to both upper es.				
	identified R22 as ha and ADL performant lacked interventions	of care dated 5/26/13, ving limitations in mobility, ce. However the care plan related to R22's therapeutic tive nursing program for days a week.				
	revealed a note date receives nursing reh motion exercises. N R22 receives nursin more a note dated 9	otes from 7/8/13 to 9/3/13 ad 7/8/13 indicated R22 ab services for range of ote dated 8/5/13 revealed g rehab services and further /3/13 indicated R22 received ses for ROM exercises.		8 **		
	dated 7/5/13, indicat recommended to co nursing program for standing frame. The program was to increan and functional mobil Nu-step 10 minutes tolerated with front w two, sit to stand five arm bike, standing fr	herapy Discharge Summary ed occupational therapy ntinue ROM with restorative upper body exercises and a goal for R22 restorative ease and maintain endurance ity. The program included: #5 or 6, ambulate as theeled walker with assist of times, pulleys/gentle stretch, ame 10 minutes can do hile standing, wand exercises				*
	pegs/nuts or bolts wi		Fael	lity ID: 00075 If contin	nuation sheet F	0000 60

		AND HUMAN SERVICES		517 D			FORM	: 11/01/2013 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		(X3) DAT CON	E SURVEY MPLETED
		245559	B. WING				09/	12/2013
NAME OF	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	1		ŕ
VIKING	MANOR NURSING HO	ME			IRST STREET NORTHWEST N, MN 56585			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD E	BE ATE	(X5) COMPLETION DATE
÷	and trunk flexion, reflexed (use cones o #2 (limited assist new The most current Pl dated 6/18/13, indic recommended to co nursing program. Di indicated restorative patient will continue goal for R 22 restora and maintain endura The program include or 6, ambulate as to walker with assist of pulleys/gentle streto 10 minutes can do p standing, wand exer forward and back st reaching activities-fo or other items), and needed with right). On 9/11/13 at 6:67 a assisting R22 to a si toilet. R22 was able next to the toilet with NA-F. Then NA-F as and pulled R22's pai assist R22 to turn, p his wheel chair. NA- the hallway by the no R22 is observed whe towards dining room using his hands to p a.m. R22 is observe	orward and back stretches baching activities-forward and r other items), and legs kicks	F	318				
	07(02-99) Previous Versions C		18 	Facility IC); 00076 If contin	uation	sheet F	Page 57 of 78

		E & MEDICAID SERVICES				APPROVE . 0938-039
ND PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A, BUILDING	CONSTRUCTION	(X3) DAT CON	E SURVEY
		245559	B. WING		09/	12/2013
1. 1			317	REET ADDRESS, CITY, STATE, ZIP C FIRST STREET NORTHWEST	And a second	
1111101			UL	EN, MN 56586		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 318	to provide minimal	ge 57 assistance with ADL's, and assistance with all ADL's,	F 318	Ϋ́.	×	
	increase/maintain e mobility included: G ambulate as tolerate with assist of two, s pulleys/gentle stretc 10 minutes can do p standing, wand exe forward and back sl reaching activities-fo or other items), and needed with right).	neet directed staff to endurance and functional inu-step 10 minutes #5 or 6, ed with front wheeled walker it to stand five times, ch, arm bike, standing frame oegs/nuts or bolts while rcises hand over hand, a tretches and trunk flexion, orward and flexed (use cones legs kicks #2 (limited assist b Flow Sheets identified the	•		7	
	received services for month, and for the r 2013 R 22 received the month, and furth 1st-31st, 2013 R 22 days during the mor	n: optember 1st-11, 2013 R 22 or only two days during the nonth of August 1st-31st, services for nine days during nermore the month of July received services for thirteen oth. However R 22 only r 24 days out of a total of 73		,		ж
	does receive therapy program and stated nursing rehab during R 22 walking if they	a.m. NA-F confirmed R 22 y from the restorative nursing "If they do not have the g the day they try to work with have time". NA-F indicated ceived services consistently				9 8

. PRINTED: 11/01/2013

	t of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DA CO	TE SURVEY
		245559	B. WING		09	0/12/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	E	
VIKING	MANOR NURSING HO	OME		317 FIRST STREET NORTHWEST ULEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP . DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 318	On 9/11/13 at 1:04 does receive range restorative nursing, alot of encouragem should be doing an	p.m. NA-D confirmed R 22 of motion services from and indicated that R22 needs ent as R22 forgets what he d needs constant reminders. I that R22 had not received	F 31	В		
			×			
		÷		ν		
		* 2	3			
				ĸ	÷	
•						20 1
	R26 dld not consiste (ROM) three times a plan of care (POC).	ently receive range of motion a week as directed on her			·	
	(decrease in heart fu	luded diabetes, heart failure inction to pump blood), lood pressure), osteoporosis,		2		

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STATEMEN AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100000000000000000000000000000000000000	PLE CONSTRUCTION	(X3) DA CO	TE SURVEY
		245559	B. WING		09)/12/2013
1001015-200	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 317 FIRST STREET NORTHWEST ULEN, MN 56585	CODE	25
(X4) ID PREFIX TAO	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FUIL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 318	dementia, depress	sion and anxiety.	F 31	3		
÷	8/7/13, indicated s and R26 was total activities of daily li	nimum Data Set (MDS) dated evere cognitively impairment ly dependent on staff for ving (ADL), transferring, olleting and personal hyglene.				
	confirmed R26 wa three to five times repetitions of ROM lower extremities. clutched to her che %'s extension of R R26's fingers. NA-	1 p.m. nursing assistant (NA)-D s to receive ROM exercises a week. NA-D completed 15 1 exercises on R26's upper and R26's arms were tightly est and NA-D was able to reach 26's arms and fully extended D extended R26's lower ached full extension and			2 2 10	
	stiffer to bend at th R26's POC dated s	ealed R26's left leg appeared the start of the exercises. 9/19/12, revealed she had				
	R26's Rehab Flow rehabilitation staff to upper and lower ex Review of R26's Re following:	ng three times a week. Sheet directed nursing to conduct ROM on R26's dtremities. ehab Flow Sheet revealed the ad the opportunity for three				
	nursing rehabilitatic Week of 8/25/13, h nursing rehabilitatic Week of 7/28/13, h nursing rehabilitatic Week of 7/7/13, ha	on sessions and received one. Lad the opportunity for three on sessions and received zero. Lad the opportunity for three on sessions and received two. In the opportunity for three on sessions and received two.			940	2
		Nursing Care policy dated staff to perform rehabilitative				

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		AND HUMAN SERVICES			FORM	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A, BUILDING	LE CONSTRUCTION	(X3) DAT COM	e survey Ipleted
		245559	B. WING		09/	12/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VIKING	MANOR NURSING HO	ME	1.1	317 FIRST STREET NORTHWEST ULEN, MN 56585		1. N.
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 318	services three to fiv resident who requir also explained the p therapist was to dev rehabilitative nursin	e times a week for those ed such services. The policy obysical or occupational velop the goals for g cares and the goals were to a therapy services (restorative	F 318			
F 323 SS=D	483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain as is possible; and	ACCIDENT	F 323	R43's tabs unit was discom 9/16/13. A chair alarm was in place of the tabs unit. The type is sensitive to R43's we and will alarm when R43's we removed from the pad. R43 plan has been updated to in the chair alarm as an interv	initiated is alarm eight weight is 3's care nclude	
	by: Based on observati review, the facility fa causative factors of fall interventions rela alarm to minimize th falls/accidents for 1 with a history of falls Findings include: R43 had diagnoses history of compressi vertebra and osteoa Data Set (MDS) data severe cognitive imp extensive assist fror living, which include Care Area Assessm	of 3 residents (R43) reviewed		for fall prevention. Staff were educated initially via commu- book when alarm changed staff will receive education 10/30/13. R43 continues to a laser alarm when in bed. staff are to sign off each shi alarms have been checked on/clipped to residents. Each with an alarm or history of fa- have a care plan review to e accuracy of current plan of Resident falls are reviewed and QA meetings to discuss	unication and all by have Nursing ift that and are ch resider alls will ensure care. at ITD	nt

	H AND HUMAN SERVICES				11/01/201 APPROVE 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		E SURVEY PLETED
	245559	B. WING	el 2011 - 10 - 10 - 10 - 10 - 10 - 10	09/*	12/2013
NAME OF PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585		*a
PREFIX (EACH DEFICIEN	ATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC {EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
self which could re identified R43 had transferring, and h assessment. The for falls and the pl laser alarm while I wheelchair. R43's plan of care focus area for risk indicated R43 was listed various inter utilize a Tabs alarr wheelchair and uti During observation 6:54 p.m., R43 wa dining room of the attached to the bac metal clip attached hung down behind wheelchair. The m to R43. At 6:55 p. was not attached a to R43's shirt. During observation 7:20 a.m., R43 was the nurses station attached to the bac clip had not been a string was hanging wheelchair. At 7:24 (DON) approached clip of the Tabs ala The DON then con	age 61 Ild forget he could not care for soult in falls. Further, The CAA problems with balance, ad fallen since the previous CAA identified R43 was a risk an included use of a low bed, in bed, and a Tabs unit in the last revised 7/10/13, included a of falls. The plan of care not aware of safety needs and ventions which directed staff to in at all times when up in ize a laser alarm when in bed. Is on 9/9/13, from 5:58 p.m. to is seated in a wheelchair in the facility. A white alarm box was sk of the wheelchair with a to an orange string, which the backside of the tetal clip had not been attached in., RN-A confirmed the clip nd she then attached the clip s on 9/11/13, from 6:55 a.m. to is seated in a wheelchair near with the white alarm box k of the wheelchair. The metal ttached to R43 and the orange down the backside of the 0 a.m., the director of nursing R43 and attached the metal im to the back of R43's shirt. firmed the clip was not ack as it should have been.	F 32:	³ interventions and care pla resident care plans will be to reflect changes in care staff will be informed and a as needed to ensure abilit out the care plan. DON or will be performing random ensure alarms are in place turned on. Audit findings w discussed at IDT meetings meetings and IDT/QA will determine when to stop au	updated and all educated y to carry designee audits to and yill be and QA	10/30/13

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 11/01/2013 FORM APPROVED OMB NO, 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		245559	B, WING	19 K. P. K	•	09/12/2013
	PROVIDER OR SUPPLIER	ME	31	REET ADDRESS, CITY, STATE, 7 FIRST STREET NORTHWE LEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD I THE APPROPR	3E COMPLET
	A Falls Investigation indicated R43 had a room. R43 had state the wheelchair. The any investigation of intervention implem Investigation Works R43 fell asleep in th and tipped onto the encouraged to ask f when feeling tired. Review of R43's nur 9/10/13, revealed or attempting to transfe the bed, alarm on. C R43 undicated he ha notes Identified the I and the fall was report facility complaints. C revealed R43 had st and was taken to the the notes revealed F due to moving fast a An interview conduc nursing assistant (Nu content in the wheel become restless or a had a laser alarm on be on at all times wh During an interview of falls in the recent par	h Worksheet dated 8/15/13, an unwitnessed fall in his ed he crawled from the bed to worksheet did not Indicate the unwitnessed fall or ented after the fall. A Falls theet dated 8/25/13, Indicated e wheelchair, leaned forward, floor. Post fall, R43 was for assistance to lay down rsing notes from 7/3/13 to n 7/18/13, R43 was ar self from the wheelchair to on 8/15/13, the notes revealed of bed in roommate's recliner. d crawled out of bed. The aser alarm had not been on orted to the office of health on 8/25/13, the nursing notes to due by himself 3 times a bathroom or bed. On 9/5/13, R43 was at high risk for falls and did not use the call light. ted on 9/11/13, at 12:33 p.m., A)-F stated R43 was usually chair but occasionally would anxious. NA-F stated R43 in his bed and a Tabs alarm to ille up in the wheelchair. on 9/12/13, at 9:11 a.m., I)-A indicated R43 had two st and RN-A confirmed she rm to be clipped to his body	F 323			

TATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		245559	B. WING		09/	12/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VIKING	MANOR NURSING H	OME		17 FIRST STREET NORTHWEST JLEN, MN 56585		*
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa	ane 63	F 323			00
1 020		/on 9/12/13, at 11:00 a.m., the				
6	DON confirmed R4	3's current plan of care and expect all fall Interventions to			·	
1	be implemented by	nursing staff.	1. T		111	1
F 353		ENT 24-HR NURSING STAFF	F 353	Upon survey it was determine		
SS≕E	FER GARE FLANS			Viking Manor Nursing Home v		L
		we sufficient nursing staff to		in substantial compliance with		*
•		d related services to attain or st practicable physical, mental,		staffing as evidenced by failur	States 11 1	
	and psychosocial w	ell-being of each resident, as		to meet residents' needs for R		
		dent assessments and		R25, R29, R43, R13, R21's		
	individual plans of o	are.		plan has been updated to incl		
		ovide services by sufficient	·* .	a bruising focus and intervent		72
1		f the following types of hour basis to provide nursing		R21's interventions and outco	mes	
	care to all residents	in accordance with resident		are discussed at IDT and QA		
1	care plans:	· · · ·		meetings. R29 was admitted t	0	5
	Except when walve	d under paragraph (c) of this	646	the hospital on 9/11/13 and		1993 1993
	section, licensed nu	urses and other nursing		deceased 9/23/13 without retu		
	personnel.			to Viking Manor Nursing Home	э,	
		d under paragraph (c) of this		R25 and R43 are being offere	d	
		must designate a licensed		ambulation via nursing rehab		
	duty.	charge nurse on each tour of		aide 3-5 times a week as is ca	re	
		* *		planned. R13, R22, R23, R25,		
	This REQUIREMEN	IT is not met as evidenced		R26, R27, and R34 are being	8	
	by:			offered ROM via nursing rehal	b	
		lon, and interview, the facility licient qualified nursing staff		3-5 times a week as is care		
1 I	were available to m	eet residents' needs for	25	planned. Viking Manor Nursing	g	
	nursing care in a co	nsistent manner for 10 of 45		Home has since altered staffin	g	
	residents R21, R25, R26, R27, R34, In ti	, R29, R43, R13, R22, R23, te sample.		to be able to provide nursing		
				care in a consistent manor. To		

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

	t of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	 March States and States V. 	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245559	B. WING		09/12/2013
	PROVIDER OR SUPPLIER MANOR NURSING HO	ME ·		STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLET
F 353		ge 64	F 353	consistently, Viking Manor	
	Findings include:			Nursing Home has trained activity alde to nursing reha	1.4
	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	residents (R21) reviewed who	4.1	The activity aide will perform nursing rehab services 2-3	
			hours/day for 2-3 days/wee One additional activity aide enrolled in Certified Nursing	is	
1	decline in ambulatio ambulate resulted in	n. R25's decline in ability to actual harm. See F310.		Assistant (CNA) classes an will also be trained to rehab upon completion of CNA	
	ambulate resulted in actual harm. See F310. The facility failed to provide assistance with ambulation for 2 of 6 residents (R29, R43) in wh were dependent on staff for ambulation. See F311. The facility failed to provide range of motion	staff for ambulation. See		classes. One additional RR/ (registered resident assistar	nt)
	services to prevent f motion (ROM) for 8 R23, R25, R26, R27	urther decrease in range of of 8 residents (R13, R22, , R29, R34) who had		has also been trained to nur rehab and will be scheduled days biweekly. All residents	1-2
	During the survey co p.m. until 8:00 p.m. a	of.motion. See F318. onducted on 9/9/13, from 4:00 and 9/10/13, from 8:00 a.m. 13, from 7:00 a.m. until 4:30		nursing rehab program are offered rehab 3-5 times a we	
	p.m. and on 9/12/13 p.m., respectively sta not be able to consis	from 8:00 a.m. until 2:30 aff were observed amd were stently provide services for		All staff will complete education of new nursing rehab staffing 10/30/13 plus an educationation	g by
the re based	the residents as dire	cted by their plans of care ensive assessment of their		in-service "Restorative Care, was assigned to all nursing s	/ROM"
1		p.m. the DON stated the ng patterns were as follows:		to complete in the month of October so that in the absen	ce
	RN working 8:00 a	.m. to 4:30 p.m. rom 6:00 a.m. to 6:30 p.m.		of a rehab aide on the scheo other staff are knowledgeabl nursing rehab program and o	e to

ND PLAN C	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245559	B. WING		09/12/2013
	Provider or Supplier Manor Nursing Ho	ME	:	STREET ADDRESS, CITY, STATE, ZIP CODE 17 FIRST STREET NORTHWEST JLEN, MN 56585	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
	1 TMA working an & 3 nursing assistants 1 nursing assistants 1 nursing assistants bath aide 1 nursing assistants bath aide 1 nursing assistants to 9:15 p.m. 1 TMA working an 8 1 nursing assistants to 9:15 p.m. 1 TMA working an 8 1 nursing assistants 10:30 p.m. 2 nursing assistants to 6:45 a.m. (12 hou 1 RN who worked fr hour shift) The night shift includ started their shifts of worked through until The staffing report for days of which 15 day and 16 days (8/1/13, 8/7/13, 8/8/13, 8/9/13 8/22/13, 8/26/13, 8/2 8/31/13) nursing assist one to two staff men 9/1/13 through 9/12// days (9/1/13, 9/3/13, 9/7/13, and 9/12/13), to two staff. Of the p	hour shift working 8 hour shift working a 6 hour shift. assigned to work 8 hours as a lgned to work 8 hours as a who worked from 11:45 a.m. hour shift who worked from 2:00 p.m. to who worked from 4:00 p.m. to who worked from 6:10 p.m. r shift) om 6:00 p.m. to 6:00 a.m. (12 led the 2 NAs and 1 RN who n the evening shift and the next morning. or August 2013, identified 31 /s were without shortages 8/2/13, 8/4/13, 8/5/13, 3, 8/16/13, 8/18/13, 8/19/13, 7/13, 8/29/13, 8/30/13, and istant staff had shortages of nbers. In September from 13, the facility had seven 9/4/13, 9/5/13, 9/6/13, of staffing shortages of one rojected nursing schedule 19/25/13, the facility daily ne to two) staff.	F 363	perform assigned exercises. The physical therapy department will also be hostin an educational in-service for staff 10/30/13 focusing on RO and transferring. Viking Manor Nursing Home has also hired full time PM shift RRA and 1 for time LPN. Viking Manor Nursin Home continues to advertise for RRA positions and will hire qualified candidates as able. RNs for each wing will be audi nursing rehab program to ensu all residents are receiving nurs rehab as is in plan of care for or resident. Nursing rehab progra and staffing will be reviewed at quarterly QA meetings.	M 1 all ng or ting ure sing each am

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES		;	FORM	0: 11/01/2013 APPROVED 0: 0938-039
STATEMENT AND PLAN C	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION		te Survey Mpleted
		245559	B, WING)	09	/12/2013
	PROVIDER OR SUPPLIER	ME .		STREET ADDRESS, CITY, STATE, ZIP 317 FIRST STREET NORTHWEST ULEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F 353	the staff if the facilit The staff had respo residents, "We are	y was short of nursing staff. nded by informing the hiring and will fill positions as scussion regarding the nurse	F٤	353		
	had to wait over 30 was answered. R2	o.m. R27 (alert resident) stated minutes before the call light 7 explained she had nent episodes because of ng.		(*) · ·	5 .5.	
	she had to wait a lo	o.m. R31 (alert resident) stated ng time for the call lights to be ted felt it was do to poor		S.	*	
	stated the facility did	0 a.m. R1 (alert resident) I not have enough staff, but hy they felt this way.			55	
	stated while sitting of	a.m. R16 (alert resident) on the toilet had turned on the walt between 15-20 minutes swered.			<u>د</u>	
	was frequently short staffing, NA-B expla complete the restora reassigned to provid residents. NA-B sta restorative program	p.m. NA-B stated the facility staffed. Because of the ined the NA assigned to ative program, frequently was le direct care for the ted when It happened, the was not completed. NA-B g shortage occurred one to not more.			đi E	
	currently working as	a.m. NA-I stated was the bath aide and would be orm direct cares one to tow		-		

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. S. S. S. C		(X3) DA CO	TE SURVEY MPLETED
		245559	B, WING	N	09	/12/2013
NAME OF	PROVIDER OR SUPPLIER	I	1	STREET ADDRESS, CITY,		
Viking	MANOR NURSING HO	ME		317 FIRST STREET NO ULEN, MN 56585	RTHWEST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE IGED TO THE APPROPRIATE EFICIENCY)	(X6) COMPLETIC DATE
.F 353	days a week. NA-I each NA was respo residents with baths the staff were usual On 9/11/13, at 8:00 stated at times the I duties to assist the confirmed the facilit enough staff to pro 9/11/13, at 8:01 a.m when working occas unit. RN-C stated v and the RN's would needed. RN-C stated not passing medical facility as the superv aide was not pulled, restorative aide was	ge 67 stated when it happened, nsible for assisting the s. NA-I stated it was hard, but ly able to get their job done. a.m. registered nurse (RN)-C RN staff were pulled from their NA's on the unit. RN-C y did not consistently have vide cares for the residents. h. on 9/11/13, RN-C stated sionally had to help out on the would pull the restorative aide help out on the unit as red on the weekends she was tions, and was extra in the visor. RN-C stated the bath but occasionally the pulled. RN-C stated, "I sound good but we do what	F 3			
	the unit as needed. On 9/11/13, at 12:30 (DON) stated was a able to be consisten taking other jobs or facility had attempte paper and had conta DON confirmed was routinely pulling the provide care for the established a system duties were complet On 9/11/13, at 2:15 a confirmed was awar	ted was able to help out on p.m. the director of nursing ware the facility had not been tly full staffed because of staff illness. The DON stated the d to advertise in the local acted the local school The aware the facility was NA from restorative duties to residents, but had not n to ensure the restorative ed, a.m. the administrator e of the nurse staffing histrator stated was aware				

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		AND HUMAN SERVICES			-4- 	FORM): 11/01/201 APPROVE
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
The second se		245559	B, WING			09/12/2013	
NAME OF	PROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE		
VIKING	ANOR NURSING HO	ME			17 FIRST STREET NORTHWEST JLEN, MN 56585		•:
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 353	resident cares. The problem, but had no the issue.	as reassigned to assist with facility was working on the t found a system to resolve	F3	53			
	confirmed the facility	a.m. NA-A and TMA-A y did not have a nursing o provide restorative nursing					10
F 431	"Viking Manor maint each shift to ensure services are met. Li and licensed nursing and monitor the deliv services." "Certified available on each sh and services of each resident's comprehe 483.60(b), (d), (e) Di	Nursing assistants are lift to provide the needs care resident as outlined on the nsive care plan."	F 43		Effective 9/17/13, housekeep staff were not allowed acces	· ·	
	a licensed pharmaci of records of receipt controlled drugs in s accurate reconciliation records are in order	ploy or obtain the services of st who establishes a system and disposition of all ufficient detail to enable an on; and determines that drug and that an account of all paintained and periodically		1	to medication rooms without presence of an RN/LPN/TMA Housekeeping will change fro cleaning medication rooms daily to cleaning them 2-3 times a week. New locks/key	A. om	
·	abeled in accordanc professional principle appropriate accessor				were installed for both medication rooms on 10/17/1 RNs, LPNs, and TMAs are th only staff that will have access to the medication rooms. All	ie	

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

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 (1) (1) (1) (1) (1) (1) (1) (1) (1) (1		CONSTRUCTION	(X3) DAT CON	TE SURVEY MPLETED
		245559	B. WING			09/12/2013	
	PROVIDER OR SUPPLIER	DME		313	REET ADDRESS, CITY, STATE, ZIP CODE 7 FIRST STREET NORTHWEST .EN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETI DATE
<u>_</u>			5		other staff will only have		
F 431	Continued From pa	ge 69	F4	31	access to the medication roo	oms	
(C)	In accordance with	State and Federal laws, the			in the presence of an		
	facility must store a	Il drugs and biologicals in		1	RN/LPN/TMA. All staff have		
		ts under proper temperature		1	received education on this		
	have access to the	t only authorized personnel to keys.		I	process and education will		
		T.)		li	be complete by 10/30/13.		
	permanently affixed	ovide separately locked, I compartments for storage of		1	Medications in each medica	tion	
	controlled drugs list	ed in Schedule II of the		r	oom refrigerator have been		
		ug Abuse Prevention and and other drugs subject to		5	separated from food items.		
		the facility uses single unit			n the west medication room		
	package drug distrik	ckage drug distribution systems in which the antity stored is minimal and a missing dose can			all supplements have been	·	
÷	be readily detected.				emoved from the refrigerate		
					Supplements are now stored		
		55 \			he refrigerator in the day		
	This REQUIREMEN	IT is not met as evidenced		- 100	lining room. Medications on	lv	8
	by:	an latendari and daarmaat			are stored in the west		
		ion, Interview, and document alled to ensure proper			nedication room refrigerator		
	medication storage	in the medication refrigerators			n the east medication room	2	
		only authorized personnel nedication rooms for 1 of 2			efrigerator, all medications l	nave	
	medication storage				been moved to the top shelf,		(e)
	Findings include:				vith supplements being plac		
	On 9/12/13. at 8:20	a.m. housekeeper-A was			in lower shelves. All staff ha	230782	
	overheard asking tra	ained medical assistant			een educated on this proce		
		e door to the medication room entrance to the facility.			Education will be complete I		
	TMA-A opened the c	toor with a key, and allowed			0/30/13. Random audits wil	S 1	
		the medication room an	¥.		e performed by the DON or		
	pulled a cleaning cal	22 a.m. housekeeper (HSK)-A		1.00	er designee. Audit findings		
	medication room do	orway. No nursing staff		1.00	vill be presented at QA		
	members were pres	ent while HSK-A was in the			ID: 00075 If continuat		

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	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A CONTRACTOR OF A CONTRACT OF	IPLE CONSTRUCTION	(X3) DA CO	TE SURVEY MPLETED
		245559	B, WING			/12/2013
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE		TELEVIS
	MANOR NURSING HO	DME		317 FIRST STREET NORTHW ULEN, MN 56585	EST	
(X4) ID Prefix Tag	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EAGH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 431	Configured From no	ao 70	F 43	meetings until QA	deems	
F 431	cleaning cart out of medication room.	ge 70 At 8:30 a.m. HSK-A moved the the doorway and exited the At no time were nursing staff /hile HSK-A was in the	F 43	auditing is no longe		10/30/13
	HSK-A stated each medication storage wiped off the counte paper towels, remov floor. HSK-A confirm administration staff	oted on 9/12/13, at 8:33 a.m. day she entered the room and cleaned the sinks, ors if needed, replaced the ved trash and mopped the med medication were not present in the nile she completed these			 2)	
	room was reviewed (DON). The DON op with a key. The room cupboards which we contained resident of of the prescription m (a medication to treat Cipro (an antibiotic) medication), vitamin prescription eye drop several over the court	ere not locked. The cupboards overflow medications. Some nedications included carafate at excessive gastric acid), Alaprxolam (a blood pressure B-12 Injection form, and ps. The cupboards had inter medications also				
	including but not limitablets, vitamin D, Lo Robitussin, and a ra 1:35 p.m. the DON s cupboard also conta DON picked up a se opened two doors ar morphine injections, were kept on the cup p.m. the DON opened	ited to Tylenol, cranberry otrimin foot powered, Maalox, ndom bottle of liquid tears. At stated the medication ined a narcotic box. The t of keys off the counter, nd removed four vials of The DON confirmed the keys bobard at all times. At 1:36 ed the unlocked the three igerator. The first shelf				

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*

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245559 B. WING	B) DATE SURVEY COMPLETED
	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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 431 Continued From page 71 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 nasai 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. 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 aldes. The DON confirmed all other staff including the housekeeping staff were to be accompanied by a nursing staff member. The DON also confirmed the medication policy revised on 11/22/2010, stated, "The nursing staff shall be responsible for maintaining medication storage AND preparation area in clean, safe and sanitary manner." "Medication rouths reafer and sanitary manner." "Medication root 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."	

TATEMEN	T OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/12/2013	
		245559	B. WING			
NAME OF	PROVIDER OR SUPPLIEF	र	18	STREET ADDRESS, CITY, STATE, ZIP CODE		
VIKING	MANOR NURSING H	OME		17 FIRST STREET NORTHWEST JLEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FUI.L LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) COMPLETIO DATE
F 441 F 441 SS=F	SPREAD, LINENS The facility must e Infection Control P safe, sanitary and to help prevent the of disease and infe (a) Infection Contro The facility must e Program under wh (1) Investigates, co in the facility; (2) Decides what p should be applied (3) Maintains a rec actions related to i (b) Preventing Spr (1) When the Infect determines that a n prevent the spread isolate the resident (2) The facility must communicable dise from direct contact direct contact will th (3) The facility must hands after each d hand washing is im- professional practice (c) Linens Personnel must ha	N CONTROL, PREVENT stablish and maintain an program designed to provide a comfortable environment and a development and transmission action. ol Program stablish an Infection Control lich it - ontrols, and prevents infections procedures, such as isolation, to an individual resident; and cord of incidents and corrective infections. ead of Infection tion Control Program resident needs isolation to l of infection, the facility must t. at prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. at require staff to wash their irect resident contact for which dicated by accepted		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 resider 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 curre The findings will be discussed the QA meetings. Staff were educated on the new process for tracking and trending employee infections/illnesses/ diseases. Staff education will I complete by 10/30/13.	ent. at	10/30/1

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		IPLE CONSTRUCTION		TE SURVEY MPLETED
		245559	B, WING _		00	/12/2013
NAME OF	PROVIDER OR SUPPLIEF	0.000.000	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C		
VIKING	MANOR NURSING H	OME		317 FIRST STREET NORTHWEST ULEN, MN 56585		
(X4) ID Prefix Tag	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 441	Continued From p	age 73	F 44	1		
	by: Based on interview facility falled to dev an infection prever related to the surve analysis of staff dis prevent, recognize possible, the onset the facility. This pra	NT is not met as evidenced w, and document review, the velop, implement, and maintain ntion and control program eillance, investigation, and seases/infections in order to and control, to the extent and spread of infection within actice had the potential to nts who resided in the facility.				*
	Findings include: Review of the facili logs revealed the la illness/disease trac					
SS=E	(DON), Infection co did not track, trend as required. 483.70(h)	3 a.m. the director of nursing ontrol lead, verifled the facility or analyze employee illness AL/SANITARY/COMFORTABL	F 465	In resident bathrooms R1 R14, R34, R28, R36, R2 R45, R33, R32, R43, an	7, R2,	
		ovide a safe, functional, ortable environment for the public.	,	R15 the plastic foam tubi that was taped to the me piping has been removed	ing . tal , d.	
	by: Based on observat review, the facility fa and maintenance s	NT Is not met as evidenced ion, interview, and document ailed to provide housekeeping ervices necessary to maintain Obsolete Event ID:M6T711		All resident bathrooms ha been reviewed to ensure free from plastic foam tub Training has been provid to staff that this practice i	bing. ed s	Page 74 of 78

PRINTED: 11/01/2013

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245559 B. WING 09/12/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 317 FIRST STREET NORTHWEST VIKING MANOR NURSING HOME **ULEN, MN 56585** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION ID PREFIX (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) not allowed. The Head F 465 F 465 Continued From page 74 Housekeeper will be sanitary conditions related to uncleanable performing routine inspections surfaces for 12 of 43 resident bathrooms (R13, R14, R34, R28, R36, R27, R2, R45, R33, R32, to ensure this will not happen R43, R15). again. Audit finds will be Findings include: presented to QA meetings until the QA committee The facility failed to maintain sanitary conditions related to uncleanable surfaces on residents' determines audits are no longer tollets in bathrooms for R13, R14, R34, R28, R36, needed. 10/30/13 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 pleces of the plastic foam missing. the foam material attached to the back of the tollets 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 tollets." 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 tollet. 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 FORM CMS-2587(02-99) Previous Versions Obsolete Event ID:M6T711 Facility ID: 00075 If continuation sheet Page 75 of 78

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/01/2013

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

PRINTED: 11/01/2013 FORM APPROVED OMB NO 0938-0391

STATEMEN	RS FOR MEDICAF T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.000	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245559	B. WING			09/12/2013	
199212046930	PROVIDER OR SUPPLIE			CODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
F 465	toilets. HSK-A sta cleaned the surfact tape and indicated cleaning products materials. HSK-A cleanable surface On 9/12/13, at 2:0 facility utilized long foam tubing duck back of toilets. Th was porous and c cleanable surface On 9/12/13, at 2:2 supervisor confirm multi-colored plass taped to the metal The housekeeping and duck tape was surface and stated The undated polic specified bedside	ted she had not routinely bes of of the foam and duck a she was not sure if the used would damage the stated "I have no idea if it is a " 5 p.m. the DON confirmed the g multi-colored plastic, porous taped to the metal piping on the e DON confirmed the material onfirmed the foam was not a 9 p.m. the housekeeping hed the facility utilized long tic, porous foam tubing duck piping on the back of toilets. g supervisor stated the foam s not washable or cleanable d, "It's porous." y titled, Cleaning Bedside Mats, mats were cleaned and	F4	65			
F 520 SS=E	residents room or The undated polic specified to wipe of and exterior bowl 483.75(o)(1) QAA COMMITTEE-MEI QUARTERLY/PLA A facility must mal assurance commit	y titled, Cleaning Toilet Bowls, Iown all pipes, valves, fittings surfaces. MBERS/MEET	F 52	²⁰ Upon survey, it was fou Viking Manor Nursing H had not identified the ne address the nursing rehabilitation program a QA (quality assurance)	lome eed to t the		

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

PRINTED: 11/01/2013 FORM APPROVED OMB NO. 0938-0391

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DA CO	te Survey Mpleted
•		245559	B. WING			09/12/2013	
	PROVIDER OR SUPPLIER	OME		3	TREET ADDRESS, CITY, STATE, ZIP CODE 17 FIRST STREET NORTHWEST JLEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) COMPLETI DATE
	facility's staff. The quality assess committee meets at issues with respect and assurance activ develops and imple action to correct ide A State or the Secr disclosure of the red except insofar as su compliance of such requirements of this Good faith attempts and correct quality of a basis for sanctions This REQUIREMEN by: Based on Interview, facility Quality Asses (QA&A) committee f implement appropria identified areas of co implementation and rehabilitative nursing ambulation and rang by physical and occu-	3 other members of the ment and assurance t least quarterly to identify to which quality assessment vities are necessary; and ments appropriate plans of intified quality deficiencies. etary may not require cords of such committee to disclosure is related to the committee with the section. by the committee to identify deficiencies will not be used as s. IT is not met as evidenced and document review, the sement and Assurance failed to develop and ate action plans for previously oncern related the lack of documentation of services that included ge of motion cares as directed upational therapy. This ential to affect all residents ative services residing in the	F 5	20	The Viking Manor Nursing He QA committee discussed the nursing rehab program at its meeting on 10/10/2013 and t action plan implemented for correcting the nursing rehab program. Nursing rehab will be continually discussed at G until the QA committee detern it no longer needs to be addre The QA committee meets 1-2 each quarter. All staff have be educated on QA committee at how to bring forth concerns to QA committee. This education be completed by all department by 10/30/13. The QA committee will also dedicate time during meetings for open discussion related to concerns identified staff and/or committee member	QA he Mines essed times een nd o the n will ents ee	

PRINTED: 11/01/2013 FORM APPROVED OMB NO. 0938-0391

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

STATEMENT	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		'E SURVEY APLETED
		245559	B. WING		09	/12/2013
	PROVIDER OR SUPPLIER	DME .	317	REET ADDRESS, CITY, STATE, ZIP C FIRST STREET NORTHWEST EN, MN 56585	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET(ON DATE
F-520	director of nursing a rehabilitation (rehal improvement relate implementation. Ad identified concerns the QA (quality assi- develop an action p On 9/12/13, at 1:51 a member of the QA aware of the lack o services and stated why the concern wa committee. In addit aware of the incons rehab services. On 9/12/13, at 1:55 member of the QA of the lack of implei services and verifie	roximately 11:00 a.m. the (DON) verified nursing	F 520		2	
	the concern was no committee for revie action plan.	t brought forth to the QA w and the development of an			ontinuation sheet	

Viking Manor of Ulen

<u>Draft</u>

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.

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION a 01 - 1965 BUILDING 01	(X3) DATE SURVEY COMPLETED
21		245559	B. WING	ē	09/18/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E
VIKING I	MANOR NURSING HO	ME		317 FIRST STREET NORTHWEST ULEN, MN 56585	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTIC
K 000	INITIAL COMMENT	-S	K 000	j.	2
•	FIRE SAFETY	(a)		POC 04 13 11-21-13	/16) (g
	01 Main Building			011-21-1	
E1-28.01	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH	DC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.		XX II.	
d d	ONSITE REVISIT C CONDUCTED TO V SUBSTANTIAL COI REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE /ALIDATE THAT MPLIANCE WITH THE S BEEN ATTAINED IN TH YOUR VERIFICATION.		2 s 2 s	
12:13	Minnesota Departm time of this survey, V 01 Main Building wa compliance with the in Medicare/Medicai 483.70(a), Life Safe edition of National F	Survey was conducted by the ent of Public Safety. At the Viking Manor Nursing Home s found not in substantial requirements for participation d at 42 CFR, Subpart ty from Fire, and the 2000 ire Protection Association 1, Life Safety Code (LSC),		DECEIVE	
XÝ.	Chapter 19 Existing PLEASE RETURN 1 CORRECTION FOF DEFICIENCIES (K 1	THE PLAN OF		MN DEPT. OF PUBLIC SAFET STATE FIRE MARSHAL DIVISIO	
	Health Care Fire Ins State Fire Marshal D 445 Minnesota Stree St. Paui, MN 55101	ivision		A CALLER FOR MALE AND THE DIALOU	
RATORY		R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	Administrator	10/31/20(3

ing 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

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

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

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING 01 - 1965 BUILDING 01		TE SURVEY MPLETED
1		245559	B. WING		09	/18/2013
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP C 317 FIRST STREET NORTHWEST ULEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF() TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	Continued From pa Or by e-mail to: Marian.Whitney@sl Barbara.Lundberg@	ate.mn.us and	KO	00		
	DEFICIENCY MUS FOLLOWING INFO 1. A description of w to correct the deficie 2. The actual, or pro 3. The name and/or responsible for corre prevent a reoccurren Viking Manor Nursir without a basement different times. The constructed in 1965 Type II (000) constru- west was constructed determined to be Typ separated from the of fire barrier. A conne 1994 to the north en the facility to an apa connecting link was south of the west win clinic. Both buildings existing nursing hor 2003 a 24 foot by 42 constructed to the so	RRECTION FOR EACH T INCLUDE ALL OF THE RMATION: what has been, or will be, done ency. posed, completion date. title of the person ection and monitoring to nce of the deficiency ing Home is a 1-story building and constructed at five original building was and was determined to be of uction. An addition to the				
FORM CMS-256	7(02-99) Previous Versions C	Desolete Event ID: M6T721	F	Facility ID: 00075 If	continuation shee	et Page 2 of 9

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

PRINTED: 10/21/2013 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		_	0	WR NO	. 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - 1965 BUILDING 01		E SURVEY IPLETED	
		245559	B. WING	_		09/18/2013		
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
VIKING	MANOR NURSING HO	ME		317 FIRST STREET NORTHWEST ULEN, MN 56585				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENT,IFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 000	Continued From pa	ge 2	ка	00				
2	automatic fire sprint accordance with NF Installation of Sprint The facility has a fir detection in the corr areas in the 1965 bi smoke detectors in 1965 building that a installed in accordan National Fire Alarm alarm system is mod department notificat automatic fire detect system in accordance Fire Code 2007 edit	is protected with a complete kler system installed in FPA 13 Standard for the kler Systems 1999 edition. e alarm system with smoke ridor system and in common uilding, with sleeping room the 1981 addition and the re on the fire alarm system noce with NFPA 72 "The Code" 1999 edition. The fire nitored for automatic fire ion. Hazardous areas have tors that are on the fire alarm ce with the Minnesota State ion. pacity of 45 beds and had a						
-	census of 40 at the t		5 (5					
K 029 SS=F	The requirement at A NOT MET as eviden NFPA 101 LIFE SAF One hour fire rated of fire-rated doors) or a extinguishing system and/or 19.3.5.4 prote the approved automa option is used, the ar other spaces by smo doors. Doors are se field-applied protectiv	42 CFR, Subpart 483.70(a) is iced by: ETY CODE STANDARD construction (with ⁹ / ₄ hour in approved automatic fire in accordance with 8.4.1 acts hazardous areas. When atic fire extinguishing system reas are separated from oke resisting partitions and lf-closing and non-rated or ve plates that do not exceed ottom of the door are	К 02		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		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: M6T721

Facility ID: 00075

If continuation sheet Page 3 of 9

DEPARTMENT OF HEALTH AND HUMAN SERVICES O FOR MEDICARE & MEDICAR SERVICES ----

	STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.1.7	TIPLE CONSTRUCTION ING 01 - 1965 BUILDING 01	(X3) DA	TE SURVEY
Ĩ	Ĺ	8	245559	B. WING		09	/18/2013
0	VIKING	PROVIDER OR SUPPLIER	ME TEMENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585 PROVIDER'S PLAN OF CORRECTION	ON	(25)
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFID		D BE	(X5) COMPLETION DATE
	K 029	Continued From page	ge 3	K 0	 have a repair tracking sheet at the east nurses' station where anyone can write down items that need 		
	ж.	Based on observati two of ten hazardou are not in accordance Safety Code" 2000 of This deficient practic combustion to trave	s not met as evidenced by: ions it was determined that s area corridor doors tested ce with NFPA 101 "The Life edition (LSC) section 18.3.2.1. ce could allow the products of I from this hazardous area		repair. This is reviewed daily by maintenance and then initialed when repaired. In addition we have added a check of doors on our		
		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.			monthly maintenance checklist.		10/22/13
	4	Findings include: Observations during September 18, 2013 pm, by surveyor 030	, between 1:00 pm and 2:45			i ac a	
ĺ	а р 1	1) The south wing st was not self-closing,	orage room corridor door and				
		2) The soiled linen ro latch.	oom corridor door did not	7			
	K 050 SS=F	the facility tour and a NFPA 101 LIFE SAF Fire drills are held at varying conditions, a The staff is familiar w that drills are part of Responsibility for pla assigned only to corr qualified to exercise	an verified this finding during at the exit conference. ETY CODE STANDARD unexpected times under t least quarterly on each shift. with procedures and is aware established routine. nning and conducting drills is upetent persons who are leadership. Where drills are PM and 6 AM a coded	K 05	I have a grid I use to show whe drills are conducted. The Administrator will ensure that drills are conducted at varying times. Fire drills since the survive were held at 2:00 p.m. for the shift and 5:30 a.m. for the night	fire I /ey day	
FC	ORM CMS-25	37(02-99) Previous Versions O	bsolete Event ID: M6T721	F	Facility ID: 00075 If continue	ation shee	et Page 4 of 9

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391									
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - 1965 BUILDING 01	(X3) DATE SURVEY COMPLETED					
1		245559	B. WING	16	09/18/2013					
NAME OF	PROVIDER OR SUPPLIEF	l		STREET ADDRESS, CITY, STATE, ZIP CODE	100					
	MANOR NURSING H	OME		317 FIRST STREET NORTHWEST ULEN, MN 56585						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION					
K 050		ay be used instead of audible	K 0	50						
3	Based on a review determined that the conducted fire exit National Fire Prote "The Life Safety Co section 19.7.1.2. N could allow confus response, which w	is not met as evidenced by: v of fire drill records, it was e facility staff have not drills in accordance with action Association (NFPA) 101 ode" (LSC) 2000 edition lot conducting fire exit drills ion and delay in the staff ould negatively impact all 45 d any visitors in a fire								
	Manor Nursing Hou the facility tour on S approximately 12:4 revealed that fire e conducted at varyin fire drills for the day between 10:30 am	exit drill records for Viking ne for 2012 and 2013, prior to September 18, 2013, at 5 pm, by surveyor 03006, xit drills are not being ng times and situations. All four y shifts have been conducted and 11:00 am, and 3 of 4 of ills were conducted between om								
K 056 SS=F	the facility tour and NFPA 101 LIFE SA If there is an autom installed in accorda for the Installation oprovide complete c	Van verified this finding during at the exit conference. FETY CODE STANDARD atic sprinkler system, it is nce with NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the m is properly maintained in	K 05	6 Repair of the sprinkler syster was completed on Septembe 2013.The ceiling tiles that ha been removed to work on the sprinkler system was replace	or 26, d					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: M6T721

Facility ID: 00075

If continuation sheet Page 5 of 9

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

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

_(CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		-			0938-0391
		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1		IPLE CONSTRUCTION IG 01 - 1965 BUILDING 01		TE SURVEY MPLETED
			245559	B. WING	i		09	/18/2013
1.5		PROVIDER OR SUPPLIER	ME			STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585		
	(X4) ID PREF/X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING.INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS=REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	K 056	accordance with NF Inspection, Testing, Water-Based Fire F supervised. There supply for the syste systems are equipp	PA 25, Standard for the and Maintenance of Protection Systems. It is fully is a reliable, adequate water m. Required sprinkler ed with water flow and tamper electrically connected to the	κo)56	6		
	5. 19	Based on observati staff it was determin sprinkler system is r with NFPA 13, Stand Sprinkler Systems a Safety Code" 2000 of This deficient practic progress throughout	a not met as evidenced by: ions and an interview with hed that the automatic fire not operational in accordance dard for the Installation of and NFPA 101 "The Life edition (LSC) section 19.3.5. ce could allow a fire to t the building and negatively esidents, all staff and any					
	ļ	September 18, 2013 surveyor 03006, rev 1) The automatic sp the the replacement 1981 building. It has	uring the facility tour on 8, 1:00 pm and 2:45 pm, by					4
		2) Ceiling tiles are m lounge.	issing in the west nurse's					
FORM	1 CMS-256	7(02-99) Previous Versions C	Obsolete Event ID:M6T721		Fac	acility ID: 00075 If contin	ation shee	t Page 6 of 9

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

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	ENTE	RS FOR MEDICANE	& MEDICAID SERVICES			-	. 0930-0391
		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 8 01 - 1965 BUILDING 01	(X3) DAT CON	TE SUAVEY MPLETED
			245559	B. WING		09	/18/2013
		Provider or Supplier Manor Nursing Ho	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585	100	
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING.INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	K 056 K 062 SS=C	The Maintenance N the facility tour and with the Administrat NFPA 101 LIFE SAN Required automatic continuously mainta condition and are in	an verified this finding during at the exit conference and or by telephone. FETY CODE STANDARD sprinkler systems are ined in reliable operating	K 056			10/22/13
ľ	(Be)	Based on a review of was determined that system may not hav accordance with NF Inspection, Maintena Suppression System properly maintain the system could affect a	not met as evidenced by: of facility documentation, it t the automatic sprinkler e been serviced in in PA 25 The Standard for ance of Water Based is (1999 edition). Failure to e automatic fire sprinkler all 45 of the residents, all staff e sprinkler system fails to a fire emergency.				
		Viking Manor Nursin Company, prior to th 18, 2013, at approxir 03006, revealed that	ystem testing records for g Home by Allied Sprinkler e facility tour on September nately 12:55 pm, by surveyor the documentation of the test was not available (the dicated 12-18-12).				
		the facility tour and a	an verified this finding during t the exit conference. ETY CODE STANDARD		The extension cord that was run through the plaster ceiling		
FORM	CMS-256	7(02-99) Previous Versions O	bsolete Event ID: M6T721	Fac	ility ID: 00075 If continua	tion shee	t Page 7 of 9

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

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	245559	B. WING		09/18/2013
PROVIDER OR SUPPLIER	DME		317 FIRST STREET NORTHWEST	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
Electrical wiring and	d equipment is in accordance	K 147		fire 10/22/13
Based on observat extension cord was and used as a subs and is not in accord National Electrical C This deficient practi of the device causin	ions it was determined that an run thorugh the plaster ciling titute for permanent wiring ance with NFPA 70 "The Code" (NEC) 1999 edition. ce could cause over heating ng a fire that will negatively		2	
Maintenance Man d September 18, 2013 pm, by surveyor 030 extension cord was ceiling in the janitors	uring the facility tour on 3, between 1:00pm and 2:45 006, revealed that a flexible extending through the plaster s closet by the main entrance,	5		*
the facility tour and a NFPA 101 LIFE SAF Where a required au out of service for mo period, the authority and the building is er watch system is pro- unprotected by the s	at the exit conference ETY CODE STANDARD utomatic sprinkler system is ore than 4 hours in a 24-hour having jurisdiction is notified, vacuated or an approved fire vided for all parties left thutdown until the sprinkler	K 154	p.m. a fire watch for the entire building was put in place. This fire watch continued until Thurs September 19,2013 at 1:45 p.r at which time the sprinkler syst was up and working. The sprin	sday n. em kler
	PROVIDER OR SUPPLIER MANOR NURSING HC SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa Electrical wiring and with NFPA 70, Nati This STANDARD is Based on observat extension cord was and used as a subs and is not in accord National Electrical C This deficient practi of the device causir impact the residents area of the cord. Findings include: Observationsa and Maintenance Mand September 18, 2013 pm, by surveyor 030 extension cord was ceiling in the janitors serving a condicatio The Maintenance M the facility tour and a NFPA 101 LIFE SAF Where a required at out of service for m period, the authority and the building is e watch system is pro- unprotected by the s	QF CORRECTION IDENTIFICATION NUMBER: 245559 PROVIDER OR SUPPLIER MANOR NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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	OF CORRECTION DENTIFICATION NUMBER: A. BUILDING 245559 B. WING	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - 1965 BUILDING 01 245559 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STRE, ZIP CODE MANOR NURSING HOME STREET NORTHWEST ULEN, MN 56585 Summary Statement of DEPICIENCIES (EACH DEPICIENCY OR LSC IDENTIFYING INFORMATION) PREV REGULATORY OR LSC IDENTIFYING INFORMATION PREV Continued From page 7 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Continued From page 7 K 147 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 K 147 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 used as a substitute for permanent wiring and is not in accordance with NFPA 70 "The National Electrical Code" (NEC) 1999 edition. Findings include: Observations 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 fiexible extension cord was extending through the plaster ceiling in the jantors closet by the main entrance, serving a condication pump. K 154 On September 18, 2013 at 2:3 p.m. a fire watch for the entire building was put in place. This fire watch continued until Thurs september 19,2013 at 1:45 p.r. at which time the spirinkler system is fire watch continued until Thurs

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

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION IG 01 - 1965 BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245559	B. WING		09/	09/18/2013	
	F PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	" ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 154	This STANDARD is Based on a review interview with staff i facility staff is not fo out of service policy system in accordan- edition sections 19.3 deficient practice co- residents, the staff a is out of service and containing a fire is p Findings include: A review of the Vikin Watch Policy, an int and an interview wit installers, during the 18, 2013, between surveyor 03006, rev automatic fire sprink to the project to repli- system in the 1981 the has been shut off sin 2013 at approximate not be operational un 2013 at noon. An im- revealed that the face watch as per facility 9.7.6.1. (Facility staff entire building by the The Maintenance Ma	s not met as evidenced by: of documentation and an t was determined that the llowing the facility's written for the automatic sprinkler ce with NFPA 101 (LSC) 2000 3.4.5.1 and 9.7.6.1. This uid negatively impact all 45 and any visitors if the system in a alternative method of rovided. In alternative method of rovided. In a daternative method of rovided. In a daternative method of rovided. In a daternative method of rovided. In a laternative method of rovided. In the Advance sprinkler system was shut off due ace the leaking dry pipe puliding. The sprinkler system for a model of the survey in the section is tarted a fire watch for the end of the survey. An verified this finding during t the exit conference and r by telephone.		on Tuesday September 24, 20 at 12:30 p.m. at which time a f watch was again put into effect On Thursday September 26, 2 at 10:45 the sprinkler system we activated so we discontinued to 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 signatu. The Administrator will ensure to the sprinkler system is out of service for more than 4 hours is 24 hour period that our fire wat plan is put in place.	ire tt. 2013 was he d ure. hat if n a tch	10/22/13	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1	LE CONSTRUCTION 3 03 - BUILDING 0202		E SURVEY
	-	245559	B. WING		09/	18/2013
AME OF	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP CODE		
/IKING I	MANOR NURSING H	OME		317 FIRST STREET NORTHWEST ULEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC.IDENTIEYING INFORMATION)		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED.TO.THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE
K 000	INITIAL COMMEN	TS	K 000			
× .	FIRE SAFETY			· A la		
	02 PT Addition			POC 0K S 11-21-13		
		POC WILL SERVE AS YOUR		6 1121-17		
		COMPLIANCE UPON THE ACCEPTANCE. YOUR		AS IT		
		HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS F COMPLIANCE.				
		OF AN ACCEPTABLE POC, AN		12		
	CONDUCTED TO				1	
89		MPLIANCE WITH THE AS BEEN ATTAINED IN		· · · · · · · · · · · · · · · · · · ·		
	ACCORDANCE W	ITH YOUR VERIFICATION.		E		
		Survey was conducted by the nent of Public Safety. At the				
	time of this survey,	Viking Manor Nursing Home found not in substantial				
	compliance with the	e requirements for participation and at 42 CFR, Subpart				
	483.70(a), Life Safe	ety from Fire, and the 2000		DECEIVER	2	
	(NFPA) Standard 1	Fire Protection Association 01, Life Safety Code (LSC),				
	Chapter 18 New He			NOV 2 0 2013	少	
	PLEASE RETURN CORRECTION FO	THE PLAN OF R THE FIRE SAFETY				
	DEFICIENCIES (K	TAGS) TO:		MN DEPT. OF PUBLIC SAFET STATE FIRE MARSHAL DIVISIO	NN.	
	Health Care Fire In: State Fire Marshal I					
	445 Minnesota Stre St. Paul, MN 55101					
				TITLE		XEVDATE
HATORY	JODON K		NI UNE	Administrator	10/3	113
leficiency	statement ending with	an asterisk (*) denotes a deficiency which	h the institutio	on may be excused from correcting providin nursing homes, the findings stated above a	g it is determ	fined that

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

ļ		STATEMENT OF DEFICIENCIES 'D PLAN OF CORRECTION ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 0202			(X3) DATE SURVEY COMPLETED	
			245559	B. WING			09/	18/2013
		Provider or Supplier Manor Nursing Ho	ME		STREET ADDRESS, CITY, STATE, 317 FIRST STREET NORTHWE ULEN, MN 56585			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC.IDENTIFYING.INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
	K 000	Continued From pa	ge 1	K OC	00			>
		Or by e-mail to: Marian.Whitney@st Barbara.Lundberg@	Østate.mn.us				8	(2)
		Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:			ż			
		1. A description of w to correct the deficie	hat has been, or will be, done ency.	ň				
ţ		2. The actual, or pro	posed, completion date.					
A	цЕ.	prevent a reoccurrer	ection and monitoring to nce of the deficiency					
	1	without a basement different times. The constructed in 1965 Type II (000) constru- west was constructe determined to be Typ separated from the c	g Home is a 1-story building and constructed at five original building was and was determined to be of action. An addition to the d in 1981 that was be V (111) construction and is original building with a 2-hour cting link was constructed in					
		1994 to the north end the facility to an apar connecting link was of south of the west wir clinic. Both buildings existing nursing hom 2003 a 24 foot by 42 constructed to the so	ting link was constructed in d of the east wing to connect tment building and a constructed in 1998 to the ng to connect the facility to a are separated from the e with 2-hour fire barriers. In foot, PT addition was buth of the east wing that is tion, 1-story without a			α 		
FC		7(02-99) Previous Versions O	bsolete Event ID:M6T721	F	acility ID: 00075	If continuat	lon sheel	Page 2 of 8

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

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION (X G 03 - BUILDING 0202	3) DATE SURVEY COMPLETED
×	1. 	245559	B. WING	129	09/18/2013
	Provider or supplier Manor Nursing HC	DME		STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
K 000	Continued From pa	ge 2	K 000	D	
9	automatic fire sprin accordance with NI Installation of Sprin The facility has a fir detection in the cor areas in the 1965 b smoke detectors in 1965 building that a installed in accorda National Fire Alarm alarm system is mo department notifical automatic fire detect system in accordan Fire Code 2007 edit The facility has a ca census of 40 at the	pacity of 45 beds and had a			
SS=F	NOT MET as evider NFPA 101 LIFE SAF Fire drills are held a varying conditions, a The staff is familiar that drills are part of Responsibility for pla assigned only to cor qualified to exercise conducted between	42 CFR, Subpart 483.70(a) is need by: ETY CODE STANDARD t unexpected times under at least quarterly on each shift. with procedures and is aware established routine. anning and conducting drills is npetent persons who are leadership. Where drills are 9 PM and 6 AM a coded be used instead of audible	° К 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 da shift and 5:30 a.m. for the night shift.	,
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 03 - BUILDING 0202	(X3) DATE SURVEY COMPLETED
		245559	B. WING_		09/18/2013
	Provider or supplier	DME		STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTIO
K 050	Continued From pa	ge 3	K 05	50	
	Based on a review determined that the conducted fire exit National Fire Protect "The Life Safety Co section 19.7.1.2. No could allow confusion response, which wo	s not met as evidenced by: of fire drill records, it was facility staff have not drills in accordance with otion Association (NFPA) 101 de" (LSC) 2000 edition of conducting fire exit drills on and delay in the staff build negatively impact all 45 I any visitors in a fire		2	
i.	Manor Nursing Horr the facility tour on S approximately 12:45 revealed that fire ex conducted at varying fire drills for the day between 10:30 am a	exit drill records for Viking the for 2012 and 2013, prior to eptember 18, 2013, at 5 pm, by surveyor 03006, it drills are not being g times and situations. All four shifts have been conducted and 11:00 am, and 3 of 4 of is were conducted between m			5
K 056 SS=F	the facility tour and a NFPA 101 LIFE SAF There is an automat in accordance with N Installation of Sprink components, device complete coverage of The system is maint NFPA 25, Standard 1	an verified this finding during at the exit conference. ETY CODE STANDARD ic sprinkler system, installed NFPA 13, Standard for the ler Systems, with approved s, and equipment, to provide of all portions of the facility. ained in accordance with for the Inspection, Testing, Water-Based Fire Protection	K 056	³ 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	d. 10/22/13

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

STATEMENT OF DEFICIEN	CIES (X1) PROVID	ER/SUPPLIER/CLIA		IPLE CONSTRUC NG 03 - BUILDIN			TE SURVEY APLETED
ſ		245559	B. WING			09/	/18/2013
NAME OF PROVIDER OR					ESS, CITY, STATE, ZIP (REET NORTHWEST 66585		
PREFIX (EACH I	MARY STATEMENT OF D DEFICIENCY MUST BE PRE TORY OR LSC.IDENTIFY.IN	ECEDED BY FULL	ID PREFIX TAG	(EAC	OVIDER'S PLAN OF CO + CORRECTIVE ACTION -REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
Systems. supply for with water	From page 4 There is a reliable, a the system. The sys low and tamper swit to the fire alarm sys	tern is equipped ches which are	K 05	56			
Based on staff it was sprinkler sy with NFPA Sprinkler S Safety Cod This deficie progress th	DARD is not met as observations and an determined that the rstem is not operatio 13, Standard for the ystems and NFPA 10 e" 2000 edition (LSC ont practice could allo roughout the building of the residents, all ne facility.	interview with automatic fire nal in accordance Installation of 01 "The Life C) section 19.3.5. bow a fire to g and negatively					
Maintenand September surveyor 03 1) The auto the the repl 1981 buildir	clude: ns and an interview w e Man during the fac 18, 2013, 1:00 pm a 006, revealed that: matic sprinkler syste acement of the dry p ng. It has been shut 6-2013 from approx	cility tour on and 2:45 pm, by em is shut off due bipe system in the down since	×				
2) Ceiling til Iounge.	es are missing in the	e west nurse's					
The Mainten the facility to	nance Man verified to our and at the exit co	his finding during onference and Event ID:M6T721		acility ID: 00075		continuation shee	

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 0202			(X3) DATE SURVEY COMPLETED			
		245559	B. WING			09/	18/2013		
	AME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585					
(X4) ID PREFIX TAG	K (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
K 056 K 062 SS=C	with the Administra NFPA 101 LIFE SA Required automatic continuously mainta condition and are in	-	ко)56 162	The sprinkler system has been tested and tagged. The tag is attached to the sprinkler valve mechanical room.		10/22/13		
н 20	Based on a review was determined that system may not hav accordance with NF Inspection, Mainten Suppression System properly maintain the system could affect	s not met as evidenced by: of facility documentation, it it the automatic sprinkler ve been serviced in in PA 25 The Standard for ance of Water Based ns (1999 edition). Failure to e automatic fire sprinkler all 45 of the residents, all staff ne sprinkler system fails to a fire emergency.							
	Viking Manor Nursir Company, prior to the 18, 2013, at approxi 03006, revealed that	system testing records for ng Home by Allied Sprinkler ne facility tour on September mately 12:55 pm, by surveyor t the documentation of the n test was not available (the dicated 12-18-12).					2		
K 154 SS=F	the facility tour and a NFPA 101 LIFE SAF	an verified this finding during at the exit conference. ETY CODE STANDARD utomatic sprinkler system is ore than 4 hours in a 24-hour	K 15		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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TATEMEN O PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROV/DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 03 - Building 0202		TE SURVEY MPLETED
		245559	B. WING			09	/18/2013
	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 17 FIRST STREET NORTHWEST JLEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC.IDENT/FYING (NEORMATION)	ID PREFID . TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REEERENCED.TO.THE APPROPRI DEFICIENCY)		(X5) COMPLETI DATE
	period, the authorit and the building is watch system is pr unprotected by the system has been re- This STANDARD in Based on a review interview with staff facility staff is not for out of service polic system in accordar edition sections 19 deficient practice of residents, the staff is out of service and containing a fire is p Findings include: A review of the Viki Watch Policy, an in and an interview wi installers, during the 18, 2013, between surveyor 03006, rev automatic fire sprint to the project to rep system in the 1981 has been shut off si 2013 at approximat not be operational u 2013 at noon. An in revealed that the far watch as per facility 9.7.6.1. (Facility sta	ty having jurisdiction is notified, evacuated or an approved fire ovided for all parties left shutdown until the sprinkler eturned to service. 9.7.6.1 is not met as evidenced by: of documentation and an it was determined that the ollowing the facility's written y for the automatic sprinkler nee with NFPA 101 (LSC) 2000 .3.4.5.1 and 9.7.6.1. This ould negatively impact all 45 and any visitors if the system d no alternative method of	K 1		fire watch continued until Thurs September 19,2013 at 1:45 p.r at which time the sprinkler syste was up and working. The sprin system was then shut down ag on Tuesday September 24, 20 at 12:30 p.m. at which time a fit watch was again put into effect On Thursday September 26, 20 at 10:45 the sprinkler system w 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 signatur The Administrator will ensure the the sprinkler system is out of service for more than 4 hours in 24 hour period that our fire watch plan is put in place.	n. em kler ain 13 re D13 as as ie	10/22/1

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STATEMENT			(X2) MULT A. BUILDIN	(X3) DATE SURVEY COMPLETED	
T		245559	B. WING		09/18/2013
	Provider or supplier) DME		STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC.IDENT.IFYING.INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED-TO-THE APPI DEFICIENCY)	ULD BE COMPLÉTION
K 154	The Maintenance M	fan verified this finding during at the exit conference and	K 15	54	
		2			a
				×	
-	x ¹ (1)			×.	