DEPARTMENT OF HEA						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL FE SURVEY AGENCY	ID: RMJU
1. MEDICARE/MEDICAID PROV (L1) 245559 2.STATE VENDOR OR MEDICA (L2) 734040100	/IDER NO.	3. NAME AND AL (L3) VIKING MA (L4) 317 FIRST S (L5) ULEN, MN	DDRESS OF FAC	CILITY NG HOMI		Facility ID: 00075 4. TYPE OF ACTION: 7_(L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE (L9) 6. DATE OF SURVEY 0: 8. ACCREDITATION STATUS: 0 Unaccredited 1 TM 2 AOA 3 Ott	5/18/2015 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	PPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/IIE 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 0 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30
 11. LTC PERIOD OF CERTIFICAT From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	FION 45 (L18) 45 (L17)	Complianc 1. A B. Not in Com		ram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A	7. Medical Director
14. LTC CERTIFIED BED BREAF	ZDOWN			Ì	15. FACILITY MEETS	
18 SNF 18/19 S 45		ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY R	EMARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Lyla Burkman, Uni	t Supervisor	0	5/21/2015	(L19)	Mark Meath	, Enforcement Specialist 05/21/2015 (L20)
]	PART II - TO BE	COMPLETED I	BY HCFA RE	GIONAI	COFFICE OR SINGLE S	TATE AGENCY
 DETERMINATION OF ELIG <u>X</u> 1. Facility is Eligible <u>2</u>. Facility is not Eligible 	to Participate		IPLIANCE WITH ITS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	IENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION 06/01/1991	BEGINNING	G DATE	ENDING DAT	ΓE	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	8
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER
	A. Suspension	n of Admissions:	(L44)		or other reason for whilehawar	07-Provider Status Change 00-Active
(L27)	B. Rescind S	uspension Date:	. ,			
			(L45)			
28. TERMINATION DATE:	29). INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)	05/13/2015		(L33)	DETERMINATION APP	ROVAL
	· · · ·			. /		



Protecting, Maintaining and Improving the Health of Minnesotans 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



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

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245559	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 5/18/2015
Name of Facility		Street Address, City, State, Zip Code	
VIKING MANOR NURSING HOME		317 FIRST STREET NORTHWE ULEN, MN 56585	EST

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	i) Date	(Y4) Item		(Y5) D	ate	(Y4)	Item		(Y5)	Date
ID Prefix	F0279	Correction Completed 05/05/2015	ID Prefix	F0282	Co	rrection mpleted 05/2015		ID Prefix	F0312		Correction Completed 05/05/2015
	483.20(d), 483.20(k)(1)			483.20(k)(3)(ii)					483.25(a)(3)		
	F0441 483.65	Correction Completed 05/05/2015	Reg. #		Co	rrection mpleted					
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Co	rrection mpleted		Reg. #			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Co	rrection mpleted		Reg. #			Correction Completed
Reg. #			Beg. #		Co	rrection mpleted		Б <i>и</i>			
Reviewed I	By Reviewed	d By	Date:	Signature	of Survey	vor:				Date:	
State Agen	cy LB/mi	n	05/21/201	5		2803	5			05/	18/2015
Reviewed I CMS RO	By Reviewed	d By	Date:	Signature	of Survey	or:				Date:	
Followup t	to Survey Completed o 4/2/2015	n:		Check for any Uncorrected					Summary of the Facility?	YES	NO

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245559	(Y2) Multiple Cons A. Building B. Wing	° 01 - 1965 BUII DING 01		(Y3) Date of Revisit 5/19/2015
Name of Facility			Street Address, City, State, Zip Code	
VIKING MANOR NURSING HOME			317 FIRST STREET NORTHWE ULEN, MN 56585	EST

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
			Correction				Correction					Correction
ID Prefix			Completed 04/22/2015	ID Prefix			Completed 05/01/2015		ID Prefix			Completed 04/22/2015
	NFPA 101				NFPA 101				-	NFPA 101		
LSC	K0025			LSC	K0027				LSC	K0029		
			Correction				Correction					Correction
ID Prefix			Completed 04/22/2015	ID Prefix			Completed 04/22/2015		ID Prefix			Completed 04/22/2015
Reg. #	NFPA 101			Reg. #	NFPA 101				Reg. #	NFPA 101		
LSC	K0046			LSC	K0047				LSC	K0052		
			Correction				Correction					Correction
ID Prefix			Completed 05/10/2015	ID Prefix			Completed 04/22/2015		ID Prefix			Completed 04/22/2015
	NFPA 101		-		NFPA 101					NFPA 101		
-	K0067			LSC	K0073				-	K0147		
			Correction				Correction					Correction
ID Prefix			Completed	ID Prefix			Completed		ID Prefix			Completed
Reg. #			-	Reg. #								_
LSC				LSC					LSC			
			Correction				Correction					Correction
ID Prefix			Completed	ID Prefix			Completed		ID Prefix			Completed
Reg. #				Reg. #								
									LSC			_
Reviewed	Зу	Reviewed	-	Date:	Signature		-				Date:	
State Agen	су	PS/mn	n	05/21/20	15		2720	00			05/	19/2015
Reviewed	Ву	Reviewed	Ву	Date:	Signature	e of Sur	veyor:				Date:	
Followup	o Survey Co	mpleted or /2015	1:							Summary of the Facility?	YES	
	3/31	12010					- (,	, -	169	NO

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245559	(Y2) Multiple Cons A. Building B. Wing	struction 03 - BU	(Y3) Date of Revisit 5/19/2015	
Name of Facility			Street Address, City, State, Zip Code	
VIKING MANOR NURSING HOME	317 FIRST STREET NORT ULEN, MN 56585			ST

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	i) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 05/10/2015	ID Prefix		Correction Completed	ID Prefix		Correction Completed
0	NFPA 101	_	Reg. #			Reg. #		
LSC	K0067	_	LSC					
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #		_	Reg. #			Dea #		
	-	-				LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Profix		Completed	ID Profix		Completed
		_						
Reg. # LSC		-	Reg. # LSC			LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #								
LSC		-	LSC			LSC		
ID Prefix		Correction Completed	ID Prefix		Correction Completed	ID Prefix		Correction Completed
Reg. #			Reg. #			Reg. #		
LSC		-	LSC			LSC		
Reviewed E	By Reviewe	d By	Date:	Signature of Sur	veyor:		Date	:
State Agen	cy PS/mr	n	05/21/2015		2720	0	05,	/19/2015
Reviewed E CMS RO	3y Reviewed	d By	Date:	Signature of Sur	veyor:		Date	:
Followup t	o Survey Completed o 3/31/2015	n:		Check for any Uncor Uncorrected Defic		iencies. Was a Su S-2567) Sent to the		NO

DEPARTMENT OF HEAI						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: RMJU
1. MEDICARE/MEDICAID PROV (L1) 245559 2.STATE VENDOR OR MEDICAI (L2) 734040100	IDER NO.	3. NAME AND AI (L3) VIKING MA (L4) 317 FIRST S (L5) ULEN, MN	DDRESS OF FAC	CILITY NG HOM		Facility ID: 00075 4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
 5. EFFECTIVE DATE CHANGE (L9) 6. DATE OF SURVEY 04 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	/ 02/2015 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/III 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 0 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30
 11LTC PERIOD OF CERTIFICAT From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	10N 45 (L18) 45 (L17)	Complianc 1. A X B. Not in Con	nce With equirements e Based On: cceptable POC	gram	2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
^{14.} LTC CERTIFIED BED BREAK 18 SNF 18/19 SN 45		ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY R	EMARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Denise Erickson, H	FE NEII	0	4/30/2015	(L19)	Mark Meath	, Enforcement Specialist 05/11/2015 (L20)
Ī	PART II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	
 DETERMINATION OF ELIGI 1. Facility is Eligible 2. Facility is not Eligible 	to Participate		IPLIANCE WITH HTS ACT:	H CIVIL		uncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	/IENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION 06/01/1991	BEGINNING	G DATE	ENDING DAT	ГЕ	<u>VOLUNTARY</u> <u>0</u> 01-Merger, Closure	0 INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	5
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER
(L27)	-	n of Admissions:	(L44)		04-Other Reason for whithdrawar	07-Provider Status Change 00-Active
	D. Reseniu St	ispension Date.	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	. ,		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE	Posted 05/13/2015 Co).
	(L32)			(L33)	DETERMINATION APP	ROVAL



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: 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

		AND HUMAN SERVICES	e 			FORM	: 04/14/2015 1APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		APR 2 7 2015		TE SURVEY MPLETED
		245559	B. WING	R.Air	merten Department of Hackh	04	/02/2015
NAME OF I	PROVIDER OR SUPPLIER		1		EET ADDRESS, CITY, STATE, ZIP CODE		
	MANOR NURSING HO	ME			FIRST STREET NORTHWEST EN, MN 56585		
		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIC	N	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	COMPLETION DATE
F 000	INITIAL COMMENT	ſS	FO	00			
	as your allegation on Department's accest	of correction (POC) will serve of compliance upon the otance. Your signature at the age of the CMS-2567 form will ion of compliance.	р. С. Д.			Appri	30/15 30/15 80
F 279 SS=D	revisit of your facilit that substantial con has been attained in verification.	acceptable POC an on-site y will be conducted to validate apliance with the regulations in accordance with your (1) DEVELOP E CARE PLANS	F 2	79	•		05/05/15
	to develop, review a comprehensive plan The facility must de plan for each reside objectives and time medical, nursing, an needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any so be required under § due to the resident's	velop a comprehensive care ent that includes measurable tables to meet a resident's nd mental and psychosocial tified in the comprehensive describe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided s exercise of rights under he right to refuse treatment			Resident R-54's careplan was on 4-4-15 to reflect a f antidepressant medication u focus for Insomnia with proper interventions. Director of reviewed all careplans of resid are on an antidepressant/hy ensure a plan of care was in pla and procedures were re-evalu- staff involved in creating carep re-educated re: careplans or Director of nursing or desi conduct random audits to e careplans are updated acco reflect resident's current plane	focus f se and goals a nursi dents w pnotic ace. Poli uated a olans we n 4-21-1 ignee v ensure rdingly of care.	for a nd ng ho to to cy nd ere L5. vill all to All
		IT is not met as evidenced			before the QA panel.	L	
LABORATOR			IATURE	Ĺ	Id no in strater	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 date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued 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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 04/14/2015 1 APPROVED): 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		FE SURVEY MPLETED
		245559	B. WING	;		04	/02/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		,
	MANOR NURSING HO	ME			317 FIRST STREET NORTHWEST ULEN, MN 56585		:
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	facility failed to deve plan that included th (sleep medication) a (antidepressant medication.) Findings include: R54's undated, Order R54's undated, Order R54 was diagnosed and diabetes. The R prescribed a sleep r milligrams (MG) at the antidepressant (Citat depression.) Review of R54's car identify the use of an insomnia, nor did the monitoring or docum and lack non-pharm related to insomnia. identify the use of an depression and lack and non-pharmalogi symptoms of depress and Citalopram were plan. During interview on a registered nurse (RM	and document review, the elop a comprehensive care ne daily use of Trazadone and Citalopram dication) for 1 of 5 resident ewed for unnecessary er Summary Report indicated with insomnia, depression deport also indicated R54 was nedication (Trazadone) 100 bedtime for insomnia and an alopram) 20 MG daily for e plan, dated 4/1/14, did not n antidepressant to aid with e plan include sleep nentation of sleep patterns, acological interventions The care plan also did not n antidepressant for ed mood/behavior monitoring cal interventions related to usion. The use of Trazadone e not addressed on the care	F2	279	9		

Facility ID: 00075

If continuation sheet Page 2 of 12

	TMENT OF HEALTH	AND HUMAN SERVICES				FORM	: 04/14/2015 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			(X3) DATE SURVEY COMPLETED	
		245559	B. WING	G		04/	02/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VIKING	MANOR NURSING HO	ME		-	JLEN, MN 56585		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
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			279		<i>¥</i>	
F 282 SS=D	Comprehensive, re develop an individu plan that included r timetables in order nursing, mental and resident. 483.20(k)(3)(ii) SEF PERSONS/PER C/ The services provided b accordance with ea care. This REQUIREMEN by: Based on observat	olicy titled, Care Plans vised on 8/06, directed staff to alized comprehensive care neasurable objectives and to meet the resident's medical, d psychological needs for each RVICES BY QUALIFIED ARE PLAN led or arranged by the facility y qualified persons in ich resident's written plan of NT is not met as evidenced tion, interview and document ailed to provide shaving	F	282	Resident R-55 was shaved on 4-2 educated on shaving all residents on bath days and prn. Staff educ purpose of a resident's careplan implementation of the careplan. designee will do random audits. information from the audits will QA.	s who r ated or and DON o The	need it n the r

Event ID: RMJU11

Facility ID: 00075

If continuation sheet Page 3 of 12

		AND HUMAN SERVICES				FOR	D: 04/14/2015 M APPROVED D. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION G		ATE SURVEY
		245559	B. WING	;		04	1/02/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
VIKING	MANOR NURSING HO	DME			317 FIRST STREET NORTHWEST ULEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 282	assistance as direc	ted by the individualized care lent (R55) who required staff	F2	282	2		
	assist R55 with per twice a day and as	ted 2/10/15, directed staff to sonal hygiene / grooming needed and to encourage she was able to do.					
	was noted to have upper lip which externa was also observed were approximately -At 4:45 p.m. R55 c hair on her upper lip extended over her	on 3/31/15, at 9:40 a.m. R55, dark, thick facial hair on her ended over her lip area. R55 to have several chin hairs that 1/4 inch or longer. continues to have dark facial b, which was very thick and ip area and also had several approximately 1/4 inch or					
	until 7:18 a.m. nurs observed to provide consisted of person combing and dressi in the bathroom. At out of the bathroom hallway and position station. Although, N R55's hair, and prov did NA-C offer or pr the facial hair.	on 4/1/15, from 7:05 a.m. ing assistant (NA)-C was e R55 morning cares which al / oral hygiene, hair ng assistance while R55 was 7:18 a.m. NA-C assisted R55 , wheeled her down the hed her next to the nurses A-C was observed to comb vide hygiene care, at no time ovide assistance to remove ed practical nurse (LPN)-A					

Event ID: RMJU11

Facility ID: 00075

If continuation sheet Page 4 of 12

		AND HUMAN SERVICES				FORM): 04/14/2015 A APPROVED). 0938-0391	
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION		TE SURVEY MPLETED	
		245559	B. WING			04	/02/2015	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
VIKINGI	MANOR NURSING HO	ME			317 FIRST STREET NORTHWEST ULEN, MN 56585			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 282	medications. At not R55's excessive fac -At 7:33 a.m. anoth R55 by pushing her room area for break During observation was observed sitting newspaper. R55 co facial hair on her up her lip area and also was approximately -At 11:01 a.m. NA-A room for her weekly -At 11:22 a.m. R55 v bird room reading th hair remained the sa During interview on confirmed R55 need and shaving. NA-A R55 because it was routine bath. NA-B s R55 and had never during the week. During interview on confirmed R55 requ grooming needs. NA excessive facial hair NA-A stated she tho	Iminister R55 her morning time did LPN-A make note of cial hair. her resident began to assist wheelchair down to the dining cfast. on 4/2/15, at 9:27 a.m. R55 g in the bird room reading the ntinued to have dark, thick oper lip which extended over to had several chin hairs that 1/4 inch or longer. A assisted R55 to the bath tub routine bath. was observed sitting in the ne newspaper. R55's facial	F 2	282	2			

If continuation sheet Page 5 of 12

		AND HUMAN SERVICES				FORM	04/14/2013 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION			E SURVEY PLETED
		245559	B. WING			04/0	2/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE		
VIKING	MANOR NURSING HO	ME		317 FIRST STREET NORTHWEST ULEN, MN 56585			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD E	BE	(X5) COMPLETION DATE
F 282	On 4/2/15, at 1:16 p room. R55's facial h however, R55 contin left upper lip area rig During interview on stated NA-A did not during her bath and her if she wanted to did it." "I didn't even today." During interview on of nursing (DON) sta offer shaving on bat DON also stated it w followed the residen	 b.m. R55 was observed in her hair had been removed, hued to have dark hair on her ght below her nose. 4/2/15, at 1:16 p.m. R55 offer to shave her facial hair stated NA-A had never asked be shaved, rather "she just have to ask her to do it 4/2/15, at 1:53 p.m. director ated she had expected staff to h days and as needed. The was her expectation that staff t's care plan. The DON ired staff assistance with 	F 2.	282			
F 312 SS=D	Plan, revised on 9/1 shall be used in dev care routines and we personal who have r care and services to 483.25(a)(3) ADL C/ DEPENDENT RESID A resident who is un daily living receives	ARE PROVIDED FOR	F 31	12			

Facility ID: 00075

If continuation sheet Page 6 of 12

PRINTED: 04/14/2015

DEPAR		AND HUMAN SERVICES	FORM APPRO OMB NO. 0938-						
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING			E SURVEY IPLETED		
		245559	B. WING	;		04	/02/2015		
	PROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE				
					317 FIRST STREET NORTHWEST				
VIKING	MANOR NURSING HC	OME		1	ULEN, MN 56585				
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
F 312	Continued From pa	ge 6	F	312	Resident R-55 was shaved on 4-				
	by: Based on observat interview, the facilit	NT is not met as evidenced tion, interview and document y failed to provide shaving 3 residents (R55) who e with grooming.			educated on shaving all residen on bath days and prn. Staff edu purpose of a resident's careplar implementation of the careplan designee will do random audits. information from the audits will QA.	cated on and . DON or The	the		
	was to assist R55 v	ted 2/10/15, indicated staff vith oral personal hygiene needed. Encourage resident ble.							
	3/19/15, indicated F impairment and req	num Data Set (MDS) dated R55 had severe cognitive Juired extensive assistance Ily living such as toileting and							
	was noted to have upper lip which extended also had several ch approximately 1/4 i	on 3/31/15, at 9:40 a.m. R55 dark, thick, facial hair on her ended over her lip area and in hairs that were nch or longer. facial hair was observed to							
	until 7:18 a.m. nurs observed to provide	on 4/1/15, from 7:05 a.m. ing assistant (NA)-C was e R55 morning cares which nal / oral hygiene, hair							

Facility ID: 00075

If continuation sheet Page 7 of 12

PRINTED: 04/14/2015

		AND HUMAN SERVICES & MEDICAID SERVICES					RM APPROVED NO. 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 Y Y		PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		245559	B. WING	;			04/02/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST		
	MANOR NURSING HO	ME			ULEN, MN 56585		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 312	combing and dressi in the bathroom. At out of the bathroom hallway and position station. Although, N R55's hair, and prov did NA-C offer or pr the facial hair. -At 7:24 a.m. license was observed to ad medications. At not R55's excessive fac -At 7:33 a.m. anoth R55 by pushing her room area for break During observation was observed sitting newspaper. R55 col facial hair on her up her lip area and also was approximately -At 11:01 a.m. NA-A room for her weekly -At 11:22 a.m. R55 bird room reading th hair remained the sa During interview on confirmed R55 need and shaving. NA-As R55 because it was routine bath. NA-B	ng assistance while R55 was 7:18 a.m. NA-C assisted R55 , wheeled her down the ned her next to the nurses A-C was observed to comb vide hygiene care, at no time ovide assistance to remove ed practical nurse (LPN)-A minister R55 her morning time did LPN-A make note of vial hair. er resident began to assist wheelchair down to the dining fast.	F	312	2		

Facility ID: 00075

If continuation sheet Page 8 of 12

		AND HUMAN SERVICES				FOR	D: 04/14/2015 MAPPROVED D. 0938-0391
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245559	B. WING			04	/02/2015
NAME OF	PROVIDER OR SUPPLIER		· · · · ·	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
VIKING	MANOR NURSING HO	ME			317 FIRST STREET NORTHWEST JLEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	During interview on confirmed R55 requ grooming needs. NA excessive facial hair NA-A stated she tho when her facial hair directed us too. On 4/2/15, at 1:16 p room. R55's facial hair directed us too. On 4/2/15, at 1:16 p room. R55's facial hair however, R55 contin left upper lip area rig During interview on 4 stated NA-A did not of during her bath and s her if she wanted to did it." "I didn't even to day." During interview on 4 of nursing (DON) sta offer shaving on bath DON also stated it wa followed the resident"	 4/2/15, at 11:26 a.m. NA-A ired staff assistance with A-A also verified R55 had on her upper lip and chin. ught R55 should be shaved got that long as her care plan m. R55 was observed in her air had been removed bued to have dark hair on her the below her nose. 4/2/15, at 1:16 p.m. R55 offer to shave her facial hair stated NA-A had never asked be shaved, rather "she just have to ask her to do it 4/2/15, at 1:53 p.m. director ted she had expected staff to days and as needed. The as her expectation that staff s care plan. The DON red staff assistance with 	F 3	\$12			
F 441	revised on 12/07, indi to promote cleanlines	cy titled, Shaving Resident, icated the purpose of this is s and to provide skin care. CONTROL, PREVENT	F 441	1			

Facility ID: 00075

If continuation sheet Page 9 of 12

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245559 04/02/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **317 FIRST STREET NORTHWEST** VIKING MANOR NURSING HOME **ULEN, MN 56585** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 441 Continued From page 9 F 441 05/05/15 The facility must establish and maintain an Infection control logbook was updated on 4-6-Infection Control Program designed to provide a 15 to include the location of the residents room safe, sanitary and comfortable environment and and what culture or organism was present. DON to help prevent the development and transmission of disease and infection. or designee will continue to monitor for trends and ensure proper surveillance and (a) Infection Control Program investigations are done of infections. A new The facility must establish an Infection Control policy was created for the monitoring of Program under which it -(1) Investigates, controls, and prevents infections infection control. DON or designee will do in the facility: random audits to ensure the proper (2) Decides what procedures, such as isolation, documentation is in place. The information should be applied to an individual resident; and (3) Maintains a record of incidents and corrective from the audits will be discussed at QA. 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:

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

Facility ID: 00075

If continuation sheet Page 10 of 12

PRINTED: 04/14/2015

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	D: 04/14/2015 MAPPROVED D. 0938-0391	
STATEMEN	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED	
		245559	B. WING	; 		04	/02/2015	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST			
VIKING	MANOR NURSING HO	ME			ULEN, MN 56585			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
	Based on interview facility failed to esta program that include investigation of infect facility. This had the residents currently r Findings include: During review of the Control Log (s) from March 2015, the folle entered: 7 upper res pneumonia, 1 aspira vomiting, 13 fever, 4 diarrhea, 2 diarrhea infection, 11 urinary 2 thrush, 1 conjuncti infection. Of this data included for infection C	and document review, the blish an infection control ed surveillance and ctions that occurred in the e potential to affect all 43 esiding the facility. facility's Resident Infection November 2014, through owing infections were piratory infection (URI), 1 tion pneumonia, 1 nausea, 3 fever / vomiting, 5 vomiting / , 8 loose stools, 1 wound v infections (UTI), 3 cellulitis, vitis, 1 boil, 1 cyst and 1 ear a the following had not been o control surveillance on the ontrol Log (s): resident name	F 4	14 ⁻				
	performed. The logs infection control coor ICC had not analyze	ne facility and culture results had been completed by the rdinator (ICC), however, the d the data in order to track of the infections within the						
	the director of nursin recently become resp control program and control coordinator h done much with it." T	on 4/02/2015, at 2:39 p.m., g (DON) indicated she had ponsible for the infection would be the infection owever, stated "I haven't 'he DON/ICC indicated ast and west nurses station optoms of infection in						

If continuation sheet Page 11 of 12

PRINTED: 04/14/2015

		AND HUMAN SERVICES				FOR	D: 04/14/2015 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTI			ATE SURVEY OMPLETED
		245559	B. WING			04	4/02/2015
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRES	S, CITY, STATE, ZIP CODE		
	MANOR NURSING HO	ME		317 FIRST STRE ULEN, MN 565	EET NORTHWEST 585		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH C	VIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO EFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	transferred by the ir main three ring bind (quality assurance) DON/ICC stated the control program was illnesses to see if th "come up with a pla verified the program organisms of infection of the infections in the confirmed the tracki area of the building not been done. The requested facili	ge 11 binders which were then affection control nurse to a ler that was taken to the QA meeting for review. The e purpose of the infection is to track staff and resident ere is was pattern and then in to take." The DON/ICC did not include review of the on nor did it track the location he building. The DON/ICC ing and trending regarding and specific organisms had ty policy regarding the gram was not provided.	F 4	41			
-ORM CMS-256	67(02-99) Previous Versions C	bsolete Event ID: RMJU11		Facility ID: 00075	If continua	ation sheet I	Page 12 of 12

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - 1965 BUILDING 01	(X3) DATE SURVEY COMPLETED
		245559	B. WING		03/31/2015
AME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 317 FIRST STREET NORTHWEST	E
IKING N	IANOR NURSING HC	DME		ULEN, MN 56585	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		HOULD BE COMPLET
K 000	INITIAL COMMEN	TS	К 0		
	FIRE SAFETY			POCok 19-27-15	
	01 Main Building	-		4-271	
-12-	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TI	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST 1S-2567 WILL BE USED AS F COMPLIANCE.		AN C	
- 51.5: 2	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN //TH YOUR VERIFICATION.			
4-2-15 D	Minnesota Departr time of this survey 01 Main Building w compliance with th in Medicare/Medic 483.70(a), Life Sat edition of National	e Survey was conducted by the ment of Public Safety. At the , Viking Manor Nursing Home vas found not in substantial ne requirements for participation raid at 42 CFR, Subpart fety from Fire, and the 2000 Fire Protection Association 101, Life Safety Code (LSC), on Health Care		RECEIV	EP
VA: 4.	PLEASE RETURN CORRECTION FO DEFICIENCIES (H	N THE PLAN OF OR THE FIRE SAFETY (TAGS) TO:		APR 2 7 20 MIN DEPT. OF PUBLIC STATE FIRE MARSHAL	SAFETY
ET .	Health Care Fire I State Fire Marsha 445 Minnesota Str St. Paul, MN 5510	l Division reet, Suite 145		TITLE	(X6) DAT

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

PRINTED	: 04/14/2015
FORM	APPROVED
OMB NO	0938-0391

CENTER	NTERS FOR MEDICARE & MEDICAID SERVICES				AND NO. COUCO COOT		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - 1965 BUILDING 01		E SURVEY PLETED
		245559	B. WING	-		03/3	81/2015
	ROVIDER OR SUPPLIER	DME		3	STREET ADDRESS, CITY, STATE, ZIP CODE 17 FIRST STREET NORTHWEST JLEN, MN 56585		
					PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLÉTION DATE
K 000	Continued From pa	age 1	к	000			
	Or by email to: Marian.Whitney@s	state.mn.us					
	or Angela.Kappenma	n@state.mn.us					
	THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:						
	1. A description of to correct the defic	what has been, or will be, done ciency.					
	2. The actual, or p	roposed, completion date.					
	responsible for co	or title of the person rrection and monitoring to rence of the deficiency.					
	without a baseme different times. The constructed in 196 Type II (000) const west was construe determined to be separated from the fire barrier. A con- 1994 to the north the facility to an a connecting link was south of the west clinic. Both buildir existing nursing h 2003 a 24 foot by	sing Home is a 1-story building int and constructed at five be original building was 55 and was determined to be of struction. An addition to the cted in 1981 that was Type V (111) construction and is e original building with a 2-hour necting link was constructed in end of the east wing to connect partment building and a as constructed in 1998 to the wing to connect the facility to a ngs are separated from the ome with 2-hour fire barriers. In 42 foot, PT addition was e south of the east wing that is triction, 1-story without a	5		Facility ID: 00075	uation she	et Page 2 of 1

		AND HUMAN SERVICES			0		PPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN C	OF DEFICIENCIES	IDENTIFICATION NUMBER:			01 - 1965 BUILDING 01	COMP	LETED
		245559	B. WING			03/3	1/2015
NAME OF	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE 17 FI RST STREET NORTHWEST		
	MANOR NURSING HC	ME			LEN, MN 56585		
					PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES	ID PREFI	x	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	D/ III
K 000	Continued From pa		ĸ	000			
	basement.	ige z					
	Dasement.						
	The entire building	is protected with a complete					
	automatic fire sprin	kler system installed in FPA 13 Standard for the			~		
	Installation of Sprin	ikler Systems 1999 edition.					
	The facility has a fi	re alarm system with smoke					
	detection in the cor	ridor system and in common					
	areas in the 1965 t	building, with sleeping room the 1981 addition and the					
	1965 building that	are on the fire alarm system					
	installed in accorda	ance with NFPA 72 "The					
	National Fire Alarm	Code" 1999 edition. The fire					
	alarm system is mo	onitored for automatic fire ation. Hazardous areas have					
	automatic fire dete	ctors that are on the fire alarm					
	system in accorda	nce with the Minnesota State					
	Fire Code 2007 ed	ition.					
		apacity of 45 beds and had a					
	census of 43 at the	e time of the survey.					
	The facility was su	rveyed as two buildings.					
	The requirement of	t 42 CFR, Subpart 483.70(a) is				. N.	
	not met.						
K 025		AFETY CODE STANDARD	ĸ	025			04/22/15
SS=F					caulk has been placed in t	the 3	
	Smoke barriers are	e constructed to provide at			1 inch diameter holes in t		
	least a one hair no	ur fire resistance rating in .3. Smoke barriers may	1		smoke barrier wall in the tor of nursing office, abo		
	terminate at an atr	ium wall. Windows are			smoke barrier doors locate	ne uic d in	
	protected by fire-ra	ated glazing or by wired glass			the southeast wing by the		
	panels and steel fr	ames. A minimum of two			tor of nursing office, and		
	separate compartr	ments are provided on each			around communication wires	above	1
	floor. Dampers are	e not required in duct					
	penetrations of sm	noke barriers in fully ducted			the ceiling tiles at the s barrier door in the center		
	heating, ventilating	, and air conditioning systems.			going down the corridor to		
1	576				going down the corrador to		

Event ID: RMJU21

Facility ID: 00075

If continuation sheet Page 3 of 12

PRINTED: 04/14/2015

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED. **IDENTIFICATION NUMBER:** A. BUILDING 01 - 1965 BUILDING 01 AND PLAN OF CORRECTION 03/31/2015 **B** WING 245559 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 317 FIRST STREET NORTHWEST VIKING MANOR NURSING HOME ULEN, MN 56585 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K025 west nurses station. 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). K027 A door coordinator (door 05/01/15 NFPA 101 LIFE SAFETY CODE STANDARD K 027 sequencing device) for the smoke SS=D barrier door leading to the Facility ID: 00075

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

Event ID: RMJU21

If continuation sheet Page 4 of 12

PRINTED: 04/14/2015

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

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				0	MB NO. C	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - 1965 BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245559	B. WING			-	03/3	1/2015
NAME OF I	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, ST 7 FIRST STREET NORT			
	ANOR NURSING HO	OME			LEN, MN 56585	HWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTIC VE ACTION SHOULI ED TO THE APPROF ICIENCY)	D BE	(X5) COMPLETION DATE
K 027	20-minute fire prote 1¾-inch thick solid protective plates th from the bottom of Horizontal sliding of Doors are self-clos accordance with 19 not required to swi	age 4 moke barriers have at least a ection rating or are at least bonded wood core. Non-rated lat do not exceed 48 inches the door are permitted. loors comply with 7.2.1.14. sing or automatic closing in 9.2.2.2.6. Swinging doors are ng with egress and positive lired. 19.3.7.5, 19.3.7.6,)27	southeast wing of nursing offi ordered and wil once received.	ce has been	1	
	Based on observa has failed to maint accordance with L practice could affe by allowing smoke compartment to ar	is not met as evidenced by: ations and interview, the facility ain smoke/fire barrier doors in SC 19.3.7.5. This deficient ct residents, staff and visitors to propagate from one smoke nother.			*			
	03/31/2015 observe barrier doors in the director of nursing	ween 9:30 AM to 2:30 PM on vation revealed that the smoke e south east wing by the office awing in the same are not equipped with a door e.						
K 029 SS=[member (CW). NFPA 101 LIFE S	ed by the Maintenance staff AFETY CODE STANDARD d construction (with ¾ hour	ĸ	029	The latch into leading to the in the service	soiled line	en room	04/22/1

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

Event ID: RMJU21

Facility ID: 00075

If continuation sheet Page 5 of 12

		AND HUMAN SERVICES				FORM A	04/14/2015 APPROVED 0938-0391
STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				E CONSTRUCTION 01 - 1965 BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245559	B. WING	-		03/3	1/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 17 FIRST STREET NORTHWEST		
VIKING MANOR NURSING HOME					ILEN, MN 56585		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 029	fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved autor option is used, the other spaces by sn doors. Doors are s field-applied protect	an approved automatic fire em in accordance with 8.4.1 otects hazardous areas. When matic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or ctive plates that do not exceed bottom of the door are	К		adjusted so the door will close and positively latch Monthly inspections of door will be conducted by mainte to ensure all doors close a properly latch.	• rs enance	9
	Based on observative revealed that the far proper protection fareas located through accordance with N section 19.3.2.1. The event of a first spread throughout areas making them.	is not met as evidenced by: ations and staff interview, it was acility has failed to provide from 1 of several hazardous ughout the facility in IFPA Life Safety Code 101 (00) This deficient conditions could re, allow smoke and flames to the effected corridors and in untenable, which could he exiting capabilities for d visitors.					
	03/31/2015, obser	ween 9:30 AM to 2:30 PM on vation revealed, that The door room in the service hall did not sitively latch into the door frame.					
	This was confirme member (CW).	ed by the Maintenance staff				1	
FORM CMS-	2567(02-99) Previous Version	ns Obsolete Event ID: RMJL	J21	F	acility ID: 00075 If continu	ation shee	et Page 6 of 1

ENTER	S FOR MEDICARE	& MEDICAID SERVICES					0938-0391 SURVEY		
ATEMENT D PLAN OF			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - 1965 BUILDING 01			COM	PLETED		
		245559	B. WING				03/31/2015		
IAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP COL	DE			
IKING M	IANOR NURSING HO	DME			FIRST STREET NORTHWEST EN, MN 56585				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
K 046 K 046 SS=D	Emergency lighting	age 6 FETY CODE STANDARD g of at least 1½ hour duration is ance with 7.9. 19.2.9.1.	K 04 K 04	16 N n e t	Maintenance has conduct ninute testing of batt emergency lights and d the results. Testing documentation will be annually.	ery backup locumented and	04 /22 / 1		
	Based on observa staff, the facility ha emergency lighting accordance with N 19.2.9.1. This defic residents, staff and emergency evacua	is not met as evidenced by: ations and an interview with a failed to ensure that a has been tested in IFPA LSC (00) Section 7.9, cient practice could affect d visitors in the event of an ation during a power outage.							
	03/31/2015, during emergency battery maintenance docu the Maintenance s the that the facility	ween 9:30 AM to 2:30 PM on g the review of available y back up exit lighting imentation and interview with staff member (CW) revealed failed to conduct the required testing of the battery backup							
K 047 SS=C	member (CW). NFPA 101 LIFE S. Exit and directional accordance with s	ed by the Maintenance staff AFETY CODE STANDARD al signs are displayed in section 7.10 with continuous verved by the emergency lighting 0.1			The exit light located main dining room has b replaced and is operat	been	04/22/3		

Event ID: RMJU21

Facility ID: 00075

		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORM A	04/14/2015 PPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (CONSTRUCTION (X 1 - 1965 BUILDING 01	(X3) DATE SURVEY COMPLETED		
	245559					03/3	1/2015
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
VIKING MANOR NURSING HOME					7 FIRST STREET NORTHWEST _EN, MN 56585		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	E ATE	(X5) COMPLETION DATE
K 047	Continued From pa	ige 7	ĸ)47			
	Based on observa provide 1 of severa marks the means of with NFPA Life Safe Sec. 7.10.5.2. The residents, staff and illuminated exit sign	s not met as evidenced by: tion, the facility has failed to a operational exit signs that of egress path in accordance ety Code 101 (2000 edition), deficient practice could affect l visitors, if the lack of properly in prevented a means of egress in a timely manner in an on.			*		
	On facility tour betw 03/31/2015, it was is located in the ma inoperative and wo						5
K 052 SS=D	member (CW). NFPA 101 LIFE SA A fire alarm system installed, tested, a with NFPA 70 Nati 72. The system ha and testing progra	d by the Maintenance staff AFETY CODE STANDARD In required for life safety is and maintained in accordance onal Electrical Code and NFPA as an approved maintenance m complying with applicable FPA 70 and 72. 9.6.1.4		052	The HVAC diffusers have been relocated allowing at least inches of space from the sm detectors by the southeast smoke barrier doors and by northwest wing by room 24.	36 oke wing	04 /22 / 15
	567(02-99) Previous Versior	ns Obsolete Event ID: RMJU	124		cility 1D: 00075 If continuat	ion shee	t Page 8 of 12

		AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	04/14/2015 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				CONSTRUCTION - 1965 BUILDING 01	(X3) DATE SURVEY COMPLETED		
	245559					03/3	1/2015
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 7 FIRST STREET NORTHWEST		
VIKING N	VIKING MANOR NURSING HOME				EN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 052	Continued From pa	ge 8	КO	52			×
in and a second s	Based on observa revealed that the fa maintain the fire all the requirements o 19.3.4.1 and 9.6, a Sections 7.1. This adversely affect the system, and could and emergency ac	s not met as evidenced by: tion and staff interview, it was acility had failed to install and arm system in accordance with f 2000 NFPA 101, Sections s well as 1999 NFPA 72, deficient condition could a functioning of the fire alarm delay the timely notification tions for the facility thus g all residents, staff, and ty.			3	*	
K 067 SS=F	03/31/2015, obser smoke detectors w a HVAC diffuses: 1) southeast wing 2) northwest wing This was confirme member (CW). NFPA 101 LIFE S/ Heating, ventilatin with the provisions in accordance with	ween 9:30 AM to 2:30 PM on vation revealed the following vere located within 36 inches of by the smoke barrier doors, by room 24. d by the Maintenance staff AFETY CODE STANDARD g, and air conditioning comply of section 9.2 and are installed in the manufacturer's 19.5.2.1, 9.2, NFPA 90A,	к		Arrangements have been ma have our fire and smoke d inspected. Test/inspectio documentation will be kep file. Arrangements will for inspections every 4 y	ampers n t on be made	05/10/15
	2567(02-99) Previous Version	ns Obsolete Event ID: RMJU	121	Fac	ility ID: 00075 If contin	uation shee	et Page 9 of 12

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM /	04/14/2015 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
1.1		245559	B. WING			03/3	1/2015
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
VIKING N	IANOR NURSING HO	ME			17 FIRST STREET NORTHWEST LEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 067	Continued From page 9		ĸ	067			
	Based on docume interview, the fire/s been maintained in requirements of NF deficient practice d operation of the fire allow smoke migra	s not met as evidenced by: ntation review and staff moke damper system has not accordance with the PA 90(99) section 3-4.7. This oes not ensure the proper e/smoke dampers and could tion to negatively affect the nts, staff and visitors in the					200
	03/31/2015, it was the facility's fire and test/inspection doc by interview with th (CW), that the facil documentation tha	ween 9:30 AM to 2:30 PM on a revealed during the review of d smoke damper umentation and was confirmed he Maintenance staff member lity failed to provide t the fire and smoke dampers nspected within the last 4					
K 073 SS=C	member (CW). NFPA 101 LIFE SA No furnishings or o character are used This STANDARD	d by the Maintenance staff AFETY CODE STANDARD decorations of highly flammable d. 19.7.5.2, 19.7.5.3, 19.7.5.4 is not met as evidenced by: ations and staff interview, the		073	Decorations on the corrido of rooms 15 and 18 have be removed. Family members wh the decorations have been instructed that decoration be treated with a fire ret treatment. Residents and will be informed upon admi of resident that any decor	en o plac s must ardant famili ssion	ed es
	567/02-99) Previous Version	s Obsolete Event ID: RMJU	21	Fa	cility ID: 00075 If continuat	ion sheet	Page 10 of 12

Event ID: RMJU21

		AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	04/14/2015 APPROVED 0938-0391
STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				E CONSTRUCTION 11 - 1965 BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245559	B. WING	-		03/31/2015	
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 7 FIRST STREET NORTHWEST		
VIKING	MANOR NURSING HO				LEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPP DEFICIENCY)	BE	(X5) COMPLETION DATE
К 073	facility failed to main in accordance with (00) section 19.7.5. maintain the combu- the facility in accord Code 101 (00) cour- rapidly migrate through negatively affect the of an emergency for	nge 10 ntain combustible decoration NFPA Life Safety Code 101 .4. The failure to treat and ustible decorations throughout dance with NFPA Life Safety Id allow smoke and fire to bugh the corridors and e egress capability in the event or residents, visitors and staff	KC		need be treated with a fire retardant.	e	
	of the facility. Findings include:					1	
	03/31/2015, observing rooms 15, 18, had corridor side of the interview with Main could not be verified	ween 9:30 AM to 2:30 PM on vations revealed that Resident decorations located on the ir room doors. After an itenance staff member (CW), It id whether or not these reated with a fire retardant					
K 147 SS=0	member (CW). NFPA 101 LIFE SA	d by the Maintenance staff AFETY CODE STANDARD Id equipment is in accordance tional Electrical Code. 9.1.2	K	147	The multi-plug adaptor in day room located in the non- east wing has been removed Staff have been instructed use multi-plug adaptors.	rth- •	04 /22 / 15
	Based on observa the facility was usi devices that are no (99), National Elec	is not met as evidenced by: ation and interview with the staff ng unapproved electrical of in accordance with NFPA 70 ctrical Code. This deficient atively affect the safety of 4 of					

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Facility ID: 00075

If continuation sheet Page 11 of 12

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			0		0938-0391
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG 0	1 - 1965 BUILDING 01		
		245559	B. WING			03/3	31/2015
NAME OF F	PROVIDER OR SUPPLIER		1		REET ADDRESS, CITY, STATE, ZIP CODE		
	MANOR NURSING HO	ME			7 FIRST STREET NORTHWEST LEN, MN 56585		
			ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	COMPLÉTION DATE
K 147	Continued From pa 45 residents, staff a		К1	47			
	Findings include:						
	03/31/2015, observed power strip that ha	ween 9:30 AM to 2:30 PM on vations revealed that there is a s been plugged into a in the day room located in the				ж 1014 р.	
	This was confirmed member (CW).	d by the Maintenance staff					
-							141
	18						
EORM CMS-	2567(02-99) Previous Version	ns Obsolete Event ID: RMJI	U21	Fa	cility ID: 00075 If continu	ation shee	Page 12 of 1

PRINTED: 04/14/2015

		AND HUMAN SERVICES	Ŧ	5559024	FORM	04/14/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 03 - BUILDING 0202		E SURVEY PLETED
		245559	B. WING _		03/3	31/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	MANOR NURSING HO	DME a		317 FIRST STREET NORTHWEST ULEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	K 00			
	FIRE SAFETY			POCIA		
	THE FACILITY'S P ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TI	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST 1S-2567 WILL BE USED AS F COMPLIANCE.		POC. 14 1-20-15		
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN /ITH YOUR VERIFICATION.				
	Minnesota Departr time of this survey 01 Main Building w compliance with th in Medicare/Medic 483.70(a), Life Saf edition of National	e Survey was conducted by the ment of Public Safety. At the , Viking Manor Nursing Home vas found not in substantial le requirements for participation aid at 42 CFR, Subpart fety from Fire, and the 2000 Fire Protection Association 101, Life Safety Code (LSC), lealth Care.		APR 2 7 2015		
	DEFICIENCIES (K	OR THE FIRE SAFETY (TAGS) TO:		MN DEPT. OF PUBLIC SAFET STATE FIRE MARSHAL DIVISIO	Y DN	
	Health Care Fire In State Fire Marsha 445 Minnesota Str St. Paul, MN 5510	l Division reet, Suite 145				
LABORATOF	RY DIRECTOR'S OR PROV		NATURE	TITLE	L	(X6) DATE
	Dove	1500	hich the ine	titution may be excused from correcting provi	ding it is dete	+ 1

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.

		AND HUMAN SERVICES & MEDICAID SERVICES			4	01	MB NO	APPROVEI
ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION BUILDING 0202	-		E SURVEY IPLETED
		245559	B. WING				03/	31/2015
	ROVIDER OR SUPPLIER		e	317 F	ET ADDRESS, CITY, STATE, Z			
IKING N	ANOR NURSING HO			ULE	N, MN 56585	000050710		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD	BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	κo	000				
	Or by email to: Marian.Whitney@s or	tate.mn.us						
	Angela.Kappenma	n@state.mn.us				ξ:		
	THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO	RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:						1
	1. A description of to correct the defic	what has been, or will be, done iency.						8
	2. The actual, or p	roposed, completion date.						A.
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency.						at Ca
	without a basemer	ing Home is a 1-story building at and constructed at five e original building was						
	constructed in 196 Type II (000) consi west was construct	5 and was determined to be of truction. An addition to the ted in 1981 that was Type V (111) construction and is						
	separated from the fire barrier. A cont 1994 to the north of the facility to an ap	e original building with a 2-hour necting link was constructed in end of the east wing to connect partment building and a						
	south of the west clinic. Both buildin existing nursing he	is constructed in 1998 to the wing to connect the facility to a gs are separated from the ome with 2-hour fire barriers. In 42 foot, PT addition was						
	constructed to the	south of the east wing that is riction, 1-story without a						

241

		AND HUMAN SERVICES			C		PPROVED 0938-0391
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE	
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING 0	3 - BUILDING 0202		
		245559	B. WING			03/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 7 FIRST STREET NORTHWEST		
	MANOR NURSING HO	ME			LEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From pa basement.	ige 2	ĸ	000			
	automatic fire sprin accordance with Ni Installation of Sprin The facility has a fi detection in the cor areas in the 1965 b smoke detectors in 1965 building that a installed in accorda National Fire Alarm alarm system is mo department notifica automatic fire dete	is protected with a complete kler system installed in FPA 13 Standard for the kler Systems 1999 edition. re alarm system with smoke rridor system and in common building, with sleeping room the 1981 addition and the are on the fire alarm system ance with NFPA 72 "The Code" 1999 edition. The fire pointored for automatic fire ation. Hazardous areas have ctors that are on the fire alarm nce with the Minnesota State lition.					
K 067 SS=F	census of 43 at the The facility was su The requirement a not met.The requir 483.70(a) is MET. NFPA 101 LIFE SA Heating, ventilating with the provisions in accordance with specifications. 9 90A	e time of the survey. rveyed as two buildings. t 42 CFR, Subpart 483.70(a) is rement at 42 CFR, Subpart AFETY CODE STANDARD g, and air conditioning comply of section 9.2 and are installed the manufacturer's 0.2, 18.5.2.1, 18.5.2.2, NFPA is not met as evidenced by:	~	067	Arrangements have been ma have our fire and smoke d inspected. Test/inspectic documentation will be kep file. Arrangements will b for inspections every 4 y	ampers n t on e made	05/10/15

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/14/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 03 - BUILDING 0202	(X3) DATE SURVEY COMPLETED	
		245559	B. WING	-		03/3	1/2015
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 17 FIRST STREET NORTHWEST		
VIKING M	IANOR NURSING HO	ME			ILEN, MN 56585		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 067	interview, the fire/s been maintained in requirements of NF deficient practice d operation of the fire allow smoke migra safety of all resider event of a fire. Findings include: On facility tour betw 03/31/2015, it was the facility's fire and test/inspection doc by interview with th (CW), that the facil documentation tha have been tested/it years.	ntation review and staff moke damper system has not accordance with the PA 90(99) section 3-4.7. This oes not ensure the proper e/smoke dampers and could tion to negatively affect the nts, staff and visitors in the ween 9:30 AM to 2:30 PM on a revealed during the review of	K	067			
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: RMJU:	21	Fa	acility ID: 00075 If continu	ation she	et Page 4 of 4

49



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 <u>only a suggestion</u> 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.

Viking Manor Nursing Home April 14, 2015 Page 2 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)

Minnesc	ta Department of He	ealth	12 13	men server and server shall an and server and		
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	APR 2 77 7015		
		00075	B. WING	ful it was a mention	0.4/0	2/2015
		00075	<u> </u>	Wirmestez Department of Health Benjidji	04/0	2/2015
NAME OF	PROVIDER OR SUPPLIER					
VIKING	MANOR NURSING HO	DME 317 FIRST ULEN, MN	STREET NO	ORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall	Minnesota Statute, section ction order has been issued ey. If, upon reinspection, it is ciency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.				
	corrected requires requirements of the number and MN R When a rule contai comply with any of lack of compliance re-inspection with a result in the assess	hether a violation has been compliance with all e rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered . Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was				
	that may result from orders provided the the Department with	hearing on any assessments n non-compliance with these at a written request is made to thin 15 days of receipt of a ent for non-compliance.				
	surveyors of this D above provider and orders were issued completed, please these orders and r Minnesota Departr	TS: 5, 4/1/15, and 4/2/15, bepartment's staff, visited the d the following correction d. When corrections are sign and date, make a copy of eturn the original to the ment of Health, Division of		Minnesota Department of Health documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. d to	
Minnesota	Department of Health	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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STATE FORM

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Administrator RMJU11

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING			
	ROVIDER OR SUPPLIER	00075	DDRESS, CITY, ST		04/02/2015	
			T STREET NOR			
	ANOR NURSING HOME	ULEN, M	N 56585			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLE	
2 000	Continued From page	e 1	2 000			
	Compliance Monitorir Certification Program Supervisor, 705 5th S Bemidji, MN 56601	, Lyla Burkman, Unit		The assigned tag number appears far left column entitled "ID Prefix T The state statute/rule out of compli listed in the "Summary Statement of Deficiencies" column and replaces Comply" portion of the correction of This column also includes the findi which are in violation of the state s after the statement, "This Rule is n as evidence by." Following the sum findings are the Suggested Method Correction and Time period for Corr PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES T FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTIO VIOLATIONS OF MINNESOTA ST STATUTES/RULES.	ag." ance is of the "To rder. ngs tatute ot met veyors t of rection. NING OF THIS	
2 302	MN State Statute 144 or related disorder tra	I.6503 Alzheimer's disease ain	2 302			
	ALZHEIMER'S DISE DISORDER TRAININ MN St. Statute 144.6	IG:				
	care staff					

STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00075	B. WING		0.4/00/0045	
IAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	04	l/02/2015
	ANOR NURSING HOME	317 FIR:	ST STREET NORTH	WEST		
		ULEN, N	AN 56585			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 302	Continued From page	e 2	2 302			
	related disorders; (2) assistance with ac (3) problem solving w and (4) communication sk (c) The facility shall p written or electronic for training program, the trained, the frequency topics covered.	Alzheimer's disease and ctivities of daily living; vith challenging behaviors;				
	by: Based on interview a facility failed to ensur information regarding dementia training, inc training program, the trained, the frequency	nt is not met as evidenced nd document review, the re consumers were provided a Alzheimer's disease and cluding a description of the categories of employees y of training and the basic training in a written or				
	Findings include:					
		staff training of Alzheimer's a as required, including				
	During an interview o	on 4/1/15, at 9:58 a.m., the				

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED
						10010045
NAME OF PI	ROVIDER OR SUPPLIER	00075	ADDRESS, CITY, STATE		04	/02/2015
	ANOR NURSING HOME	317 FIRS	ST STREET NORTH			
		•	IN 56585			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 302	Continued From page	e 3	2 302			
	not provided consume	Alzheimer's training. The				
	DON or designee coustaff training to the reconsumer information	OD OF CORRECTION: The uld add information regarding sident admission packet for n. The DON or designee nd conduct audits to ensure				
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-one				
2 560	MN Rule 4658.0405 S Plan of Care; Conten	Subp. 2 Comprehensive ts	2 560			
	objectives and timeta long- and short-term and mental and psych identified in the comp assessment. The com must include the indiv	of care must list measurable bles to meet the resident's goals for medical, nursing, hosocial needs that are rehensive resident mprehensive plan of care <i>v</i> idual abuse prevention plan a Statutes, section 626.557,				
	by: Based on interview a facility failed to develo	t is not met as evidenced nd document review, the op a comprehensive care daily use of Trazadone d Citalopram				

STATE FORM

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STATEMENT	a Department of Healt	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00075	B. WING		04	1/02/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
VIKING M	ANOR NURSING HOME		ST STREET NORTH IN 56585	IWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE
2 560	Continued From page	e 4	2 560			
(R54)	(antidepressant medi (R54) who was review medication.	cation) for 1 of 5 resident ved for unnecessary				
	Findings include:					
	R54 was diagnosed w and diabetes. The Re prescribed a sleep me milligrams (MG) at be	Summary Report indicated with insomnia, depression eport also indicated R54 was edication (Trazadone) 100 edtime for insomnia and an opram) 20 MG daily for				
	identify the use of an insomnia, nor did the monitoring or docume and lack non-pharma related to insomnia. T identify the use of an depression and lacke and non-pharmalogic symptoms of depress	entation of sleep patterns, cological interventions The care plan also did not				
	currently receiving Tr Citalopram for depres medications were not plan and stated if a re)- A confirmed R54 was azadone for insomnia and ssion daily and verified the addressed on R54's care				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	00075	ADDRESS, CITY, STATE		04	/02/2015
	ANOR NURSING HOME		ST STREET NORTH			
	ANOR NURSING HOME	ULEN, N	IN 56585			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From page	9 5	2 560			
	director of nursing (D currently receiving Tr Citalopram for depres medications were not plan and stated "I do	/2/15, at 1:47 p.m. the ON) confirmed R54 was azadone for insomnia and ssion daily and verified the addressed on R54's care not know how that got was not done, I would p the care plan on				
	develop an individual plan that included me timetables in order to	cy titled, Care Plans sed on 8/06, directed staff to ized comprehensive care easurable objectives and meet the resident's medical, osychological needs for each				
	The director of nursin develop and impleme related to care plan d staff. Then develop m	HOD FOR CORRECTION: g (DON) or designee could ent policies and procedures evelopment and educate all nonitoring systems to ensure and report the findings to the pommittee.				
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty one				
2 565	MN Rule 4658.0405 S Plan of Care; Use	Subp. 3 Comprehensive	2 565			

STATE FORM

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		00075	B. WING		04	/02/2015
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	04	102/2013
/IKING M	ANOR NURSING HOME		ST STREET NORTH	IWEST		
		ULEN, N	IN 56585			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From page	9 6	2 565			
		nprehensive plan of care ersonnel involved in the				
	by: Based on observatior review, the facility fail assistance as directed	t is not met as evidenced n, interview and document ed to provide shaving d by the individualized care nt (R55) who required staff ing.				
	Findings include:					
	assist R55 with perso	d 2/10/15, directed staff to nal hygiene / grooming eeded and to encourage ne was able to do.				
	was noted to have da upper lip which exten was also observed to were approximately 1 -At 4:45 p.m. R55 cor hair on her upper lip, extended over her lip	n 3/31/15, at 9:40 a.m. R55, rk, thick facial hair on her ded over her lip area. R55 have several chin hairs that /4 inch or longer. ntinues to have dark facial which was very thick and area and also had several oproximately 1/4 inch or				
nonota Da	until 7:18 a.m. nursing	n 4/1/15, from 7:05 a.m. g assistant (NA)-C was R55 morning cares which				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00075	B. WING		04	1/02/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
VIKING M	ANOR NURSING HOME		ST STREET NORTH IN 56585	WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	in the bathroom. At 7: out of the bathroom, At 7: station. Although, NA R55's hair, and provide did NA-C offer or provide the facial hair. -At 7:24 a.m. licensed was observed to adm medications. At not the R55's excessive facial -At 7:33 a.m. another R55 by pushing her w room area for breakfar During observation or was observed sitting newspaper. R55 cont facial hair on her uppe her lip area and also was approximately 1/ -At 11:01 a.m. NA-A at room for her weekly r -At 11:22 a.m. R55 was bird room reading the hair remained the sar During interview on 4. confirmed R55 needed and shaving. NA-A st R55 because it was d routine bath. NA-B sta	/ oral hygiene, hair g assistance while R55 was 18 a.m. NA-C assisted R55 wheeled her down the ed her next to the nurses -C was observed to comb de hygiene care, at no time vide assistance to remove d practical nurse (LPN)-A inister R55 her morning me did LPN-A make note of al hair. r resident began to assist vheelchair down to the dining ast.	2 565			

STATEMENT	a Department of Healt	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00075	B. WING		04	1/02/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
VIKING M	ANOR NURSING HOME		ST STREET NORTH IN 56585	IWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From page	28	2 565			
	confirmed R55 requir grooming needs. NA- excessive facial hair of NA-A stated she thou	/2/15, at 11:26 a.m. NA-A ed staff assistance with A also verified R55 had on her upper lip and chin. ght R55 should be shaved lot that long as her care plan				
	room. R55's facial ha	ued to have dark hair on her				
	stated NA-A did not o during her bath and s her if she wanted to b	/2/15, at 1:16 p.m. R55 ffer to shave her facial hair tated NA-A had never asked be shaved, rather "she just have to ask her to do it				
	of nursing (DON) stat offer shaving on bath DON also stated it wa followed the resident'	/2/15, at 1:53 p.m. director ted she had expected staff to days and as needed. The as her expectation that staff s care plan. The DON ed staff assistance with g.				
	Plan, revised on 9/10 shall be used in deve care routines and wo	cy titled, Using The Care D/14, indicated the care plan loping the resident's daily uld be available to staff esponsibility for providing the resident.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00075	B. WING		04	/02/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
/IKING M	ANOR NURSING HOME		ST STREET NORTH IN 56585	IWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From page	9	2 565			
	director of nursing, or staff regarding the pu	OD OF CORRECTION: The designee, could inservice rpose of a resident care of the care plan and then liance.				
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-one				
2 920	MN Rule 4658.0525 \$	Subp. 6 B Rehab - ADLs	2 920			
	comprehensive reside home must ensure th B. a resident who is activities of daily living	unable to carry out g receives the necessary good nutrition, grooming,				
	by: Based on observatior					
	Findings include:					
	was to assist R55 wit	d 2/10/15, indicated staff h oral personal hygiene eeded. Encourage resident				

STATE FORM

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00075	B. WING		04	/02/2015
IAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
/IKING M	ANOR NURSING HOME		ST STREET NORTH N 56585	WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE DATE
2 920	Continued From page to do what she is able		2 920			
	3/19/15, indicated R5 impairment and requ	Im Data Set (MDS) dated 55 had severe cognitive ired extensive assistance v living such as toileting and				
	was noted to have da upper lip which exter also had several chir approximately 1/4 inc					
	until 7:18 a.m. nursin observed to provide I consisted of persona combing and dressin in the bathroom. At 7 out of the bathroom, hallway and positione station. Although, NA R55's hair, and provi- did NA-C offer or pro- the facial hair. -At 7:24 a.m. licenser was observed to adm medications. At not ti R55's excessive facia -At 7:33 a.m. anothe	g assistance while R55 was (18 a.m. NA-C assisted R55 wheeled her down the ed her next to the nurses A-C was observed to comb de hygiene care, at no time vide assistance to remove d practical nurse (LPN)-A ninister R55 her morning ime did LPN-A make note of al hair. er resident began to assist wheelchair down to the dining				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00075	B. WING		04/02/	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	. ZIP CODE	04	/02/2015
			ST STREET NORTH			
	ANOR NURSING HOME	ULEN, N	IN 56585			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
2 920	Continued From page	e 11	2 920			
	was observed sitting newspaper. R55 conf facial hair on her upp her lip area and also was approximately 1/ -At 11:01 a.m. NA-A a room for her weekly r -At 11:22 a.m. R55 w	assisted R55 to the bath tub outine bath. as observed sitting in the e newspaper. R55's facial				
	confirmed R55 neede and shaving. NA-A st R55 because it was c routine bath. NA-B st	/2/15, at 10:05 a.m. NA-B ed assistance with grooming ated she had never shaved lone once a week during her ated she had never shaved ad to do a touch up shave				
	confirmed R55 requir grooming needs. NA- excessive facial hair NA-A stated she thou	/2/15, at 11:26 a.m. NA-A ed staff assistance with A also verified R55 had on her upper lip and chin. ght R55 should be shaved lot that long as her care plan				
	room. R55's facial ha	ued to have dark hair on her				
	stated NA-A did not o	/2/15, at 1:16 p.m. R55 ffer to shave her facial hair tated NA-A had never asked				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00075	B. WING		04	/02/2015
			ADDRESS, CITY, STATE, ST STREET NORTH			
	ANOR NURSING HOME	ULEN, N	IN 56585			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE
2 920	Continued From page	9 12	2 920			
		e shaved, rather "she just ave to ask her to do it				
	of nursing (DON) stat offer shaving on bath DON also stated it wa followed the resident	/2/15, at 1:53 p.m. director ed she had expected staff to days and as needed. The as her expectation that staff s care plan. The DON ed staff assistance with g.				
	revised on 12/07, indi	cy titled, Shaving Resident, cated the purpose of this is s and to provide skin care.				
	The DON or designed as necessary the poli regarding the need for of daily living. The Do provide training for al policies and procedur	r assistance with adctivities ON or designee (s) could l appropriate staff on these es. The DON or designee ssure all residents are				
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-one				
21375	MN Rule 4658.0800 S Program	Subp. 1 Infection Control;	21375			
	Subpart 1. Infection	control program. A nursing				

STATE FORM

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00075	B. WING		04	1/02/2015
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		102/2013
/IKING M/	ANOR NURSING HOME		ST STREET NORTH IN 56585	IWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375		and maintain an infection gned to provide a safe and	21375			
	by: Based on interview a facility failed to estab program that included investigation of infect	ions that occurred in the potential to affect all 43				
	Findings include:					
	Control Log (s) from March 2015, the follo entered: 7 upper resp pneumonia, 1 aspirat vomiting, 13 fever, 4 diarrhea, 2 diarrhea, infection, 11 urinary 2 thrush, 1 conjunctiv infection. Of this data included for infection Resident Infection Co and location within th performed. The logs infection control coor ICC had not analyzed	facility's Resident Infection November 2014, through wing infections were biratory infection (URI), 1 tion pneumonia, 1 nausea, 3 fever / vomiting, 5 vomiting / 8 loose stools, 1 wound infections (UTI), 3 cellulitis, vitis, 1 boil, 1 cyst and 1 ear a the following had not been control surveillance on the portrol Log (s): resident name the facility and culture results had been completed by the dinator (ICC), however, the d the data in order to track of the infections within the				
		on 4/02/2015, at 2:39 p.m., g (DON) indicated she had				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00075	B. WING		04/02/	
AME OF PR	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	1 04	102/2013
		317 FIR:	ST STREET NORTH	WEST		
/IKING M/	ANOR NURSING HOME	ULEN, N	IN 56585			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From page	e 14	21375			
	control program and y control coordinator he done much with it." T nursing staff at the ea had documented sym separate three ring bi transferred by the infe main three ring binde (quality assurance) m DON/ICC stated the p control program was illnesses to see if the "come up with a plan verified the program of organisms of infection of the infections in the confirmed the tracking	bonsible for the infection would be the infection owever, stated "I haven't he DON/ICC indicated ast and west nurses station optoms of infection in inders which were then ection control nurse to a r that was taken to the QA neeting for review. The ourpose of the infection to track staff and resident re is was pattern and then to take." The DON/ICC did not include review of the n nor did it track the location e building. The DON/ICC g and trending regarding nd specific organisms had				
	The requested facility infection control progr	policy regarding the ram was not provided.				
	nursing or her design procedures regarding The director of nursin	eillance analysis and				
	Time Period for Corre days.	ection: Twenty one (21)				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
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IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
IKING M	ANOR NURSING HOME		ST STREET NORTH MN 56585	IWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE DATE
21426	MN St. Statute 144A. Prevention And Cont	.04 Subd. 3 Tuberculosis rol	21426			
	maintain a comprehe infection control prog current tuberculosis i issued by the United Control and Preventio Tuberculosis Elimina Morbidity and Mortali This program must in infection control plan unpaid employees, cor residents, and volunt Health shall provide to regarding implementa	ram according to the most nfection control guidelines States Centers for Disease on (CDC), Division of tion, as published in CDC's ty Weekly Report (MMWR). Include a tuberculosis that covers all paid and ontractors, students, eers. The Department of rechnical assistance ation of the guidelines.				
	by: Based on interview a facility failed to ensur test (TST) was comp	nt is not met as evidenced nd document review the re a two-step tuberculin skin leted for 1 of 5 newly hired assistant (NA)-G) reviewed TB) program.				
	Findings include:					
	NA-G was hired on 3 completed the TB ba	-				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00075	B. WING		04/02/2015	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	04	HUZ/2015
/IKING M	ANOR NURSING HOME			WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
21426	Mantoux (another terr Clay County Public H following information: NA-G's name Date given: 2/23/15 a Date read: 2/26/15 at Result: was 0 mm (mi During interview on 4/ director of nursing (D0 not receive the secon TST with a negative r The DON stated it wa two-step TST to all ne The facility's Tubercul policy dated 2001, inc first skin test was neg	ned a copy of NA-G's health m used for TST) card from ealth which included the t 4:40 p.m. in left forearm 1:00 p.m. illimeter) negative /2/15, at 1:34 p.m. the ON) confirmed NA-G did d TST, and received the first esult at another location. s the facility's policy to give ewly hired employees.	21426			

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 04/02/2015	
		00075				
IAME OF P	ROVIDER OR SUPPLIER	I.	ADDRESS, CITY, STATE			102/2013
IKING M	ANOR NURSING HOME		ST STREET NORTH MN 56585	IWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From page	e 17	21426			
	The director of nursin review/revise policies Tuberculosis screenir ensure the policy was	on resident and employee ng and perform audits to				