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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RMJU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00075

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/18/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 05/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/21/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/13/2015
(L33)

DETERMINATION APPROVAL

CMS Certification Number (CCN): 245559

May 21, 2015

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 May 10, 2015 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
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 21, 2015

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

RE: Project Number S5559023

Dear Mr. Kjos:

On April 14, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 2, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 18, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 19, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 2, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 10, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 2, 2015, effective May 10, 2015 and therefore remedies outlined in our letter to you dated April 14, 2015, will not be imposed.

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.

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

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245559	A. Building B. Wing	5/18/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **05/05/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/05/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **05/05/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/05/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	05/21/2015	28035	05/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/2/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245559	A. Building B. Wing **01 - 1965 BUILDING 01**	5/19/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **04/22/2015**	ID Prefix	Correction Completed **05/01/2015**	ID Prefix	Correction Completed **04/22/2015**
Reg. # **NFPA 101** LSC K0025		Reg. # **NFPA 101** LSC K0027		Reg. # **NFPA 101** LSC K0029	
ID Prefix	Correction Completed **04/22/2015**	ID Prefix	Correction Completed **04/22/2015**	ID Prefix	Correction Completed **04/22/2015**
Reg. # **NFPA 101** LSC K0046		Reg. # **NFPA 101** LSC K0047		Reg. # **NFPA 101** LSC K0052	
ID Prefix	Correction Completed **05/10/2015**	ID Prefix	Correction Completed **04/22/2015**	ID Prefix	Correction Completed **04/22/2015**
Reg. # **NFPA 101** LSC K0067		Reg. # **NFPA 101** LSC K0073		Reg. # **NFPA 101** LSC K0147	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	05/21/2015	27200	05/19/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/31/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245559	03 - BUILDING 0202	5/19/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0067	Correction Completed 05/10/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	05/21/2015	27200	05/19/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/31/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RMJU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00075

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/02/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NEII 04/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/11/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 05/13/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0204

April 14, 2015

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

RE: Project Number S5559023

Dear Mr. Kjos:

On April 2, 2015, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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:

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

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

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

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

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

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 12, 2015, 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 May 12, 2015 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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 July 2, 2015 (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 October 2, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting 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 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5559s15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245559	A. BUILDING _____ B. WING _____	04/02/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Approved 4/30/15 SS	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	Resident R-54's careplan was updated on 4-4-15 to reflect a focus for antidepressant medication use and a focus for Insomnia with proper goals and interventions. Director of nursing reviewed all careplans of residents who are on an antidepressant/hypnotic to ensure a plan of care was in place. Policy and procedures were re-evaluated and staff involved in creating careplans were re-educated re: careplans on 4-21-15. Director of nursing or designee will conduct random audits to ensure all careplans are updated accordingly to reflect resident's current plan of care. All results from the audits will be brought before the QA panel.	05/05/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 4/24/2015

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

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F 279	Continued From page 1 by: Based on interview and document review, the facility failed to develop a comprehensive care plan that included the daily use of Trazadone (sleep medication) and Citalopram (antidepressant medication) for 1 of 5 resident (R54) who was reviewed for unnecessary medication. Findings include: R54's undated, Order Summary Report indicated R54 was diagnosed with insomnia, depression and diabetes. The Report also indicated R54 was prescribed a sleep medication (Trazadone) 100 milligrams (MG) at bedtime for insomnia and an antidepressant (Citalopram) 20 MG daily for depression. Review of R54's care plan, dated 4/1/14, did not identify the use of an antidepressant to aid with insomnia, nor did the plan include sleep monitoring or documentation of sleep patterns, and lack non-pharmacological interventions related to insomnia. The care plan also did not identify the use of an antidepressant for depression and lacked mood/behavior monitoring and non-pharmalogical interventions related to symptoms of depression. The use of Trazadone and Citalopram were not addressed on the care plan. During interview on 4/2/15, at 1:20 p.m. registered nurse (RN)- A confirmed R54 was currently receiving Trazadone for insomnia and	F 279		

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F 279	Continued From page 2 Citalopram for depression daily and verified the medications were not addressed on R54's care plan and stated if a resident was on psychotropics, they were to have a care plan developed. During interview on 4/2/15, at 1:47 p.m. the director of nursing (DON) confirmed R54 was currently receiving Trazadone for insomnia and Citalopram for depression daily and verified the medications were not addressed on R54's care plan and stated "I do not know how that got missed, the care plan was not done, I would expect staff to develop the care plan on admission." Review of facility policy titled, Care Plans Comprehensive, revised on 8/06, directed staff to develop an individualized comprehensive care plan that included measurable objectives and timetables in order to meet the resident's medical, nursing, mental and psychological needs for each resident.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide shaving	F 282	Resident R-55 was shaved on 4-2-15. All staff educated on shaving all residents who need it on bath days and prn. Staff educated on the purpose of a resident's careplan and implementation of the careplan. DON or designee will do random audits. The information from the audits will be brought to QA.	05/05/15

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F 282	Continued From page 3 assistance as directed by the individualized care plan for 1 of 1 resident (R55) who required staff assistance for grooming. Findings include: R55's care plan, dated 2/10/15, directed staff to assist R55 with personal hygiene / grooming twice a day and as needed and to encourage resident to do what she was able to do. During observation on 3/31/15, at 9:40 a.m. R55, was noted to have dark, thick facial hair on her upper lip which extended over her lip area. R55 was also observed to have several chin hairs that were approximately 1/4 inch or longer. -At 4:45 p.m. R55 continues to have dark facial hair on her upper lip, which was very thick and extended over her lip area and also had several chin hairs that was approximately 1/4 inch or longer. During observation on 4/1/15, from 7:05 a.m. until 7:18 a.m. nursing assistant (NA)-C was observed to provide R55 morning cares which consisted of personal / oral hygiene, hair combing and dressing assistance while R55 was in the bathroom. At 7:18 a.m. NA-C assisted R55 out of the bathroom, wheeled her down the hallway and positioned her next to the nurses station. Although, NA-C was observed to comb R55's hair, and provide hygiene care, at no time did NA-C offer or provide assistance to remove the facial hair. -At 7:24 a.m. licensed practical nurse (LPN)-A	F 282		

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F 282	Continued From page 4 was observed to administer R55 her morning medications. At not time did LPN-A make note of R55's excessive facial hair. -At 7:33 a.m. another resident began to assist R55 by pushing her wheelchair down to the dining room area for breakfast. During observation on 4/2/15, at 9:27 a.m. R55 was observed sitting in the bird room reading the newspaper. R55 continued to have dark, thick facial hair on her upper lip which extended over her lip area and also had several chin hairs that was approximately 1/4 inch or longer. -At 11:01 a.m. NA-A assisted R55 to the bath tub room for her weekly routine bath. -At 11:22 a.m. R55 was observed sitting in the bird room reading the newspaper. R55's facial hair remained the same. During interview on 4/2/15, at 10:05 a.m. NA-B confirmed R55 needed assistance with grooming and shaving. NA-A stated she had never shaved R55 because it was done once a week during her routine bath. NA-B stated she had never shaved R55 and had never had to do a touch up shave during the week. During interview on 4/2/15, at 11:26 a.m. NA-A confirmed R55 required staff assistance with grooming needs. NA-A also verified R55 had excessive facial hair on her upper lip and chin. NA-A stated she thought R55 should be shaved when her facial hair got that long as her care plan directed us too.	F 282		

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F 282	Continued From page 5 On 4/2/15, at 1:16 p.m. R55 was observed in her room. R55's facial hair had been removed, however, R55 continued to have dark hair on her left upper lip area right below her nose. During interview on 4/2/15, at 1:16 p.m. R55 stated NA-A did not offer to shave her facial hair during her bath and stated NA-A had never asked her if she wanted to be shaved, rather "she just did it." "I didn't even have to ask her to do it today." During interview on 4/2/15, at 1:53 p.m. director of nursing (DON) stated she had expected staff to offer shaving on bath days and as needed. The DON also stated it was her expectation that staff followed the resident's care plan. The DON confirmed R55 required staff assistance with grooming and shaving. Review of facility policy titled, Using The Care Plan, revised on 9/10/14, indicated the care plan shall be used in developing the resident's daily care routines and would be available to staff personal who have responsibility for providing care and services to the resident.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document interview, the facility failed to provide shaving assistance for 1 of 3 residents (R55) who required assistance with grooming. Findings include: R55's care plan, dated 2/10/15, indicated staff was to assist R55 with oral personal hygiene twice a day and as needed. Encourage resident to do what she is able. R55's 60 day Minimum Data Set (MDS) dated 3/19/15, indicated R55 had severe cognitive impairment and required extensive assistance with activities of daily living such as toileting and personal hygiene. During observation on 3/31/15, at 9:40 a.m. R55 was noted to have dark, thick, facial hair on her upper lip which extended over her lip area and also had several chin hairs that were approximately 1/4 inch or longer. -At 4:45 p.m. R55's facial hair was observed to remain the same. During observation on 4/1/15, from 7:05 a.m. until 7:18 a.m. nursing assistant (NA)-C was observed to provide R55 morning cares which consisted of personal / oral hygiene, hair	F 312	Resident R-55 was shaved on 4-2-15. All staff educated on shaving all residents who need it on bath days and prn. Staff educated on the purpose of a resident's careplan and implementation of the careplan. DON or designee will do random audits. The information from the audits will be brought to QA.	05/05/15

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F 312	Continued From page 7 combing and dressing assistance while R55 was in the bathroom. At 7:18 a.m. NA-C assisted R55 out of the bathroom, wheeled her down the hallway and positioned her next to the nurses station. Although, NA-C was observed to comb R55's hair, and provide hygiene care, at no time did NA-C offer or provide assistance to remove the facial hair. -At 7:24 a.m. licensed practical nurse (LPN)-A was observed to administer R55 her morning medications. At not time did LPN-A make note of R55's excessive facial hair. -At 7:33 a.m. another resident began to assist R55 by pushing her wheelchair down to the dining room area for breakfast. During observation on 4/2/15, at 9:27 a.m. R55 was observed sitting in the bird room reading the newspaper. R55 continued to have dark, thick, facial hair on her upper lip which extended over her lip area and also had several chin hairs that was approximately 1/4 inch or longer. -At 11:01 a.m. NA-A assisted R55 to the bath tub room for her weekly routine bath. -At 11:22 a.m. R55 was observed sitting in the bird room reading the newspaper. R55's facial hair remained the same. During interview on 4/2/15, at 10:05 a.m. NA-B confirmed R55 needed assistance with grooming and shaving. NA-A stated she had never shaved R55 because it was done once a week during her routine bath. NA-B stated she had never shaved R55 and had never had to do a touch up shave during the week.	F 312		

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F 312	Continued From page 8 During interview on 4/2/15, at 11:26 a.m. NA-A confirmed R55 required staff assistance with grooming needs. NA-A also verified R55 had excessive facial hair on her upper lip and chin. NA-A stated she thought R55 should be shaved when her facial hair got that long as her care plan directed us too. On 4/2/15, at 1:16 p.m. R55 was observed in her room. R55's facial hair had been removed however, R55 continued to have dark hair on her left upper lip area right below her nose. During interview on 4/2/15, at 1:16 p.m. R55 stated NA-A did not offer to shave her facial hair during her bath and stated NA-A had never asked her if she wanted to be shaved, rather "she just did it." "I didn't even have to ask her to do it today." During interview on 4/2/15, at 1:53 p.m. director of nursing (DON) stated she had expected staff to offer shaving on bath days and as needed. The DON also stated it was her expectation that staff followed the resident's care plan. The DON confirmed R55 required staff assistance with grooming and shaving. Review of facility policy titled, Shaving Resident, revised on 12/07, indicated the purpose of this is to promote cleanliness and to provide skin care.	F 312		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 9 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	Infection control logbook was updated on 4-6-15 to include the location of the residents room and what culture or organism was present. DON or designee will continue to monitor for trends and ensure proper surveillance and investigations are done of infections. A new policy was created for the monitoring of infection control. DON or designee will do random audits to ensure the proper documentation is in place. The information from the audits will be discussed at QA.	05/05/15

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F 441	Continued From page 10 Based on interview and document review, the facility failed to establish an infection control program that included surveillance and investigation of infections that occurred in the facility. This had the potential to affect all 43 residents currently residing the facility. Findings include: During review of the facility's Resident Infection Control Log (s) from November 2014, through March 2015, the following infections were entered: 7 upper respiratory infection (URI), 1 pneumonia, 1 aspiration pneumonia, 1 nausea, 3 vomiting, 13 fever, 4 fever / vomiting, 5 vomiting / diarrhea, 2 diarrhea, 8 loose stools, 1 wound infection, 11 urinary infections (UTI), 3 cellulitis, 2 thrush, 1 conjunctivitis, 1 boil, 1 cyst and 1 ear infection. Of this data the following had not been included for infection control surveillance on the Resident Infection Control Log (s): resident name and location within the facility and culture results performed. The logs had been completed by the infection control coordinator (ICC), however, the ICC had not analyzed the data in order to track trends and patterns of the infections within the facility. During an interview on 4/02/2015, at 2:39 p.m., the director of nursing (DON) indicated she had recently become responsible for the infection control program and would be the infection control coordinator however, stated "I haven't done much with it." The DON/ICC indicated nursing staff at the east and west nurses station had documented symptoms of infection in	F 441		

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F 441	Continued From page 11 separate three ring binders which were then transferred by the infection control nurse to a main three ring binder that was taken to the QA (quality assurance) meeting for review. The DON/ICC stated the purpose of the infection control program was to track staff and resident illnesses to see if there is was pattern and then "come up with a plan to take." The DON/ICC verified the program did not include review of the organisms of infection nor did it track the location of the infections in the building. The DON/ICC confirmed the tracking and trending regarding area of the building and specific organisms had not been done. The requested facility policy regarding the infection control program was not provided.	F 441		

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

F5559024

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

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Viking Manor Nursing Home 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	POCok JS 4-27-15 RECEIVED APR 27 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 5-12-15
EXIT: 4-2-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 4/24/2015

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245559	A. BUILDING **01 - 1965 BUILDING 01** B. WING _____	**03/31/2015**

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

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K 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Viking Manor Nursing Home is a 1-story building without a basement and constructed at five different times. The original building was constructed in 1965 and was determined to be of Type II (000) construction. An addition to the west was constructed in 1981 that was determined to be Type V (111) construction and is separated from the original building with a 2-hour fire barrier. A connecting link was constructed in 1994 to the north end of the east wing to connect the facility to an apartment building and a connecting link was constructed in 1998 to the south of the west wing to connect the facility to a clinic. Both buildings are separated from the existing nursing home with 2-hour fire barriers. In 2003 a 24 foot by 42 foot, PT addition was constructed to the south of the east wing that is Type II(000) constriction, 1-story without a	K 000		

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	245559	A. BUILDING 01 - 1965 BUILDING 01 B. WING _____	03/31/2015

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K 000	Continued From page 2 basement. The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridor system and in common areas in the 1965 building, with sleeping room smoke detectors in the 1981 addition and the 1965 building that are on the fire alarm system installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 45 beds and had a census of 43 at the time of the survey. The facility was surveyed as two buildings. The requirement at 42 CFR, Subpart 483.70(a) is not met.	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems.	K 025	Red-4-hour rated Fire Barrier caulk has been placed in the 3 1 inch diameter holes in the smoke barrier wall in the director of nursing office, above the smoke barrier doors located in the southeast wing by the director of nursing office, and around communication wires above the ceiling tiles at the smoke barrier door in the center wing going down the corridor to the	04/22/15

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K 025	Continued From page 3 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of several smoke barrier walls construction that meet the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect residents, staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 9:30 AM to 2:30 PM on 03/31/2015 observation revealed, The following deficient practices were found affecting the smoke barriers throughout the facility: 1) there are three 1 inch diameter holes in the smoke barrier wall that is part of the director of nursing office, 2) there is a penetration in the smoke barrier above the smoke barrier doors located in the south east wing by the director of nursing office, and 3) there is a penetration around communication wires above the ceiling tiles at the center wing smoke barrier by the nurses station. This was confirmed by the Maintenance staff member (CW).	K 025	west nurses station.	
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 027	A door coordinator (door sequencing device) for the smoke barrier door leading to the	05/01/15

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K 027	Continued From page 4 Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect residents, staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 9:30 AM to 2:30 PM on 03/31/2015 observation revealed that the smoke barrier doors in the south east wing by the director of nursing office awing in the same direction and they are not equipped with a door sequencing device. This was confirmed by the Maintenance staff member (CW).	K 027	southeast wing by the director of nursing office has been ordered and will be installed once received.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029	The latch into the door frame leading to the soiled linen room in the service hall has been	04/22/15

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K 029	Continued From page 5 fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors. Findings include: On facility tour between 9:30 AM to 2:30 PM on 03/31/2015, observation revealed, that The door to the soiled linen room in the service hall did not fully close and positively latch into the door frame. This was confirmed by the Maintenance staff member (CW).	K 029	adjusted so the door will fully close and positively latch. Monthly inspections of doors will be conducted by maintenance to ensure all doors close and properly latch.	

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K 046	Continued From page 6	K 046		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9, 19.2.9.1. This deficient practice could affect residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 9:30 AM to 2:30 PM on 03/31/2015, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance staff member (CW) revealed the that the facility failed to conduct the required annual 90 minute testing of the battery backup emergency lights. This was confirmed by the Maintenance staff member (CW).	K 046	Maintenance has conducted 90 minute testing of battery backup emergency lights and documented the results. Testing and documentation will be conducted annually.	04/22/15
K 047 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 047	The exit light located in the main dining room has been replaced and is operational.	04/22/15

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K 047	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation, the facility has failed to provide 1 of several operational exit signs that marks the means of egress path in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.5.2. The deficient practice could affect residents, staff and visitors, if the lack of properly illuminated exit sign prevented a means of egress from being utilized in a timely manner in an emergency situation. Findings include: On facility tour between 9:30 AM to 2:30 PM on 03/31/2015, it was observed that the exit light that is located in the main dining room was inoperative and would not illuminate. This was confirmed by the Maintenance staff member (CW).	K 047		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	The HVAC diffusers have been relocated allowing at least 36 inches of space from the smoke detectors by the southeast wing smoke barrier doors and by the northwest wing by room 24.	04/22/15

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K 052	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the facility. Findings include: On facility tour between 9:30 AM to 2:30 PM on 03/31/2015, observation revealed the following smoke detectors were located within 36 inches of a HVAC diffuses: 1) southeast wing by the smoke barrier doors, 2) northwest wing by room 24. This was confirmed by the Maintenance staff member (CW).	K 052		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	Arrangements have been made to have our fire and smoke dampers inspected. Test/inspection documentation will be kept on file. Arrangements will be made for inspections every 4 years.	05/10/15

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K 067	Continued From page 9 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect the safety of all residents, staff and visitors in the event of a fire. Findings include: On facility tour between 9:30 AM to 2:30 PM on 03/31/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Maintenance staff member (CW), that the facility failed to provide documentation that the fire and smoke dampers have been tested/inspected within the last 4 years. This was confirmed by the Maintenance staff member (CW).	K 067		
K 073 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, the	K 073	Decorations on the corridor side of rooms 15 and 18 have been removed. Family members who placed the decorations have been instructed that decorations must be treated with a fire retardant treatment. Residents and families will be informed upon admission of resident that any decorations	04/22/15

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K 073	Continued From page 10 facility failed to maintain combustible decoration in accordance with NFPA Life Safety Code 101 (00) section 19.7.5.4. The failure to treat and maintain the combustible decorations throughout the facility in accordance with NFPA Life Safety Code 101 (00) could allow smoke and fire to rapidly migrate through the corridors and negatively affect the egress capability in the event of an emergency for residents, visitors and staff of the facility. Findings include: On facility tour between 9:30 AM to 2:30 PM on 03/31/2015, observations revealed that Resident rooms 15, 18, had decorations located on the corridor side of their room doors. After an interview with Maintenance staff member (CW), It could not be verified whether or not these decorations were treated with a fire retardant treatment. This was confirmed by the Maintenance staff member (CW).	K 073	need be treated with a fire retardant.	
K 147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD 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 observation and interview with the staff the facility was using unapproved electrical devices that are not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of 4 of	K 147	The multi-plug adaptor in the day room located in the north-east wing has been removed. Staff have been instructednot to use multi-plug adaptors.	04/22/15

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K 147	Continued From page 11 45 residents, staff and visitors. Findings include: On facility tour between 9:30 AM to 2:30 PM on 03/31/2015, observations revealed that there is a power strip that has been plugged into a multi-plug adaptor in the day room located in the northeast wing. This was confirmed by the Maintenance staff member (CW).	K 147		

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	245559	A. BUILDING 03 - BUILDING 0202 B. WING _____	03/31/2015

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 4/24/2015

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

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K 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Viking Manor Nursing Home is a 1-story building without a basement and constructed at five different times. The original building was constructed in 1965 and was determined to be of Type II (000) construction. An addition to the west was constructed in 1981 that was determined to be Type V (111) construction and is separated from the original building with a 2-hour fire barrier. A connecting link was constructed in 1994 to the north end of the east wing to connect the facility to an apartment building and a connecting link was constructed in 1998 to the south of the west wing to connect the facility to a clinic. Both buildings are separated from the existing nursing home with 2-hour fire barriers. In 2003 a 24 foot by 42 foot, PT addition was constructed to the south of the east wing that is Type II(000) constriction, 1-story without a	K 000		

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	245559	A. BUILDING 03 - BUILDING 0202 B. WING _____	03/31/2015

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K 000	Continued From page 2 basement. The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridor system and in common areas in the 1965 building, with sleeping room smoke detectors in the 1981 addition and the 1965 building that are on the fire alarm system installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 45 beds and had a census of 43 at the time of the survey. The facility was surveyed as two buildings. The requirement at 42 CFR, Subpart 483.70(a) is not met.The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by:	K 067	Arrangements have been made to have our fire and smoke dampers inspected. Test/inspection documentation will be kept on file. Arrangements will be made for inspections every 4 years.	05/10/15

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K 067	Continued From page 3 Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect the safety of all residents, staff and visitors in the event of a fire. Findings include: On facility tour between 9:30 AM to 2:30 PM on 03/31/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Maintenance staff member (CW), that the facility failed to provide documentation that the fire and smoke dampers have been tested/inspected within the last 4 years. This was confirmed by the Maintenance staff member (CW).	K 067		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0204

April 14, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5559023

Dear Mr. Kjos:

The above facility was surveyed on March 30, 2015 through April 2, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104 Fax: (218) 308-2122

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at the phone number or email listed above.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

5559s15lic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00075	A. BUILDING: _____ B. WING _____	04/02/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/30/15, 3/31/15, 4/1/15, and 4/2/15, surveyors of this Department's staff, visited the above provider and the following correction orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program, Lyla Burkman, Unit Supervisor, 705 5th St. N.W., Suite A Bemidji, MN 56601	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care.	2 302		

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2 302	Continued From page 2 (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided information regarding Alzheimer's disease and dementia training, including a description of the training program, the categories of employees trained, the frequency of training and the basic topics covered in the training in a written or electronic form. Findings include: No documentation was found to include information regarding staff training of Alzheimer's disease and dementia as required, including review of the facility admission packet. During an interview on 4/1/15, at 9:58 a.m., the	2 302		

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2 302	Continued From page 3 director of nursing (DON) verified the facility had not provided consumers with the required information regarding Alzheimer's training. The DON indicated she was not aware of the requirement. SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet for consumer information. The DON or designee could educate staff and conduct audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan that included the daily use of Trazadone (sleep medication) and Citalopram	2 560		

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2 560	Continued From page 4 (antidepressant medication) for 1 of 5 resident (R54) who was reviewed for unnecessary medication. Findings include: R54's undated, Order Summary Report indicated R54 was diagnosed with insomnia, depression and diabetes. The Report also indicated R54 was prescribed a sleep medication (Trazadone) 100 milligrams (MG) at bedtime for insomnia and an antidepressant (Citalopram) 20 MG daily for depression. Review of R54's care plan, dated 4/1/14, did not identify the use of an antidepressant to aid with insomnia, nor did the plan include sleep monitoring or documentation of sleep patterns, and lack non-pharmacological interventions related to insomnia. The care plan also did not identify the use of an antidepressant for depression and lacked mood/behavior monitoring and non-pharmalogical interventions related to symptoms of depression. The use of Trazadone and Citalopram were not addressed on the care plan. During interview on 4/2/15, at 1:20 p.m. registered nurse (RN)- A confirmed R54 was currently receiving Trazadone for insomnia and Citalopram for depression daily and verified the medications were not addressed on R54's care plan and stated if a resident was on psychotropics, they were to have a care plan developed.	2 560		

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2 560	Continued From page 5 During interview on 4/2/15, at 1:47 p.m. the director of nursing (DON) confirmed R54 was currently receiving Trazadone for insomnia and Citalopram for depression daily and verified the medications were not addressed on R54's care plan and stated "I do not know how that got missed, the care plan was not done, I would expect staff to develop the care plan on admission." Review of facility policy titled, Care Plans Comprehensive, revised on 8/06, directed staff to develop an individualized comprehensive care plan that included measurable objectives and timetables in order to meet the resident's medical, nursing, mental and psychological needs for each resident. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to care plan development and educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use	2 565		

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2 565	Continued From page 6 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide shaving assistance as directed by the individualized care plan for 1 of 1 resident (R55) who required staff assistance for grooming. Findings include: R55's care plan, dated 2/10/15, directed staff to assist R55 with personal hygiene / grooming twice a day and as needed and to encourage resident to do what she was able to do. During observation on 3/31/15, at 9:40 a.m. R55, was noted to have dark, thick facial hair on her upper lip which extended over her lip area. R55 was also observed to have several chin hairs that were approximately 1/4 inch or longer. -At 4:45 p.m. R55 continues to have dark facial hair on her upper lip, which was very thick and extended over her lip area and also had several chin hairs that was approximately 1/4 inch or longer. During observation on 4/1/15, from 7:05 a.m. until 7:18 a.m. nursing assistant (NA)-C was observed to provide R55 morning cares which	2 565		

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2 565	Continued From page 7 consisted of personal / oral hygiene, hair combing and dressing assistance while R55 was in the bathroom. At 7:18 a.m. NA-C assisted R55 out of the bathroom, wheeled her down the hallway and positioned her next to the nurses station. Although, NA-C was observed to comb R55's hair, and provide hygiene care, at no time did NA-C offer or provide assistance to remove the facial hair. -At 7:24 a.m. licensed practical nurse (LPN)-A was observed to administer R55 her morning medications. At not time did LPN-A make note of R55's excessive facial hair. -At 7:33 a.m. another resident began to assist R55 by pushing her wheelchair down to the dining room area for breakfast. During observation on 4/2/15, at 9:27 a.m. R55 was observed sitting in the bird room reading the newspaper. R55 continued to have dark, thick facial hair on her upper lip which extended over her lip area and also had several chin hairs that was approximately 1/4 inch or longer. -At 11:01 a.m. NA-A assisted R55 to the bath tub room for her weekly routine bath. -At 11:22 a.m. R55 was observed sitting in the bird room reading the newspaper. R55's facial hair remained the same. During interview on 4/2/15, at 10:05 a.m. NA-B confirmed R55 needed assistance with grooming and shaving. NA-A stated she had never shaved R55 because it was done once a week during her routine bath. NA-B stated she had never shaved R55 and had never had to do a touch up shave during the week.	2 565		

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2 565	Continued From page 8 During interview on 4/2/15, at 11:26 a.m. NA-A confirmed R55 required staff assistance with grooming needs. NA-A also verified R55 had excessive facial hair on her upper lip and chin. NA-A stated she thought R55 should be shaved when her facial hair got that long as her care plan directed us too. On 4/2/15, at 1:16 p.m. R55 was observed in her room. R55's facial hair had been removed, however, R55 continued to have dark hair on her left upper lip area right below her nose. During interview on 4/2/15, at 1:16 p.m. R55 stated NA-A did not offer to shave her facial hair during her bath and stated NA-A had never asked her if she wanted to be shaved, rather "she just did it." "I didn't even have to ask her to do it today." During interview on 4/2/15, at 1:53 p.m. director of nursing (DON) stated she had expected staff to offer shaving on bath days and as needed. The DON also stated it was her expectation that staff followed the resident's care plan. The DON confirmed R55 required staff assistance with grooming and shaving. Review of facility policy titled, Using The Care Plan, revised on 9/10/14, indicated the care plan shall be used in developing the resident's daily care routines and would be available to staff personal who have responsibility for providing care and services to the resident.	2 565		

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2 565	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could inservice staff regarding the purpose of a resident care plan, implementation of the care plan and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document interview, the facility failed to provide shaving assistance for 1 of 3 residents (R55) who required assistance with grooming. Findings include: R55's care plan, dated 2/10/15, indicated staff was to assist R55 with oral personal hygiene twice a day and as needed. Encourage resident	2 920		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 10 to do what she is able. R55's 60 day Minimum Data Set (MDS) dated 3/19/15, indicated R55 had severe cognitive impairment and required extensive assistance with activities of daily living such as toileting and personal hygiene. During observation on 3/31/15, at 9:40 a.m. R55 was noted to have dark, thick, facial hair on her upper lip which extended over her lip area and also had several chin hairs that were approximately 1/4 inch or longer. -At 4:45 p.m. R55's facial hair was observed to remain the same. During observation on 4/1/15, from 7:05 a.m. until 7:18 a.m. nursing assistant (NA)-C was observed to provide R55 morning cares which consisted of personal / oral hygiene, hair combing and dressing assistance while R55 was in the bathroom. At 7:18 a.m. NA-C assisted R55 out of the bathroom, wheeled her down the hallway and positioned her next to the nurses station. Although, NA-C was observed to comb R55's hair, and provide hygiene care, at no time did NA-C offer or provide assistance to remove the facial hair. -At 7:24 a.m. licensed practical nurse (LPN)-A was observed to administer R55 her morning medications. At not time did LPN-A make note of R55's excessive facial hair. -At 7:33 a.m. another resident began to assist R55 by pushing her wheelchair down to the dining room area for breakfast.	2 920		

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	00075	A. BUILDING: _____ B. WING _____	04/02/2015

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2 920	Continued From page 11 During observation on 4/2/15, at 9:27 a.m. R55 was observed sitting in the bird room reading the newspaper. R55 continued to have dark, thick, facial hair on her upper lip which extended over her lip area and also had several chin hairs that was approximately 1/4 inch or longer. -At 11:01 a.m. NA-A assisted R55 to the bath tub room for her weekly routine bath. -At 11:22 a.m. R55 was observed sitting in the bird room reading the newspaper. R55's facial hair remained the same. During interview on 4/2/15, at 10:05 a.m. NA-B confirmed R55 needed assistance with grooming and shaving. NA-A stated she had never shaved R55 because it was done once a week during her routine bath. NA-B stated she had never shaved R55 and had never had to do a touch up shave during the week. During interview on 4/2/15, at 11:26 a.m. NA-A confirmed R55 required staff assistance with grooming needs. NA-A also verified R55 had excessive facial hair on her upper lip and chin. NA-A stated she thought R55 should be shaved when her facial hair got that long as her care plan directed us too. On 4/2/15, at 1:16 p.m. R55 was observed in her room. R55's facial hair had been removed however, R55 continued to have dark hair on her left upper lip area right below her nose. During interview on 4/2/15, at 1:16 p.m. R55 stated NA-A did not offer to shave her facial hair during her bath and stated NA-A had never asked	2 920		

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2 920	Continued From page 12 her if she wanted to be shaved, rather "she just did it." "I didn't even have to ask her to do it today." During interview on 4/2/15, at 1:53 p.m. director of nursing (DON) stated she had expected staff to offer shaving on bath days and as needed. The DON also stated it was her expectation that staff followed the resident's care plan. The DON confirmed R55 required staff assistance with grooming and shaving. Review of facility policy titled, Shaving Resident, revised on 12/07, indicated the purpose of this is to promote cleanliness and to provide skin care. SUGGESTED METHOD OF CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with adctivities of daily living. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing	21375		

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21375	Continued From page 13 home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program that included surveillance and investigation of infections that occurred in the facility. This had the potential to affect all 43 residents currently residing the facility. Findings include: During review of the facility's Resident Infection Control Log (s) from November 2014, through March 2015, the following infections were entered: 7 upper respiratory infection (URI), 1 pneumonia, 1 aspiration pneumonia, 1 nausea, 3 vomiting, 13 fever, 4 fever / vomiting, 5 vomiting / diarrhea, 2 diarrhea, 8 loose stools, 1 wound infection, 11 urinary infections (UTI), 3 cellulitis, 2 thrush, 1 conjunctivitis, 1 boil, 1 cyst and 1 ear infection. Of this data the following had not been included for infection control surveillance on the Resident Infection Control Log (s): resident name and location within the facility and culture results performed. The logs had been completed by the infection control coordinator (ICC), however, the ICC had not analyzed the data in order to track trends and patterns of the infections within the facility. During an interview on 4/02/2015, at 2:39 p.m., the director of nursing (DON) indicated she had	21375		

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21375	Continued From page 14 recently become responsible for the infection control program and would be the infection control coordinator however, stated "I haven't done much with it." The DON/ICC indicated nursing staff at the east and west nurses station had documented symptoms of infection in separate three ring binders which were then transferred by the infection control nurse to a main three ring binder that was taken to the QA (quality assurance) meeting for review. The DON/ICC stated the purpose of the infection control program was to track staff and resident illnesses to see if there is was pattern and then "come up with a plan to take." The DON/ICC verified the program did not include review of the organisms of infection nor did it track the location of the infections in the building. The DON/ICC confirmed the tracking and trending regarding area of the building and specific organisms had not been done. The requested facility policy regarding the infection control program was not provided. Suggested Method of Correction: The director of nursing or her designee could review policy and procedures regarding infection control program. The director of nursing or her designee could educate staff on policy and procedures and develop a monitoring system to ensure compliance with surveillance analysis and trending was completed. Time Period for Correction: Twenty one (21) days.	21375		

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21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure a two-step tuberculin skin test (TST) was completed for 1 of 5 newly hired employees (nursing assistant (NA)-G) reviewed for the tuberculosis (TB) program. Findings include: NA-G was hired on 3/12/15. The facility completed the TB baseline screening tool on	21426		

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21426	Continued From page 16 3/12/2015, and obtained a copy of NA-G's health Mantoux (another term used for TST) card from Clay County Public Health which included the following information: NA-G's name Date given: 2/23/15 at 4:40 p.m. in left forearm Date read: 2/26/15 at 1:00 p.m. Result: was 0 mm (millimeter) negative During interview on 4/2/15, at 1:34 p.m. the director of nursing (DON) confirmed NA-G did not receive the second TST, and received the first TST with a negative result at another location. The DON stated it was the facility's policy to give two-step TST to all newly hired employees. The facility's Tuberculosis Employee Screening policy dated 2001, indicated if the reaction to the first skin test was negative, the facility will administer a second skin test 1 to 2 weeks after the first test.	21426		

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21426	Continued From page 17 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		