## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

INDEX CONFIDENCE IN THE STALE SURVEY ACKEY         Family 10:0017           11         26559		MED	ICARE/MEDICA	ATION A	ND TRANSMITTAL	ID: 1	ID: RXQ5			
1.1. 2 26500*       1.0.1 VIENC MARKE FLOWE FLOWE STREET MOUTH CATEGORY       1.0.1 CLEMANN       1.0.1 CLEMANNN       1.0.1 CLEMANNNN       1.0.1 CLEMANNNN       1.0.1 CLEMANNNNN       1.0.1 CLEMANNNNNNNNNNNNNNNNNNNNNNNNNNNNNNNNNNNN		PART	I - TO BE COM	HE STAT	E SURVEY AGENCY	Facil	ity ID: 00075			
1.23       7.3484000       1.51       1.51       1.51       1.51       1.51       1.51       1.51       1.51       1.51       1.50	(L1) <b>245559</b>	0.	(L3) VIKING MA	NOR NURSING	HOME					
S. ETTECHNERUATION LATURE CLAIMED OWNERS INTY       7. REWINDERSUPPLIER CATCOORY       97. REWINDERSUPPLIER CATCOORY       197. REWINDERSUPPLIER CAT				TREET NORTH	WEST	(L6) <b>56585</b>	5. Validation	6. Complaint		
A. ACCEDITATION SERVES		VERSHIP				× /				
B SOUND OF CERTIFICATION       NSP       NO OF TWO TWO TWO THE FACTORY IS CERTIFICATION       ALLOSATION OF CERTIFICATION       ALLOSATION OF THE FACTORY IS CERTIFICATION         10. LIC DEBLOD OF CERTIFICATION       A. B. COMPLIANCE WITH OLSON TURE       ALLOSATION OF THE FACTORY IS CERTIFICATION       ALLOSATION OF THE FACTORY IS CERTIFICATION OF THE FACTOR		. ,					FISCAL YEAR ENDING DA	TE: (L35)		
Prom       0):       And/2 Agneted Mintan Of The following Agnetaments:			04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30			
To       0:	11LTC PERIOD OF CERTIFICATION		10. THE FACILITY	IS CERTIFIED AS:						
10       0.7	From (a):		X A. In Compliar	nce With		And/Or Approved Waivers Of The	e Following Requirements:	_		
12. Total Finding Heds       45       (1.1) <t< td=""><td>To (b) :</td><td></td><td></td><td></td><td></td><td></td><td></td><td>Limit</td></t<>	To (b) :							Limit		
13 Toul Certified Robs       45       (1.7)       8. Not in Compliance with Program Requirements and or Applied Warrence       *Code: $x \cdot x \cdot (L12)$ 14. LIC CERTIFIED BED BRIGALDOWN       19. SNF       10. SN	12.Total Facility Beds	<b>45</b> (L18)				4. 7-Day RN (Rural SNF)	8. Patient Room Size			
$ \begin{array}{ c c c c c } 18 SNF & 19 SNF & 10 SNF & ICF & ID \\ \hline 45 \\ \hline (1.37) & (1.3) & (1.39) & (1.42) & (1.43) \\ \hline \\ 10 STATE SURVEY A GENARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): \\ \hline \\ $	13.Total Certified Beds	<b>45</b> (L17)					(L12)			
45       10 <t< td=""><td>14. LTC CERTIFIED BED BREAKDOWN</td><td></td><td>1</td><td></td><td></td><td>15. FACILITY MEETS</td><td></td><td></td></t<>	14. LTC CERTIFIED BED BREAKDOWN		1			15. FACILITY MEETS				
$ \begin{array}{c c c c c } (13) & (13) & (14) & (14) & (14) \\ \hline \begin{tabular}{ c c } (14) & (14) & (14) \\ \hline \begin{tabular}{ c c } (14) & (14) & (14) \\ \hline \begin{tabular}{ c c } (14) & (14) & (14) & (14) \\ \hline \begin{tabular}{ c c } (14) & (14) & (14) & (14) \\ \hline \begin{tabular}{ c c } (14) & (15) & (16) & $	18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)			
Sea Attached Remarks         17. SURVEYOR SIGNATURE Tammy Williams, HFE NEII       Date: 10/13/2013       18. STATE SURVEYAGENCY APPROVAL FEEDFORCEMENT Specialist       Date: Enforcement Spe		(L39)	(L42)	(L43)						
Sea Attached Remarks         17. SURVEYOR SIGNATURE Tammy Williams, HFE NEII       Date: 10/13/2013       18. STATE SURVEYAGENCY APPROVAL FEEDFORCEMENT Specialist       Date: Enforcement Spe	16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELI	ATION DATE):						
Tammy Williams, HFE NEII         10/13/2013         Enforcement Specialist         10/13/2014         (1.20)           Image: Complete Day Her Reaction and the participation of the parteripation of the participation of the participation of the part		× ·		,						
Tammy Williams, HFE NEII         10/13/2013         Enforcement Specialist         10/13/2014         (1.20)           Image: Complete Day Her Reaction and the participation of the parteripation of the participation of the participation of the part	17 SURVEYOR SIGNATURE		Date :			18 STATE SURVEY AGENCY AP	PPROVAL	Date:		
Image: Constraint of the second problem of the se		FE NEII	Duce .			Mark M	reath	But.		
Mart II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY         19. DETERMINATION OF ELIGIBILITY       20. COMPLIANCE WITH CIVIL RIGHTS ACT:       21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Simt (HCFA-1513) 3. Both of the Above :         2. Facility is not Eligible (L21)       (L21)       20. COMPLIANCE WITH CIVIL RIGHTS ACT:       21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Simt (HCFA-1513) 3. Both of the Above :         2. Facility is not Eligible (L21)       (L21)       20. COMPLIANCE WITH CIVIL RIGHTS ACT:       21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Simt (HCFA-1513) 3. Both of the Above :         2. Facility is not Eligible (L21)       (L21)       20. CTERMINATION ACTION:       (L30)         22. ORIGINAL DATE       23. LTC AGREEMENT       24. LTC AGREEMENT       26. TERMINATION ACTION:       (L30)         (L24)       (L41)       (L25)       02-Dissatisfaction W. Reimbursement       06-Fail to Meet Agreement         03. REMARKS       (L44)       B. Rescind Suspension Date:       (L44)       03-OH       07-Provider Status Change         03001       (L25)       (L31)       30. REMARKS       Posted 10/22/2014 Co.       Posted 10/22/2014 Co.				10/13/2013	(L19)	Enforcement S	Specialist			
I. Facility is Eligible to Participat       I. Facility is Eligible to Participat       I. Pacility is Eligible to Participat       I. Ownership/Control Interest Disclosure Stmt (HCFA-1513)         2. Facility is not Eligible       (L21)       I. Cagneement       I. Cagneement         22. ORIGINAL DATE       23. LTC AGREEMENT       24. LTC AGREEMENT       26. TERMINATION ACTION:       (L30)         OF PARTICIPATION       BEGINNING DATE       ENDING DATE       26. TERMINATION ACTION:       (L30)         (L24)       (L41)       (L25)       05-Fail to Meet Health/Safery       05-Fail to Meet Health/Safery         0.Fail to Meet Agreement       06-Fail to Meet Agreement       06-Fail to Meet Agreement       06-Fail to Meet Agreement         0.L25)       0.L25       I. CASTENSION DATE:       27. ALTERNATIVE SANCTIONS       04-Other Reason for Withdrawal       OTHER         0.L27)       B. Rescind Suspension Date:       (L44)       04-Other Reason for Withdrawal       OTHER         0.L28)       (L45)       30. REMARKS       Posted 10/22/2014 Co.       Posted 10/22/2014 Co.         1. RO RECEIPT OF CMS-1539       32. DETERMINATION OF APPROVAL DATE       (L31)       97. Determination OF APPROVAL DATE       Posted 10/22/2014 Co.		PART II - TO	BE COMPLETE	D BY HCFA RI	. ,	OFFICE OR SINGLE STAT	TE AGENCY	(120)		
X       1. Facility is Tacility is Not Eligible to Participate       3. Both of the Above :         -       2. Facility is not Eligible       (L21)         22. ORIGINAL DATE       23. LTC AGREEMENT       24. LTC AGREEMENT       26. TERMINATION ACTION:       (L30)         OF PARTICIPATION       BEGINNING DATE       ENDING DATE       20. TERMINATION ACTION:       (L30)         06/01/1991       (L41)       (L25)       00. More Health/Safety       00. Fail to Meet Health/Safety         (L24)       (L41)       (L25)       03. Risk of Involuntary Termination       04. Other Reason for Withdrawal       07. Provider Status Change         (L27)       B. Rescind Suspension Date:       (L44)       04. Other Reason for Withdrawal       00. Active         28. TERMINATION DATE:       29. INTERMEDIARY/CARRIER NO.       30. REMARKS       Posted 10/22/2014 Co.       Posted 10/22/2014 Co.         31. RO RECEIPT OF CMS-1539       32. DETERMINATION OF APPROVAL DATE       (L31)       OF APROVAL DATE       09. Call to Meet Meet Meet Meet Meet Meet Meet M	19. DETERMINATION OF ELIGIBILITY				TVIL			12)		
(121)       22. ORIGINAL DATE       23. LTC AGREEMENT       24. LTC AGREEMENT       26. TERMINATION ACTION:       (1.30)         0F PARTICIPATION       BEGINNING DATE       ENDING DATE       ENDING DATE       00       INVOLUNTARY         06/01/1991       (1.41)       (1.25)       02-Dissatisfaction W/ Reimbursement       06-Fail to Meet Health/Safety         1. L24)       (1.41)       (1.25)       02-Dissatisfaction W/ Reimbursement       06-Fail to Meet Agreement         03. Risk of Involuntary Termination       07HER       00-Active       07-Provider Status Change         04-Other Reason for Withdrawal       07-Provider Status Change       00-Active         04-Other Reason for Withdrawal       07-Provider Status Change       00-Active         1. RO RECEIPT OF CMS-1539       32. DETERMINATION OF APPROVAL DATE       30. REMARKS         03. RELEPT OF CMS-1539       32. DETERMINATION OF APPROVAL DATE       0.10/22/2014 Co.	<b>X</b> 1. Facility is Eligible to Part	icipate	KIOI	IISACI.		-		15)		
OF PARTICIPATION     BEGINNING DATE     ENDING DATE     VOLUNTARY     OO       06/01/1991     (L4)     (L4)     (L25)       25. LTC EXTENSION DATE:     27. ALTERNATIVE SANCTIONS A. Suspension of Admissions:     (L44)       0.1.207     B. Rescind Suspension Date:     (L44)       28. TERMINATION DATE:     29. INTERMEDIARY/CARRIER NO.     03. REMARKS       03001     (L28)     (L31)       31. RO RECEIPT OF CMS-1539     32. DETERMINATION OF APPROVAL DATE     03. REMARKS	2. Facility is not Eligible	(L21)								
06/01/1991     ILAIN	22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	24. LTC AGREEME	ENT	26. TERMINATION ACTION:	(L30)	)		
(L24)     (L41)     (L25)     02-Dissatisfaction W/ Reimbursement     06-Fail to Meet Agreement       25. LTC EXTENSION DATE:     27. ALTERNATIVE SANCTIONS A. Suspension of Admissions:     03-Risk of Involuntary Termination 04-Other Reason for Withdrawal     07-Provider Status Change 00-Active       (L27)     B. Rescind Suspension Date:     (L44)       (L27)     B. Rescind Suspension Date:     04-Other Reason for Withdrawal     07-Provider Status Change 00-Active       28. TERMINATION DATE:     29. INTERMEDIARY/CARRIER NO.     30. REMARKS       03001     04-Diter Reason for Withdrawal     05-Fail to Meet Agreement       03001     04-Other Reason for Withdrawal     06-Fail to Meet Agreement       03001     04-Other Reason for Withdrawal     06-Fail to Meet Agreement       03001     04-Other Reason for Withdrawal     06-Fail to Meet Agreement       03001     04-Other Reason for Withdrawal     06-Fail to Meet Agreement       03001     04-Other Reason for Withdrawal     06-Fail to Meet Agreement       03001     04-Other Reason for Withdrawal     06-Fail to Meet Agreement       03. REMARKS     05-Disatisfaction W/ Reimbursement     06-Fail to Meet Agreement       03. REMARKS     06-Fail to Meet Agreement     06-Fail to Meet Agreement       03. REMARKS     06-Fail to Meet Agreement     06-Fail to Meet Agreement       03. REMARKS     06-Fail to Meet Agreement	OF PARTICIPATION	BEGINNING	DATE	ENDING DATI	Е	<u>VOLUNTARY</u> 00	<u>INVOLUNTAR</u>	<u>Y</u>		
(L24)       (L41)       (L23)       03-Risk of Involuntary Termination       07-HER         25. LTC EXTENSION DATE:       27. ALTERNATIVE SANCTIONS       04-Other Reason for Withdrawal       07-Provider Status Change         (L27)       B. Rescind Suspension Date:       04-Other Reason for Withdrawal       00-Active         28. TERMINATION DATE:       29. INTERMEDIARY/CARRIER NO.       30. REMARKS         03001       (L28)       (L31)         31. RO RECEIPT OF CMS-1539       32. DETERMINATION OF APPROVAL DATE       Posted 10/22/2014 Co.	06/01/1991					-		Health/Safety		
25. LICEXTENSION DATE: 27. ALLERNATIVE SANCTIONS A. Suspension of Admissions: (L27) B. Rescind Suspension Date: (L45) 28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. (L28) (L28) (L31) 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE 94-Other Reason for Withdrawal 07-Provider Status Change 00-Active 30. REMARKS Posted 10/22/2014 Co. 1000000000000000000000000000000000000	(L24)	(L41)		(L25)			ent 06-Fail to Meet A	Agreement		
Image: A. Suspension of Admissions:     (L44)       (L27)     B. Rescind Suspension Date:       (L45)       28. TERMINATION DATE:     29. INTERMEDIARY/CARRIER NO.       03001       (L28)       (L28)       (L31)       31. RO RECEIPT OF CMS-1539       32. DETERMINATION OF APPROVAL DATE	25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS							
(L27) B. Rescind Suspension Date: (L45) 28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 03001 (L28) (L31) 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE 09/24/2014		A. Suspension	of Admissions:	(1.44)		of other reason for whitehawar		us Change		
28. TERMINATION DATE:     29. INTERMEDIARY/CARRIER NO.     30. REMARKS       O3001       (L28)     (L31)       31. RO RECEIPT OF CMS-1539     32. DETERMINATION OF APPROVAL DATE       09/24/2014     0	(L27)	B. Rescind Sus	pension Date:	(144)						
03001     Posted 10/22/2014 Co.       (L28)     (L31)       31. RO RECEIPT OF CMS-1539     32. DETERMINATION OF APPROVAL DATE       09/24/2014     09/24/2014				(L45)						
(L28) (L31) Posted 10/22/2014 Co. 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE 09/24/2014 01	28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS				
(L28) (L31) 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE 09/24/2014			03001			Posted 10/22/2014 Co	).			
09/24/2014		(L28)			(L31)					
	31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (	OF APPROVAL DAT	ГЕ					
		(L32)	09/24/2014		(L33)	DETERMINATION APPRO	VAL			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

### PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: RXQ5 Facility ID: 00075

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

#### CCN: 24-5559

On September 30, 2014 a Post Certification Revisit (PCR) was completed at this facility and verified correction. of the deficience is issued pursuant to the August 15, 2014 extended survey, effective September 23, 2014. As a result of PCR findings, this Department discontinued the Category 1 remedy of State monitoring, effective September 23, 2014.

In addition, this Department recommended the following remedies to the CMS Region V office for imposition:

- Civil Money Penalty for the deficiency cited at F314, remain in effect

- Civil Money Penalty for the deficiency cited at F323, remain in effect

The facility is subject to a two year loss of NATCEP beginning August 15, 2014 as a result of the extended survey which identified

SQC.

Refer to the CMS 2567b for the result of this visit.

Effective September 23, 2014, the facility is certified for 45 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 245559

October 13, 2014

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

Dear Mr. Kjos:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 23, 2014 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 eNotice.

Sincerely,

## Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health 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

October 13, 2014

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

RE: Project Number S5559022

Dear Mr. Kjos:

On August 28, 2014, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective September 3, 2014. (42 CFR 488.422)

On August 28, 2014, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Civil money penalty for the deficiency cited at F314 (S/S=G). (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323 (S/S=J). (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on August 15, 2014. The survey found the most serious deficiency to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On September 30, 2014, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on August 15, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 23, 2014. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on August 15, 2014, as of September 23, 2014.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 23, 2014.

However, as we notified you in our letter of August 28, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 15, 2014.

Viking Manor Nursing Home October 13, 2014 Page 2

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of August 28, 2014:

- Civil money penalty for the deficiency cited at F314 (S/S=G), remain in effect. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323 (S/S=J), remain in effect. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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,

Mart meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

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

Enclosure

cc: Licensing and Certification File

5559r14

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	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 9/30/2014
Name	of Facility		Street Address, City, State, Zip Code	
VI	KING MANOR NURSING HOME		317 FIRST STREET NORTHWEST ULEN, MN 56585	

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

(Y4) Item	(Y5	) Date	(Y4) Item		(Y5) I	Date	(Y4)	ltem		(Y5)	Date
	F0280 483.20(d)(3), 483.10(k)(2)	Correction Completed _09/23/2014	ID Prefix Reg. # LSC	F0314 483.25(c)	Co	orrection ompleted //23/2014		ID Prefix Reg. # LSC	_F0323 483.25(h)		Correction Completed 09/23/2014
	F0386 483.40(b)	- Correction Completed 09/23/2014	ID Prefix	F0387 483.40(c)(1)-(2)	Co	orrection ompleted //23/2014		ID Prefix			Correction Completed
ID Prefix Reg. # LSC		Correction Completed 	ID Prefix Reg. # LSC		Cc	orrection ompleted		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		_	Reg. #		Co	orrection ompleted					
ID Prefix Reg. # LSC		_	ID Prefix Reg. # LSC		Cc	orrection ompleted					
Reviewed By State Agency		•	Date: 10/13/20	Signature of S	Surveyoi 3260					Date: 09/3	30/2014
Reviewed By CMS RO		Ву	Date:	Signature of S	Surveyoi	r:				Date:	
Followup to	Survey Completed on: 8/15/2014				-				a Summary of to the Facility?	YES	NO

### State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00075	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 9/30/2014
Name of Facility			Street Address, City, State, Zip Code	
VIKING MANOR NURSING HOME			317 FIRST STREET NORTHWEST ULEN, MN 56585	

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4)	ltem	(Y5)	)	Date	(Y4)	ltem		(Y5) D	ate
			Correction				С	orrection					Correction
			Completed					ompleted					Completed
ID Prefix	20570		09/23/2014		ID Prefix	20830	_09	9/23/2014		ID Prefix	20900		09/23/2014
-	MN Rule 4658.0405 Su	bp. (	4		-	MN Rule 4658.0520 Subp.	_1			•	MN Rule 4658.0	525 Subp.	3
LSC					LSC		_		<u> </u>	LSC			
			Ormertien				~						O a mar at i a m
			Correction Completed					orrection ompleted					Correction Completed
ID Prefix			Completed		ID Prefix		U	ompieteu		ID Prefix			Completed
Reg. #			-		Reg. #					Reg. #			-
							_						-
									+-				
			Correction				С	orrection					Correction
			Completed					ompleted					Completed
ID Prefix					ID Prefix		_			ID Prefix			-
Reg. #					Reg. #		_			Reg. #			
LSC				<u> </u>	LSC		_		<u> </u>	LSC			
			Ormertien				~						O
			Correction Completed					orrection ompleted					Correction Completed
ID Prefix			Completed		ID Prefix		U	ompieteu		ID Prefix			Completed
Reg. #			•		Reg. #					Reg. #			-
LSC					LSC		_			LSC			-
				1					+-				
			Correction				С	orrection					Correction
ID Drofiv			Completed		ID Drofiv		С	ompleted		ID Drofiv			Completed
ID Prefix			-				_			ID Prefix			-
Reg. # LSC					Reg. # LSC					Reg. # LSC			
					200		_		+-	200			
Reviewed By			•	Da	ite:	Signature of Surve	eyo	r:				Date:	
State Agency	, GA	'mı	m	10	/13/201	.4 32	260	03				09/30	0/2014
Reviewed By	Review	ed E	Зу	Da	ite:	Signature of Surve	eyo	r:				Date:	
CMS RO													
Followup to	Survey Completed on:					Check for any	/ Ur	ncorrected D	efic	iencies. Was	a Summary of		
8/15/2014				Uncorrecte	ed D	Deficiencies	(CM	S-2567) Sent	to the Facility?	YES	NO		
STATE FORM	I: REVISIT REPORT	(5	/99)			Page 1 of 1					Event ID: F	RXQ512	



Protecting, Maintaining and Improving the Health of Minnesotans

October 13, 2014

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

Re: Enclosed Reinspection Results - Project Number S5559022

Dear Mr. Kjos:

On September 30, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 15, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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 Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

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

Enclosure(s)

cc: Original - Facility Licensing and Certification File

5559r14licltr

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

			ND TRANSMITTAL E SURVEY AGENCY	D: RXQ5 Facility ID: 00075			
MEDICARE/MEDICAID PROVIDER NO. (L1) 245559     STATE VENDOR OR MEDICAID NO. (L2) 734040100     S. EFFECTIVE DATE CHANGE OF OWN (L9)		3. NAME AND ADI (L3) VIKING MA (L4) 317 FIRST S' (L5) ULEN, MN 7. PROVIDER/SUP	NOR NURSING TREET NORTHV	HOME WEST	(L6) <b>56585</b> <u>02</u> (L7) 13 PTIP 22 CLIA	<ol> <li>TYPE OF ACTION:</li> <li>1. Initial</li> <li>3. Termination</li> <li>5. Validation</li> <li>7. On-Site Visit</li> <li>8. Full Survey After Comparison</li> </ol>	<u>2 (L8)</u> 2. Recertification 4. CHOW 6. Complaint 9. Other mplaint
6. DATE OF SURVEY 08/15/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2014 (L34) (L10)	01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESKD 10 NF 11 ICF/IID 12 RHC	14 CORF	FISCAL YEAR ENDING 09/30	DATE: (L35)
<ol> <li>II. LTC PERIOD OF CERTIFICATION         From (a):</li></ol>	<b>45</b> (L18) <b>45</b> (L17)	X B. Not in Com	ce With quirements		And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: <b>B</b> *	6. Scope of Servi 7. Medical Direct	tor
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 45 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARK See Attached Remarks	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):				
17. SURVEYOR SIGNATURE <u>Miriam Thornquist, H</u>			09/15/2014	(L19)	18. STATE SURVEY AGENCY AF Enforcement S	Specialist	Date: 09/23/2014 (L20)
19. DETERMINATION OF ELIGIBILITY          1. Facility is Eligible to Particular          2. Facility is not Eligible		20. COM	IPLIANCE WITH CL		21. 1. Statement of Finance	tial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA	A-1513)
22. ORIGINAL DATE OF PARTICIPATION 06/01/1991 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEMI BEGINNING (L41) 27. ALTERNATIVI	DATE	4. LTC AGREEME ENDING DATE (L25)		26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>01</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	D         INVOLUNT           05-Fail to M           ent         06-Fail to M           OTHER	eet Health/Safety eet Agreement
(L27)	<ul> <li>A. Suspension of B. Rescind Sus</li> </ul>		(L44) (L45)			07-Provider 00-Active	Status Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C 03001	ARRIER NO.	(L31)	30. REMARKS		
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION C	DF APPROVAL DAT	ЪЕ (L33)	DETERMINATION APPRO	WAL	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

### ID: RXQ5 Facility ID: 00075

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

#### CCN: 24-5559

On August 15, 2014, an extended survey was completed at this facility. Deficiencies were found. Conditions in the facility constituted both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ) to residents health or safety. The facility has not been given an opportunity to correct before remedies were imposed. as a result this Department imposed the Category 1 remedy of State monitoring, effective September 3, 2014.

In addition, this Department recommended the following remedies to the CMS Region V office for imposition:

-Per Instance Civil Money Penalty for the deficiency cited at F314 -Per Instance Civil Money Penalty for the deficiency cited at F323

The facility is subject to a two year loss of NATCEP beginning August 15, 2014 as a result of the extended survey which identified SQC.

Refer to the CMS 2567 along with the plan of correction for both health and life safety code. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 2147

August 28, 2014

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

RE: Project Number S5559022

Dear Mr. Kjos:

On August 15, 2014, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not

immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 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.

## **REMOVAL OF IMMEDIATE JEOPARDY**

We also verified, on August 15, 2014, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

## DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota 56537-3858

Phone: (218) 332-5140 Fax: (218) 332-5196

## **NO OPPORTUNITY TO CORRECT - REMEDIES**

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective September 3, 2014. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Per instance civil money penalty for the deficiency cited at F314 (S/S=G) (42 CFR 488.430 through 488.444)

 $\bullet$  Per instance civil money penalty for the deficiency cited at F323 (S/S=J) (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

# SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the</u> <u>following information, you are required to provide to this agency within ten working days of</u> <u>your receipt of this letter the name and address of the attending physician of each resident found</u> <u>to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Viking Manor Nursing Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 15, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

# APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality

of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

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

# 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 remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

# PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

# VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

# 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 November 15, 2014 (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 February 15, 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 Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

cc: Licensing and Certification File

5559s14

•

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245559	B. WING _		08/15/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST	<u> </u>	
VIKING		DME		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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTIO	
F 000		ſS	F 00	0		
	surveyors of this de	13, 14 and 15, 2014, epartment's staff visited the the following federal ued.				
	Minnesota Departm through 8/15/14. Th Immediate Jeopard facility's failure to co implement interven for falls. The IJ beg and was removed co	y was conducted by the nent of Health on 8/11/14, ne survey resulted in an ly (IJ) at F323 related to the comprehensively assess and tions for R16 who was at risk an on 7/22/14, at 3:32 p.m., on 8/15/14, at 12:20 p.m.;		•		
	scope and severity actual harm with po harm that was not in The facility's plan c as your allegation o Department's accep	f correction (POC) will serve f compliance upon the otance. Your signature at the age of the CMS-2567 form will				
F 280 SS=D	on-site revisit of you validate that substa regulations has bee your verification. 483.20(d)(3), 483.10	acceptable electronic POC, an ar facility will be conducted to ntial compliance with the n attained in accordance with D(k)(2) RIGHT TO NNING CARE-REVISE CP	F 280	It is the policy of VMNH that all care plans are developed with participation from the resident and resident's representatives. Care plans are reviewed and revised by a team of qualified persons//Interdisciplinary Team ("IDT) after each required assessment		
	incompetent or othe incapacitated under participate in planni changes in care and	the laws of the State, to ng care and treatment or t treatment.		at admission, quarterly, and more frequently if needed. <u>Corrective action for identified residents:</u> As the findings indicate, on 7/31/14, a 5-day Medicare assessment was completed on R16 after her return from the hospital on 7/22/14. R16's care plan was updated on 7/22/14 to include:	n So	
BORATORY		ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE	(X6) DATE	
er safegua	ards provide sufficient plot date of survey whether or g the date these documen	ection to the patients. (See instructions not a plan of correction is provided. For	ch the institu s.) Except fo or nursing ho	tion may be excused from correcting providing or nursing homes, the findings stated above ar omes, the above findings and plans of correcti are cited, an approved plan of correction is re	e disclosable 90 days on are disclosable 14	

MN Dept of Health Fergus Falls

PRINTED: 09/01/2014 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245559	B. WING	)	0	8/15/2014	
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP COI 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 PREFI TAG		OULD BE	(X5) COMPLETION DATE	
	within 7 days after t comprehensive ass interdisciplinary tear physician, a register for the resident, and disciplines as detern and, to the extent put the resident, the resi- legal representative and revised by a tea- each assessment. This REQUIREMEN by: Based on observati review the facility fai 1 of 3 residents (R1 and for 1 of 4 reside pressure ulcers. Findings include: R16's 5-day Medica Set (MDS) dated 7/3 diagnoses which inco osteoporosis, osteo R16's falls Care Are 4/3/14, was a check documented assess falls for R16. The C addressed in the cars suggested interventi R16's current care p indicated R16 had d falls. The care plan i	are plan must be developed he completion of the essment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's ; and periodically reviewed am of qualified persons after IT is not met as evidenced ion , interview and document iled to revise the care plan for 6) reviewed for accidents; ents (R46) reviewed for re assessment Minimum Data B1/14, identified R16 had cluded hip fracture, arthritis and dementia. a Assessment (CAA) dated list of risk factors with no ment to indicate the affect on AA indicated falls would be re plan but did not include	F 2	e Receiving Hospice care b	in therapy very 2-3 ty, 2-3 hours, 1 cares; y 2-3 g on se oted dence hed; were onducted ng with d safety. ued sing er ntions d with sted for n 8/4/14. ecliner he on m covers		

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

Facility ID: 00075

If continuation sheet Page 2 of 25

PRINTED: 09/01/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ° ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245559	B. WING	i		08/	15/2014
NAME OF	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
	MANOR NURSING HO	ME			17 FIRST STREET NORTHWEST		•
				L	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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	every 2 to 3 hours a care plan directed s reach, encourage to as needed and to b requests for assista On 7/16/14, at 4:45 at the hallway, lying indicated R16 had s left shoe lace had b her walker at the tim hospital and require fracture on 7/17/14. R16 returned from t 12:15 p.m There h plan to reflect chang post-operative statu found on the bathro to the care plan. De plan was not revised reduce the risk of in On 8/12/14, at 3:15 (DON) stated that at included a laser alar therapy; and freque whereabouts. The c The facility's Fall Pro- directed "primary R1 resident's care plan prevent the likely ho Pressure Ulcer R46's quarterly MDS	g every 2 hours, offer toileting and as needed. Further, the taff to place call light within o use call light for assistance e prompt in responding to all nce. a.m. R16 was found on floor on right side. The report stated her "hip broken." R16's een untied and was not using ne of fall. R16 was sent to the d surgical repair of the left hip he hospital on 7/22/14 at ad been no update to the care ges related to R16's s. At 7:15 p.m. R16 was om floor and still no revision spite multiple falls the care d to include interventions to.	F2		<ul> <li>After surveyors notified VMNH of the immediate jeopardy on 8/13/14, R16 was assess. This assessment included: <ul> <li>Consultation with her family who as satisfied with the interventions that her continued independence and undher risk for falls;</li> <li>Consultation with VMNH consultin pharmacist who recommended that I thyroid level could be drawn now, in scheduled in September; Consultation evaluation by her primary physician.</li> <li>The following interventions were added to the consultation by her primary physician.</li> <li>Hourly rounding safety checks with R16 about bathroom/food/water/repor/pain relief is needed.</li> <li>Signs posted in her room to remind call for help;</li> <li>Call light within reach.</li> </ul> </li> <li>The following interventions were continued: <ul> <li>Auto lock wheelchair brakes,</li> <li>PT,</li> <li>OT,</li> <li>Offering ambulation three times per Since survey, staff continue to assess R16 in consultation with her family and primary physis</li> <li>Her care plan has been updated as follows:</li> <li>Night light in bathroom Trialing las alarm set to silent but does link to clight.</li> <li>Wireless and silent alarm system. Stassigned to care for R16 will carry pager that links to system, immediat alerting staff if R16 has risen off of R 46 continues to receive routine evaluation an treatment from the Sanford Wound Clinic that sfirst visited on 6/10/14. Prior to survey, R46 vi the Wound Clinic on 6/18/14, 6/25, 7/2, 7/9, 7/2 and 8/5, 2014. VMNH staff will continue to with R46 and R46's family to accommodate R4's sleep in order to carry on pressure relieving measures and treatment when R46 is asleep.</li> </ul> </li> </ul>	re support lerstand g ner nstead of a m and care plan: staff askin positioning R16 to cday. cian. er all taff a tely sensor. d she sited 22, ork 6's	
	severe cognitive imp	Jannient, needed extensive			her care plan to assure that it included the		

.

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

Facility ID: 00075

PRINTED: 09/01/2014 FORM APPROVED OMB NO: 0938-0391

		U MEDIO/ AD OLIVIOLO	· · · · · · · · · · · · · · · · · · ·			1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		E SURVEY
		245559	B. WING	·		08,	15/2014
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				3	17 FIRST STREET NORTHWEST		
VIKING	MANOR NURSING HC			ι	JLEN, MN 56585		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION	N	(X5) COMPLETION
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE
F 280 F 314 SS=G	assist with all ADL's (known pressure ul coverage of wound tissue) pressure ulc type of eschar (blac adheres firmly to the may be softer or ha and is not evidence R46's care plan rev was at risk for press related to decrease plan did not identify ulcers. The care pla which included: to re hours, notify nurse of and report any new care plan directed s keep both pedals up utilized a wheelchai interventions to pro- ulcers to both heels On 8/13/14, at 8:43 care plan and confir interventions to floa The DON, interview verified a comprehe not been completed pressure ulcers, and not been updated to bilateral unstageabl 483.25(c) TREATMI PREVENT/HEAL PI	and had two unstageable cer but not stageable due to bed in slough or eschar eers with most severe tissue ek, yellow brown tissue that e wound bed or ulcer edges, rder than surrounding skin of healing). ised 8/4/14, identified R46 sure ulcer development d mobility. However, the care R46 had current pressure an listed various interventions eposition R46 every 2-3 of any concerns, document pressure areas. Further the taff to utilize foot rests and to to help with pain when R46 r. The care plan lacked mote healing of unstageable a.m. confirmed R46's current med the care plan lacked t heels at all times. ed on 8/13/14, 10:10 a.m. nsive skin assessment had after R46 developed the d verified R46's care plan had or eflect interventions for the e pressure ulcers. ENT/SVCS TO	F 2	280	following interventions: <ul> <li>Floating of heels at all times while</li> <li>Arginade (protein supplement) twice a day;</li> </ul> <li>Tissue tolerance testing while lying was componed by the stiting on 8/26/14.</li> <li>R46's Pressure Ulcer focus of care plan was revised to include a gel cushion in wheelchain to be repositioned/offloaded every 2 hours an PRN.</li> <li>Identification and action for other VMNH rest with potential to be affected: <ul> <li>Director of Nursing or designee reviewed and updated resident care plans and NAR kardex and tasks in Point of Care documentation system to confirm appropriate and accurate for falls and repositioning.</li> <li>All resident care plans will be reviewed quarted at care conferences and updated with any chara at each care conference and more frequently if needed. Changes to care plans will be communicated to staff via communication book Kardex, and/or oral report. Specifically, in regards to care plan changes for R16 and R46 on 8/15/14, staff were educated via communication book and oral report for care plan changes:</li> <li>All staff will receive education to be complete by 9/23/14 related to revision of care plans, ho determine need for assessment and policy review related to care planning.</li> </ul></li>	pleted r and d <u>sidents</u> erly nges ok, d w to	9/23/14

Facility ID: 00075

If continuation sheet Page 4 of 25

PRINTED: 09/01/2014 FORMAPPROVED OMB.NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LTIP DING	(X3) DATE SURVEY COMPLETED		
		245559	B. WING	;		08/	/15/2014
NAME OF	PROVIDER OR SUPPLIER	······	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	MANOR NURSING HO	ME		3	317 FIRST STREET NORTHWEST		
				ι	JLEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	who enters the facil does not develop pr individual's clinical of they were unavoida pressure sores rece services to promote prevent new sores f This REQUIREMEN by: Based on observati review, the facility fa comprehensively as appropriate interven reviewed for unstage deficient practice res Findings include: R46's admission Mir 2/27/2014, identified included dementia, f mental status. Their cognitive status or p MDS identified R46 of pressure ulcers, r all activities of daily I current pressure ulce (CAA) dated 2/27/20 factors for developm included requiring ex and urinary incontine antianxiety medicatio	ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having sives necessary treatment and healing, prevent infection and rom developing. IT is not met as evidenced on, interview and document illed to timely identify, sess, and implement tions for 1 of 1 resident (R46) able pressure ulcers. This sulted in actual harm for R46. himum Data Set (MDS) dated R46 had diagnosis which ailure to thrive and altered was no assessment of R46's resence of delirium. The was at risk for development equired extensive assist with iving (ADL's) and had no ers. or Care Area Assessment 14, listed R46 had risk ent of pressure ulcers which tensive assist in bed mobility ence, antipsychotic and on use, and newly admitted. R46's care plan would	F3	314	<ul> <li>that any resident having pressure</li> <li>sores receives necessary treatment</li> <li>and service to promote healing,</li> <li>prevent infection and prevent new</li> <li>sores from developing.</li> <li><u>Corrective Action for identified</u></li> <li>resident:</li> <li>R 46 continues to receive routine</li> <li>evaluation and treatment from the</li> <li>Sanford Wound Clinic that she</li> <li>first visited on 6/10/14. Prior to</li> <li>survey, R46 visited the Wound</li> <li>Clinic on 6/18, 6/25, 7/2, 7/9,</li> <li>7/22, and 8/5, 2014. VMNH</li> <li>staff will continue to work with</li> <li>R46 and R46's family to</li> <li>accommodate R46's resistance</li> <li>and concerns about disrupting</li> <li>R46's sleep in order to carry on</li> <li>pressure relieving measures</li> <li>and treatment when R46 is asleep.</li> <li>(NA)I and other staff report that</li> <li>R46 moves independently in</li> <li>bed and shifts the pillow that</li> <li>they have placed under her</li> <li>heels.</li> <li>VMNH staff have included</li> <li>recommendations and orders</li> <li>from the Wound Clinic on</li> <li>R46's care plan.</li> <li>VMNH staff completed a</li> <li>comprehensive assessment</li> <li>for R46 on 8/15/14, and</li> <li>reviewed her care plan to</li> </ul>		
	(CAA) dated 2/27/20 factors for developm included requiring ex and urinary incontine antianxiety medication The CAA identified F	14, listed R46 had risk ent of pressure ulcers which ttensive assist in bed mobility ence, antipsychotic and on use, and newly admitted. R46's care plan would			from the Wound Clinic on R46's care plan. VMNH staff completed a comprehensive assessment for R46 on 8/15/14, and		

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

Facility ID: 00075

If continuation sheet Page 5 of 25

PRINTED: 09/01/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /			(X3) DATE SURVEY COMPLETED	
		245559	B. WING			08/	15/2014
	PROVIDER OR SUPPLIER	ME		3	TREET ADDRESS, CITY, STATE, ZIP CODE 17 FIRST STREET NORTHWEST JLEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	A quarterly MDS da had severe cognitiv extensive assist witi unstagable due to cov or eschar tissue) pri severe tissue type of tissue that adheres ulcer edges, may be surrounding skin an The MDS also indic treatments, includin program, nutritional care and dressings R46's care plan revi was at risk for press related to decrease plan did not identify ulcers. The care plan which included: to re hours, notify nurse of and report any new care plan directed s keep both pedals up utilized a wheelchain interventions to pror ulcers to both heels On 8/12/14, at 3:00 and licensed practic observed to provide lower leg wound, an pressure ulcers to th was completed for ti- was provided for bila ulcers to both heels	ted 8/6/2014, identified R26 e impairment, needed h all ADL's and had two pressure ulcer but not erage of wound bed in slough essure ulcers with most of eschar (black, yellow brown firmly to the wound bed or e softer or harder than d is not evidence of healing). ated skin and ulcer g a turning and repositioning intervention, pressure ulcer to feet were provided for R46. Seed 8/4/14, identified R46 sure ulcer development d mobility. However, the care R46 had current pressure n listed various interventions eposition R46 every 2-3 of any concerns, document pressure areas. Further the taff to utilize foot rests and to help with pain when R46 . The care plan lacked mote healing of unstagable	F3	314	<ul> <li>following interventions: <ul> <li>Floating of heels at all times while in bed;</li> <li>Arginade (protein supplement) twice a day;</li> </ul> </li> <li>Tissue tolerance testing while lying was completed on 8/21/14 and while sitting on 8/26/14. R46's Pressure Ulcer focus of care plan was revised to include a gel cushion in wheelchair and to be repositioned/offloaded every 2 hours and PRN. Identification and action for other VMNH residents with potential to be affected:</li> <li>To ensure other residents of VMNH will receive necessary treatment and services to promote healing, prevent infection and prevent new sores from developing,</li> <li>All residents with occurrence of skin breakdown and/or high risk of skin breakdown will be discussed at weekly IDT and quarterly Quality Assurance meetings.</li> <li>RRAs (nursing assistants) will continue to</li> </ul>		
CODM CMS 25	67(02-99) Previous Versions	Obsolete Event ID: RXQ511		Fac	ility ID: 00075 If continuati	on sheet	Page 6 of 25

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

PRINTED:	09/01/2014
FORM/	APPROVED
OMPNO	0038 0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1`´		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245559	B, WING			08/	15/2014
	NG HO	DME	IID	:	STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585 PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX (EACH DEFI	CIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	COMPLÉTION DATE
the middle of cm. The press hard to the tou the dirty foam heel. The uns 7.1 cm by 3.0 the touch indi- wound. Both p normal saline applied and w applied tubign type devices) RN-B placed a elevated R46' On 8/13/14, 6 lying on her ba- under both kn a 45 degree a observed on b directly on the continuous ob a.m. R46 rem directly on the request, nursi room and con the mattress v NA-I verified F 6:56 a.m. to 8 minutes in wh mattress.) NA have been ress pressure ulcer room at 8:35 a attempted, to mattress.	cm) b the ul sure u dress cating or ssi into bo a pillo s hee :56 a. ack. ( ees, l ngle. both h surfa serva ained matt rappos into bo surfa serva ained rappos into bo surfa serva ained rappos	y 2.0 cm with an open area in cer measuring 2 cm by 0.8 ilcer was black in color and dicating eschar tissue. Then sing was removed from the left le pressure ulcer measured vas black in color and hard to eschar tissue was present in ure ulcers were cleansed with resh foam dressings were ed with gauze. RN-B then lastic stretch band stocking th feet covering the heels. w under each calf and	F	314	<ul> <li>document every shift on skin observations in the Point Click Care-Point of Care charting system for all residents.</li> <li>RRAs will continue to alert nurse to any skin breakdown/ redness/ abnormalities.</li> <li>Nurses will continue to conduct Braden assessments upon admission and quarterly,</li> <li>Nurses will conduct Tissue Tolerance assessments upon admission and annually, and also if any skin breakdown occurs, and</li> <li>Pressure Sore Risk assessments will be added and completed with every admission and quarterly.</li> </ul>		

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

Facility ID: 00075

If continuation sheet Page 7 of 25

PRINTED: 09/01/2014 FORM APPROVED OMB NO: 0938-0391

Tride       REGULATORY OR LISC IDENTIFYING INFORMATION       TAG       CROSS-REFERENCED TO THE APPROPRIATE       DATE         F 314       Continued From page 7       Editation in the surface of the mattress. RN-A entered the room at the surveyor's request and confirmed R46's heels rested on the mattress. RN-A stated she would expect R46's heels would have been "floated" over the mattress using a pillow under both calves to prevent further pressure on her heels at any time due to presence of the pressure ulcers. She confirmed R46's current care plan and confirmed R46's current is assessment and treatment if any.       Verify data collected.         Review of the Nursing Quarterly Note dated 5/28/14, identified R46 was occasionally incontinent of bowel and bladder, required the use of a mechanical lift to utilize the toilet, and required assistance with mobility. The note indicated skin inspections were completed PRN (as needed) and R46 had a current infected skin tear on the left lower leg. No other skin issues were identified on the quarterly nursing note.       System changes: All staff will have completed additional education regarding proper care for skin breakdown by 9/23/14. Education may include review of skin care policies and documentation			a mediorad deratoed				100110	
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       VIKING MANOR NURSING HOME     317 FIRST STREET NORTHWEST       ULEN, MN 56585       TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)       F 314     Continued From page 7 bed with both heels resting directly on the surface of the mattress. RN-A entered the room at the surveyor's request and confirmed R46's heels rested on the mattress. RN-A stated she would expect R46's heels would have been "floated" over the mattress using a pillow under both calves to prevent further pressure on both heels. RN-A verified R46 was never to have pressure of the pressure ulcers. She confirmed R46's current care plan and confirmed R46's current interventions to float heels at all times.     F 314       Review of the Nursing Quarterly Note dated for 28/14, identified R46 was accasionally incontinent of bowel and bladder, required the use of a mechanical lift to utilize the toilet, and required assistance with mobility. The note indicated skin inspections were completed PRN (as needed) and R46 had a current infected skin itear on the left lower leg. No other skin issues were identified on the quarterly nursing note.     System changes: All staff will have completed additional education regarding proper care for skin breakdown by 9/23/14. Education may include review of skin care policies and documentation of skin condition and				1 ' '				
VIKING MANOR NURSING HOME     317 FIRST STREET NORTHWEST ULEN, NM 56865       (X4)10 PREEX TXG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PROVIDERY PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DORRECTIVE ACTION SHOULD BE DEFICIENCY)     Constant of the appropriate DEFICIENCY     Constant of the appropris of the appropri			245559	B. WING	i		08/	/15/2014
VIKING MANOR NURSING HOME         317 FIRST STREET NORTHWEST ULEN, MN 56865           VKING MANOR NURSING HOME         317 FIRST STREET NORTHWEST ULEN, MN 56865           VKING MANOR NURSING HOME         PROVIDER'S PLANOF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREVIX TAG         PROVIDER'S PLANOF CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)         Consecutive Action SHOULD BE (EACH CORRECTIVE	NAME OF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
Viking MANOR NURSING HOME     ULEN, MN 56585       Maj D Preferx TAG     Summary stratement of periclencies (EACH Dericlency wast step Preceded By Full, REGULATORY OR LSC IDENTIFYING INFORMATION)     ID Preferx TAG     PREVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCE TO THE APPROPRIATE DEFICIENCY)     00 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCE TO THE APPROPRIATE DEFICIENCY)     00 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCE TO THE APPROPRIATE DEFICIENCY)     00 (EACH CORRECTIVE ACG     00 (EACH CORECTIVE ACG     00 (EACH CORECTIVE ACG					3	317 FIRST STREET NORTHWEST		
PREFIX TAGCECH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAGCACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)F 314Continued From page 7 bed with both heels resting directly on the surface of the mattress. RN-A entered the room at the surveyor's request and confirmed R46's heels rested on the mattress. RN-A stated she would expect R46's heels using a pillow under both calves to prevent further pressure on her heels at any time due to presence of the pressure ulcers. She confirmed R46's current care plan and confirmed R46's current indicated skin inspections were completed PRN (as needed) and R46 had a current infected skin tear on the left lower leg. No other skin issues were identified on the quarterly nursing note.PREFIX F 314PREFIX Care plans F 314Correstor Correstor Correstor care plan intervention for R46 related to promotion of healing pressure ulcers via communication book and oral report as changes to care plan were initiated on 8/15/14.Continue to address skin R46 rela	VIKING	MANOR NURSING HC	OME		ι	JLEN, MN 56585		
F 314Continued From page 7 bed with both heels resting directly on the surface of the mattress. RN-A entered the room at the surveyor's request and confirmed R46's heels rested on the mattress. RN-A stated she would expect R46's heels would have been "floated" over the mattress using a pillow under both calves to prevent further pressure on both heels. RN-A verified R46 was never to have pressure on her heels at any time due to pressence of the pressure ulcers. She confirmed R46's current care plan and confirmed the care plan lacked interventions to float heels at all times.F 314will be updated quarterly and PRN per assessment data collected.Review of the Nursing Quarterly Note dated 5/28/14, identified R46 was occasionally incontinent of bowel and bladder, required the use of a mechanical lift to utilize the toilet, and required assistance with mobility. The note indicated skin inspections were completed PRN (as needed) and R46 had a current infected skin tear on the left lower leg. No other skin issues were identified on the quarterly nursing note.F 314will be updated quarterly and PRN per assessment data collected.Review of the facility's form titled, Braden Scale for Predicting Pressure sore Risk (a tool to identify risk for developing pressure ulcers) dated 8/4/14, identified R46 was at moderate risk for pressure ulcer development.F 314Will be updated quarterly and PRN per assessment data collected.F 314will continue to additional education regarding proper care for skin breakdown by 9/23/14. Education may include review of skin care policies and documentation of skin condition and	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	COMPLETION
No further assessments were documented for R46.treatment, as well as when to alert nursing staff to skin concerns/breakdown.Review of R46's nurses progress notes from 3/18/14 to 6/4/14, revealed the following: various documentation regarding the resident's left leg wound, however, the record lacked documentation of skin checks for R46, and lacked documentation of identification of pressure ulcer development. Continued review of progresstreatment, as well as when to alert nursing staff to skin concerns/breakdown. Monitoring plan: The DON and/or designee will perform random audits weekly of	F 314	bed with both heels of the mattress. RN surveyor's request a rested on the mattre expect R46's heels over the mattress u calves to prevent fu RN-A verified R46 w her heels at any tim pressure ulcers. Sh care plan and confil interventions to floa Review of the Nursi 5/28/14, identified R incontinent of bowe use of a mechanica required assistance indicated skin inspe (as needed) and R4 tear on the left lowe were identified on th Review of the facility for Predicting Press identify risk for deve 8/4/14, identified R4 pressure ulcer deve No further assessm R46. Review of R46's nur 3/18/14 to 6/4/14, re documentation rega wound, however, the documentation of sk lacked documentation	resting directly on the surface I-A entered the room at the and confirmed R46's heels ess. RN-A stated she would would have been "floated" sing a pillow under both orther pressure on both heels. vas never to have pressure on e due to presence of the e confirmed R46's current rmed the care plan lacked t heels at all times. ng Quarterly Note dated R46 was occasionally I and bladder, required the I lift to utilize the toilet, and with mobility. The note ctions were completed PRN 6 had a current infected skin r leg. No other skin issues he quarterly nursing note. y's form titled, Braden Scale ure Sore Risk (a tool to eloping pressure ulcers) dated 6 was at moderate risk for lopment. ents were documented for ses progress notes from evealed the following: various rding the resident's left leg e record lacked in checks for R46, and on of identification of pressure	F	314	<ul> <li>Care plans will be updated quarterly and PRN per assessment data collected.</li> <li>Weekly charting will continue to address skin assessment and treatment if any.</li> <li>Staff were initially educated regarding new care plan intervention for R46 related to promotion of healing pressure ulcers via communication book and oral report as changes to care plan were initiated on 8/15/14.</li> <li>System changes: All staff will have completed additional education regarding proper care for skin breakdown by 9/23/14. Education may include review of skin care policies and documentation of skin condition and treatment, as well as when to alert nursing staff to skin concerns/breakdown.</li> <li>Monitoring plan: The DON and/or designee will perform random audits weekly of</li> <li>Skin breakdown</li> </ul>		

Facility ID: 00075

.

If continuation sheet Page 8 of 25

.

PRINTED: 09/01/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245559	B. WING		08	8/15/2014
	PROVIDER OR SUPPLIER MANOR NURSING H			STREET ADDRESS, CITY, STATE, Z 317 FIRST STREET NORTHWES ULEN, MN 56585	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	notes from 6/5/14 following: -6/5/14, the note in reported R46 had The note indicated an unstagable darf 10 cm by 10 cm. T was another press which presented as and measured 6 cr identified R46 had loss of dermis press with red or pink wo also present as an pressure ulcer to th by 3 cm. The progr the care plan for pl indicated a referral care clinic at that ti - 6/6/14, revealed regarding use of pre However, the note have her heels off of under her lower leg - 6/8/14, R46 had of staff that R46 was I room due to wound the right heel. R46 evaluation from the including: "no press nurse clinic".	to 8/14/14, revealed the dicated a bath aid had pressure areas to both heels. If the back of the left heel had complet under which measured he note further identified there ure under to R46's right heel is dark purple, was unstagable, m by 5 cm. In addition, the note a stage 2 (partial thickness centing as a shallow open under und bed, without slough, may intact or open blister) he left ankle measuring 3 cm ress note directed to refer to an of care. The note further had been made to the wound me. education to resident essure relieving boots due to both heels, but that R46 had ssure relieving boots. indicated R46 had agreed to of the mattress with a pillow	F3	ensure interva are in place a being follows • Assessment f for completio • Weekly chart on skin condi Audit findings will be reviewed at weekly ID meetings and quarterly Quality Assurance me The Quality Assurance committee will determ direction for future compliance monitorin audits and training. Director of Nursing or designee is responsible for compliance.	nd ed; forms n; and ing tion. T / etings. e ine g,	9/23/14
ORM CMS-256	67(02-99) Previous Versions	Obsolete Event ID: RXQ511	1	Facility ID: 00075	If continuation sheet	Page 9 of 25

PRINTED: 09/01/2014 FORM APPROVED OMB NO. 0938-0391

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		E CONSTRUCTION	(X3) DATE COMF	SURVEY
		245559	B. WING			08/1	5/2014
	PROVIDER OR SUPPLIER	DME		3	TREET ADDRESS, CITY, STATE, ZIP CODE 17 FIRST STREET NORTHWEST ILEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	area was covered w message left for RI - 6/21/14, R46's rig measured 6 cm lon measurements. - 6/22/14, R46's rig cleansed and redre - 6/23/14, notification heel condition, dress bloody drainage. - 6/26/14, daughter bags filled with rolle each of R46's feet. provided R46 with pressure off of R46 -6/29/14, dressing revealed that R46 I 3 cm x 2 cm red/pi - 7/1/14, stage one coccyx, measured blanchable. - 7/3/14, small blood dressing changed. -7/6/14, dressing c was noted on dirty and purulent (gree infection). The pre- 5.3 cm, purple area	with gauze and wraps, N. ht heel blister was open, area ag, no width or depth ght heel was bleeding, area essed. on to physician regarding right ssing change to right heel with was using two plastic grocery ed up plastic bags one under The note indicated staff elevated foot rests to keep S's feet. change to right heel and also had a reddened area to coccyx nk area which was not open. e pressure ulcer noted to 2 cm by 1.5 cm red area, non ody drainage form right heel, hange to right heel, drainage dressing consisting of blood nish/yellowish indicative of ssure ulcer measured 6 cm by		314			
FORM CMS-2	heel which measur 567(02-99) Previous Version	red 5.2 cm by 6.5 cm, peeling	11	Fa	acility ID: 00075 If continua	ation sheet	Page 10 of 25

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u> JMR NO</u>	. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		E SURVEY IPLETED
		245559	B. WING	)		08/	/15/2014
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
VIKING N	MANOR NURSING HO	ME			317 FIRST STREET NORTHWEST ULEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES WINT BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	base there was an wound bed which n necrotic (dead tissu- bed. A further note to have staff educa the foot pedals. - 7/14/14, dressing was soft and "mush ulcer measured 4 of noted to be scaly in cm by 4.5 cm with 2 tissue noted. - 7/16/14, order to of right heel per daug E to right heel daily - 7/17/14, vitamin E change with foam w -7/21/14, left heel n 4 cm by 1.2 cm dar the ulcer. The right with a 2 cm by 2 cm the ulcer bed. -7/25/14, left heel n 3.5 cm by 1.0 cm d of the ulcer. The right	color. However, at the wound opening in the pressure ulcer neasured 3 cm by 2 cm . Black ue) was noted at the wound revealed daughter requested ted to keep R46's heels off of change to left heel, ulcer area ny" with "bruised" center. The m by 2 cm. The right heel was appearance and measured 7 2.1 cm by 1 cm of necrotic discontinue foam dressing to hters request, ordered Vitamin and to leave area open to air. discontinued and dressing vas re-ordered. heasured 8 cm by 4 cm with a k purple area in the middle of heel measured 8 cm by 4 cm with a ark purple area in the center of	F	314		· · · · · · · · · · · · · · · · · · ·	
	cm with a 2 cm by 2 cm necrotic area in the center. - 7/29/14, left heel measured 5.5 cm by 4 cm and right heel measured 8 cm by 4 cm with a 2.2 cm by 2.5 cm opening in the middle. Both pressure ulcers had necrotic tissue present on wound bed.						

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

Facility ID: 00075

If continuation sheet Page 11 of 25

PRINTED: 09/01/2014 FORMAPPROVED

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245559	B. WING	;		08/	15/2014
	PROVIDER OR SUPPLIER	) DME		:	STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	<ul> <li>8/2/14, left heel m purple in color and heel measured 2.1 color.</li> <li>Review of weekly p from 6/5/14 to 8/12 measurements of t progress notes. Th progress notes did assessment of R46</li> <li>Review of physician 7/22/14 revealed th -6/10/14, ensure not heels floated at all under calves.</li> <li>-6/18/14, keep hee pillows under calves</li> <li>-6/25/14, discontin legs with pillows.</li> <li>-7/2/14, continue w</li> <li>-8/5/14, continue w</li> <li>-8/5/14, continue v</li> <li>please avoid puttin</li> <li>During interview on nursing (DON) veri at risk for developm that she expected f checked weekly on of such in the resid stated she expected</li> </ul>	easured 7 cm by 3 cm, dark hard to the touch. The right cm by 2 cm and was black in pressure ulcer progress notes /14, reveled the he wounds as noted in the e weekly pressure ulcer not include comprehensive the skin condition. In order's from 6/10/14 to be following: o pressure on heels, keep times with boots or pillows as floated at all times, use s to float heels, do not need	F		4		

Facility ID: 00075

If continuation sheet Page 12 of 25

,

MID PLAN OF DURNED TO A BUILDING       245559       B. WNO       08/15/2014         NAME OF PROVIDER OR SUPPLIER       STREETADDRESS, CITY, STATE, ZIP CODE       317 FIRST STREET NORTHWEST         VIKING MANOR NURSING HOME       STREETADDRESS, CITY, STATE, ZIP CODE       317 FIRST STREET NORTHWEST         ULEN, MN 66665       SUPPLIER       STREETADDRESS, CITY, STATE, ZIP CODE       07/10         PREFX       CANID DEFICIENCES       PREFX       CANID CORRECTION       07/10         PREFX       CANID DEFICIENCES       PREFX       CONTRETS FLAN OF CORRECTION       07/10         PREFX       Continued From page 12       PREFX       PREFX       CONTRETS INA OF CORRECTION       07/10         F 314       Continued From page 12       F 314       PREFX       F 314       Continued From page 12       F 314         nurse. The DON stated she would have expected       the inspections to be completed faily since R46's admission. The DON stated she would have expected, and verified R46's Skin as she would have expected, and verified R46's Skin as she would have expected, and verified R46's Skin as she would have expected, and verified R46's Skin as she would have expected, and verified R46's Care plan had not been completed fair R46 had developed the pressure ulcers, and verified R46's Care plan had not been updated to reflect interventons for the bilateral outstagable pressure ulcers, and verified R46's Care plan had not been updated to reflect interventons for the bilateral outstagable pressure ulcer had, and dincted staff	STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       VIKING MANOR NURSING HOME     STREET ADDRESS, CITY, STATE, ZIP CODE       (Y4) ID PREET     SUMMARY STATEMENT OF DEFICIENCIES (ECO) DEFICIENCY MUST BE PRECEDED BY FULL TAG     PROVIDER PAU OF CORRECTION (ECO) DEFICIENCY MUST BE PRECEDED BY FULL TAG     PROVIDER PAU OF CORRECTION (ECO) DEFICIENCY MUST BE PRECEDED BY FULL TAG     PROVIDER PAU OF CORRECTION (ECO) DEFICIENCY MUST BE PRECEDED BY FULL TAG     PROVIDER PAU OF CORRECTION (ECO) DEFICIENCY TAG     PROVIDER PAU OF CORRECTION (ECO) DEFICIENCY     COMPTEND (ECO) DEFICIENCY       F 314     Continued From page 12 nurse. The DON stated she would have expected the inspections to be completed daily since R40's admission. The DON stated she would have expected the inspections to be completed daily since R40's skin as she would have expected, and not been completed for R46, and also acknowledged that neither pressure ulcers "to be found long before they were, because of the size they were." The DON indicated staff had not observed R40's skin as she would have expected, and verified R46 should not been completed after R46 had developed the pressure ulcers, and verified R46's care plan had not been updated to reflect interventions for the bilateral unstagable pressure ulcers. The DON confirmed the facility policies and confirmed R46 should and ways have both heels' Totade'' to aid in healing and prevent further breakdown.       Review of the facility's policy titled Pressure Ulcer Risk Assessment revised 12/28/09, revealed staff were supposed to complete skin assessments weekly and more often as needed, and directed staff were to provide preventative measures and interventions for those identified at risk for			045550					
VIKING MANOR NURSING HOME     317 FIRST STREET NORTHWEST ULEN, MN 56585       VIKING MANOR NURSING HOME       VIKING MANOR NURSING HOME <th></th> <th></th> <th>245559</th> <th>B. WING</th> <th></th> <th></th> <th>08/</th> <th>15/2014</th>			245559	B. WING			08/	15/2014
VIKING MANOR NURSING HOME     ULEN, MN 56585       (M) ID TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID TAG     PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     D PROVIDENTIFY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     CMI DEFICIENCY       F 314     Continued From page 12 nurse. The DON stated she would have expected the inspections to be completed daily since R46's admission. The DON stated she would have expected for R46, and also acknowledged that neither pressure ulcer had been found in a timely manner. The DON stated she would have expected the pressure ulcers "to be found long before they were, because of the size they were." The DON indicated staff had not observed R46's skin as she would have expected, and verified R46 should not have any pressure to her heels at any time.     F 314       During a second interview on 8/13/14, 10:10 a.m. the DON confirmed the facility policies and confirmed R46 should atways have both heels' floated' to aid in healing and prevent further breakdown.     F Review of the facility's policy titled Pressure Ulcer Risk Assessment revised 12/28/09, revealed staff were supposed to complete shin assessments weekly and more often as needed, and directed staff to monitor skin daily.       Review of the facility's policy titled Prevention of Pressure Ulcers revised 12/28/09 revealed the staff were to provide preventative measures and interventions for thes bidentified at risk for	NAME OF I	PROVIDER OR SUPPLIER						
Image: TAG       (EACH DEFICIENCY WIGST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRÉPX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDED TO THE APPROPRIATE DEFICIENCY)         F 314       Continued From page 12 nurse. The DON stated she would have expected the inspections to be completed daily since R46's admission. The DON variated she would have expected the pressure uicers hab been found in a timely manner. The DON stated she would have expected the pressure uicers "to be found long before they were, because of the size they were." The DON indicated staff had not beer vertified R46 should have expected, and verified R46 should have expected, and verified R46 should have expected and verified R46's care plan had not been ough event uicers. The DON confirmed the facility policies and confirmed R46 should always have both hee's "foated" to aid in healing and prevent further breakdown.         Review of the facility's policy titled Pressure Ulcer Risk Assessment revised 12/28/09, revealed staff were supposed to complete skin staff were to provide preventative measures and interventions for the facility applicy titled Prevention of Pressure Ulcers revised 12/28/09 revealed the staff were to provide preventative measures and interventions for the scientified at the staff were to provide preventative measures and interventions for the scientified at the staff were to provide preventative measures and interventions for the scient assessments		MANOR NURSING HO	DME					
nurse. The DON stated she would have expected the inspections to be completed daily since R46's admission. The DON verified this had not been completed for R46, and also acknowledged that neither pressure ulcer had been found in a timely manner. The DON stated she would have expected the pressure ulcers "to be found long before they were, because of the size they were." The DON indicated staff had not observed R46's skin as she would have expected, and verified R46 should not have any pressure to her heels at any time. During a second interview on 8/13/14, 10:10 a.m. the DON verified a comprehensive skin assessment had not been completed after R46 had developed the pressure ulcers, and verified R46's care plan had not been updated to reflect interventions for the bilateral unstagable pressure ulcers. The DON confirmed the facility policies and confirmed R46 should always have both heels "floated" to aid in healing and prevent further breakdown. Review of the facility's policy titled Pressure Ulcer Risk Assessment revised 12/28/09, revealed staff were supposed to complete skin assessments weekly and more often as needed, and directed staff to monitor skin daily. Review of the facility's policy titled Prevention of Pressure Ulcers revised 12/28/09 revealed the staff were to provide preventative measures and interventions for these lidetified at risk for	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	
Review of the facility's policy titled Pressure Ulcer Treatment revised 12/28/09, revealed the staff	F 314	nurse. The DON sta the inspections to b admission. The DO completed for R46, neither pressure uld manner. The DON expected the press before they were, b The DON indicated skin as she would h R46 should not hav any time. During a second int the DON verified a assessment had no had developed the R46's care plan had interventions for the ulcers. The DON co and confirmed R46 heels "floated" to ai further breakdown. Review of the facilit Risk Assessment re were supposed to co weekly and more of staff to monitor skin Review of the facilit Pressure Ulcers revisat fwere to provid interventions for the pressure ulcer deve	ated she would have expected be completed daily since R46's in verified this had not been and also acknowledged that cer had been found in a timely stated she would have ure ulcers "to be found long ecause of the size they were." staff had not observed R46's have expected, and verified re any pressure to her heels at terview on 8/13/14, 10:10 a.m. comprehensive skin of been completed after R46 pressure ulcers, and verified d not been updated to reflect e bilateral unstagable pressure onfirmed the facility policies should always have both d in healing and prevent ty's policy titled Pressure Ulcer evised 12/28/09, revealed staff complete skin assessments ften as needed, and directed in daily. ty's policy titled Prevention of vised 12/28/09 revealed the e preventative measures and ose identified at risk for elopment.	F	314			

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

Facility ID: 00075

If continuation sheet Page 13 of 25

STATEMENT	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245559	B. WING			08/	15/2014
	PROVIDER OR SUPPLIER	DME		STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314 F 323 SS=J	and provide educat Review of the facilit Ulcers/Skin Breakd 12/28/09, revealed and recognize those determine cause, p management and n 483.25(h) FREE OF HAZARDS/SUPER <sup>1</sup> The facility must en environment remain as is possible; and adequate supervisio prevent accidents. This REQUIREMEN by: Based on observat review, the facility fa assess residents at ensure appropriate implemented to min (R16) residents revi practice resulted in situation for R16. Findings include: The immediate jeop findings revealed R comprehensively as self-transfers leadin administrator and th	Is, provide pressure ulcer care ion and quality improvement. y's policy titled Pressure own - Clinical Protocol revised staff were supposed to assess e at risk for pressure ulcers, rovide treatment, and provide nonitoring of pressure ulcers. ACCIDENT VISION/DEVICES sure that the resident hs as free of accident hazards each resident receives on and assistance devices to IT is not met as evidenced ion, interview and document ailed to comprehensively risk for falls and failed to interventions were imize risk for falls for 1 of 3 ewed for falls. This deficient an immediate jeopardy pardy began on 7/22/14 when	F 3	314	It is the policy of VMNH to ensure the resident environment remains as free fro accident hazards as is possible and that each resident receives adequate supervis and assistance devices to prevent accide <u>Corrective action for identified residents</u> As the findings indicate, on 7/31/14, a 5 Medicare assessment was completed on R16 after her return from the hospital on 7/22/14. R16's care plan was updated on 7/22/14 to include: • Receiving Hospice care becaus she had refused to participate i therapy at the hospital; • Assist of 2 with toileting every 2-3 hours and PRN, • Assist of 1 with bed mobility, • Turn and reposition every 2-3 hours, • Assist of 1 with all personal can • Reminders to use call light; • Offering the bathroom every 2- hours. At its regularly scheduled Falls Meeting of 7/23/14, the IDT completed a root cause analysis of R16's falls on 7/16/14 and 7/22/14 and revised R16's care plan to ind • Laser alarm and TABS unit	sion nts. 2: -day 1 5e n res; 3	

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

Event ID: RXQ511

Facility ID: 00075

If continuation sheet Page 14 of 25

PRINTED: 09/01/2014 FORM APPROVED OMB NO: 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	TIPLE CONSTRUCTION		E SURVEY IPLETED
		245559	B. WING		08/	15/2014
NAME OF	PROVIDER OR SUPPLIER	L	T	STREET ADDRESS, CITY, STATE, ZIP		
	MANOR NURSING HO	OME		317 FIRST STREET NORTHWEST		
Thur o		···		ULEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	8/13/14, at 3:39 p.m was removed at 12 facility submitted ar noncompliance rem severity level of D v with potential for m not immediate jeop R16's 5-day Medica dated 7/31/14, iden included hip fractur and dementia. The severe cognitive im assistance with bec room, walk in corric dressing, toilet use was not steady duri seated to standing facing opposite dire transfer between be used walker and wh Further, the MDS id sustained a fracture fallen since admissi R16's Care Area As 4/3/14, indicated R1 loss and confusion communication prol psychoactive medic R16 had risk factors osteoporosis, arthrit depression, and hea CAA identified R16 related to use of psy required use of assi interventions would to prevent or minim R16's Fall Assessm identified R16 was a	n. The immediate jeopardy 20 p.m. on 8/15/14, after the nacceptable removal plan, but hained at the lower scope and which indicated no actual harm ore than minimal harm that is ardy. are Minimum Data Set (MDS) tified diagnoses which e, osteoporosis, osteoarthritis MDS identified R16 had pairment, required extensive mobility, transfers, walk in for, locomotion on unit, and personal hygiene. R16 ng transitions (moving from position, turning around and ction, moving on and off toilet, ad and chair) or walking. R16 heelchair as mobility devices. entified R16 had fallen and prior to admission, and had on with no injury. sessment (CAA) dated 16 was forgetful, had memory at times, mood decline, olems, and received ations. The CAA identified s for falls that included tis, cognitive impairment, aring impairments. The Fall was at high risk for falls ychotropic medications and stive device and indicated be implemented in an attempt ize further falls. ent form dated 7/30/14, at moderate risk for falls due he assessment identified R16	F 3:	<ul> <li>in her familiar setting, so the f noted on her care plan: <ul> <li>Hospice care was dis</li> <li>Physician orders for obtained. Evaluation and OT and PT bega R16 on strength, bala</li> </ul> </li> <li>On 7/29/14, both alarms were of and removed from care plan du increased agitation to R16.</li> <li>After R16's fall on 8/1/14 from in her room, the following inter added to her care plan: <ul> <li>The glider chair was family's permission;</li> <li>Auto lock brakes wer her wheelchair and agitation receives floor next to her. The care plan include removal of recliner arm room, so she could securely gra- if she stood on her own.</li> </ul> </li> <li>It is VMNH's position that its a care of R16 was in compliance 483.25(h) and that no immedia situation existed regarding R16 for in law and regulation, VMN informal dispute resolution to q deficiency.</li> </ul>	independence following were acontinued; and PT/OT were a was conducted in working with ance, and safety. discontinued to causing the glider chair eventions were removed with the and re requested for oplied on 8/4/14. For her recliner cliner. One of a noted on the a was updated to in covers from the chair arm assessment and with 42 CFR § te jeopardy the jeopardy the sequesting uestion this a for the R16 was	Page 15 of 25

PRINTED: 09/01/2014 FORMAPPROVED OMB NO, 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245559	B. WING			08/	15/2014
	PROVIDER OR SUPPLIER	ME		3′	TREET ADDRESS, CITY, STATE, ZIP CODE 17 FIRST STREET NORTHWEST ILEN, MN 56585		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	of bladder and bow was not able to star assist of one with g walker for mobility. R16's current care p identified R16 had of risk" for falls. The c required assistance and walker, repositi toileting every 2 to 3 Further, the care pla light within reach, et assistance as need responding to all reacher 8/12/14 revealed the -On 7/16/14, at 4:45 in the hallway, lying indicated R16 stated report indicated R16 untied and R16 was time of fall. R16 had had required surgics on 7/17/14. -On 7/22/14, at 7:15 bathroom floor, yelli re-admitted to the fa 12:15 p.m. on 7/22/ A Root Cause Analy indicated R16 had b was no documentat she'd been to the ba kept close to nursing the resident did not evidence of actions	cture, occasional incontinence el, some agitated behaviors, nd independently, required ait belt for transfers, and used blan, last revised on 7/29/14, dementia, and was at "low are plan indicated R16 with transfers with a gait belt oning every 2 hours, and offer 8 hours and as needed. an directed staff to place call ncourage to use call light for ed and to be prompt in quests for assistance. ident reports from 7/16/14 to	F 3	T	<ul> <li>Consultation with her family who satisfied with the interventions the support her continued independer and understand her risk for falls;</li> <li>Consultation with VMNH consul pharmacist included:         <ul> <li>Review of pain medication betwoe of pain medications and falls;</li> <li>Orthostatic blood presses measurements that note correlation between blood pressu changes and falls</li> <li>Thyroid level drawn not instead of as scheduled September, and Synthre level adjusted.</li> </ul> </li> <li>Consultation and evaluation by her primary physician.</li> <li>The following interventions were added to are plan:         <ul> <li>Hourly rounding safety checks w staff asking R16 about bathroom/food/water/repositioning/pain relisin needed.</li> <li>Signs posted in her room to remin R16 to call for help;</li> <li>Call light within reach.</li> </ul> </li> <li>Thy offering ambulation three times plants are used as solution with her family and primary plater care plan has been updated as follows:         <ul> <li>OT,</li> <li>Offering ambulation three times plater and under stand any other resident having mu falls and/or unsafe self-transferring mu</li></ul></li></ul>	at nce ting tion to ween ure ed no re ww, in oid er the ith ief nd d: per day. n hysician. larm th R16 ltiple	

Facility ID: 00075

If continuation sheet Page 16 of 25

PRINTED: 09/01/2014 FORMAPPROVED OMB NO. 0938-0391

,

STATEMENT OF DEFICIENCIES AND PLAN OF COMERCINON         (XX) PREOMDERSUPPLIER(LA IDENTIFICATION NUMBER:         (XX) PREOMDERSUPPLIER(LA IDENTIFICATION NUMBER:         (XX) PREOMDERSUPPLIER(LA IDENTIFICATION NUMBER:         (XX) PREOMDERSUPPLIER(LA IDENTIFICATION								. 0000-000
MAKE OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, 2JP CODE         VIKING MANOR NURSING HOME       STREET ADDRESS, CITY, STATE, 2JP CODE         VIKING MANOR NURSING HOME       STREET NORTHWEST         VIKING MANOR NURSING HOME       JD         PREPRINT CONSTRUCTION OF DEFICIENCIES       JD         Continued From page 16       JD         Invesse's station or ensuring scheduled toileting.       PREPRINT         The care plan was not revised.       F 323         Continued From page 16       This system requires staff to carry a pager, along with a central monitoring station or ensuring scheduled toileting.         The care plan was not revised.       F 323         Nursing notes on 7/24/14, at 8:30 a.m. and 9:40 a.m. described ongoing self transfers. At 7/24/14, at 8:30 a.m. and 9:40 a.m. described ongoing self transfers. At 7/24/14, at 8:30 a.m. and 9:40 a.m. described ongoing self transfers. At 7/24/14, at 10:20 p.m. findicated R16 was setting off the laser alarm on the described additional self transfers with no interventions and the settings. Comprehensive mays suff the care plan. Or 7/28/14, at 10:30 p.m. indicated R16 was setting off the laser alarm but didn't want anything. There was no mention of a laser alarm on the care plan. Or 7/28/14, at 10:30 p.m. indicated R16 was setting off the laser alarm. Interventions and neare plan. On 7/28/14, at 10:30 p.m. the norse's note indicated R16 was uspet by the TABS alarm. And Wheelchair, having forgoten about her hip fracture. On 7/28/14, at 10:15 a.m. indicated R16 had broken both the laser alarm and TABS alarm.         Nursing notes on 8/1/14, at 10:				· ·				
VIKING MANOR NURSING HOME         317 FIRST STREET ORTHWEST ULEN, MN 56585           (V) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (LACH DEFICIENCY MUST BE PRECEDED BY FULL REQUATORY OR LIS LIDENTIFYING INFORMATION)         D PREFIX TAG         D PREFIX TAG         PROPENT (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APROPENTATE DEFICIENCY)         OWN TAG           F 323         Continued From page 16 nurses' station or ensuring scheduled toileting. The care plan was not revised.         F 323         This system requires staff to carry a page; along with a central monitoring station that will aler staff with commission of the than reminders to use the call light. Nursing notes on 7/26/14 and 7/27/14 described additional self transfers with no interventions other than reminders to use the call light. Nursing notes on 7/26/14, at 10:20 p.m. the care of alwas setting off the laser alarm but dicht want anything. There was no mention of a laser alarm on the care plan. On 7/28/14, at 3:10 p.m. the note indicated ATR6 was setting off the laser alarm but dicht want anything. There was no mention of a laser alarm on the care plan. On 7/28/14, at 3:10 p.m. the note indicated ATR6 was setting off the laser alarm but dicht want anything. There was no mention of a laser alarm on the care plan. On 7/28/14, at 3:10 p.m. the note indicated ATR6 was setting off the laser alarm but dicht want anything. There was no mention of a laser alarm on the care plan. On 7/28/14, at 3:10 p.m. the note indicated ATR6 was setting off the laser alarm but dicht want anything. There was no mention of a laser alarm on the care plan. On 7/28/14, at 3:10 p.m. the note indicated ATR6 was setting off the laser alarm but dicht want anything. There was no mention of a laser alarm on the care plan was alor to accipate the casus of ache w		·	245559	B. WING	÷		08/	/15/2014
Viking MANOR NURSING HOME         ULEN, MN 66686           (xi) (b) PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULTATIONY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH OCHRECTW ACTION SHOULD BE CROSS-REFERENCE ACTION AND COMPLET DEFICIENCY         Comparison (EACH OCHRECTW ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE PREVIX           F 323         Continued From page 16 nurses' station on the senses of the than sign of the asset at 19.40 additional self transfers. At 772/4/14, the cause of Nurse and TROS/14 at 07/2714 described additional self transfers with no interventions of staff via communication book, Kardex, and/or oral report.           Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and the atorken both he laser alarm and TABS alarm.           Nursing notes on 8/1/14, at 10	NAME OF	PROVIDER OR SUPPLIER	*		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
Continued From page 16 nurses' station or ensuring scheduled toleting. The care plan was not revised.         Dispension of the second schedule toleting. The care plan was not revised.         F 323         Continued From page 16 nurses' station or ensuring scheduled toleting. The care plan was not revised.         F 323           Nursing notes on 7/24/14, at 8:30 a.m. and 9:40 a.m. desoribed ongoing self transfers. At 7/24/14, the nursing note indicated a TABS alarm (electronic alarm) on the whech thar was sounding because R16 had self transferred. The care plan did not address the use of a TABS alarm. Staff reminded R16 to use the call light. Nursing notes on 7/27/14, at 10:30 p.m. the note indicated R16 was setting off the laser alarm but didn't want anything. There was no mention of a laser alarm on the knees on the floor in the rice indicated R16 had so that the laser alarm and TABS alarm.         F 323         F 323         Continued From page 16 nurses's totic table and other unusual occurrences will be completed for any resident who sustains a full. Root cause analysis will be utilized as alb to decipter the TABS alarm and wheelchair having forgotto p.m. the nurse's note indicated R16 was setting off the laser alarm but didn't want anything. There was no mention of a laser alarm on the knees on methor of alarer alarm and TABS alarm.         F 323           Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with P1/10 (physical therapy and occupational therapy), and to keep call light within reach.         System requires and buil interventions an dualid macidentifial interventions are in meeting will be end						317 FIRST STREET NORTHWEST		
PREFX TAGCEACH CORFECTIVE ACTION SHOLLD BE REGULATORY OR LSC IDENTIFYING INFORMATIONPREFX TAGCEACH CORFECTIVE ACTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE DECINETYCOMMETTING OWNEDF 323Continued From page 16 nurses' station or ensuring scheduled toileting. The care plan was not revised.This system requires staff to carry a pager, along with a central monitoring station that will aler staff when an assigned resident has risen of of sensor.Constitute of sensor.Nursing notes on 7/24/14, at 8:30 a.m. and 9:40 a.m. described ongoing self transfers. At 7/24/14, the nursing notes on 7/24/14 and 7/27/14 described additional self transfers with no interventions a larm. Staff reminded R16 to use the call light. Nursing notes on 7/27/14 and 7/27/14 described additional self transfers with no interventions other than reminders to use the call light.F 323F 323Committee Weillight a cantral monitoring station that will aler tails and other numsual occurrences will be discussed at weekly IDT and Falls Committee Meetings. Comprehensive assessments will be completed for any resident who sustains a fall. Root cause analysis will be utilized as able to decipter the cause of such everkly IDT and Falls Committee Meetings. Comprehensive assessments will be completed for any resident who sustains a fall. Root cause analysis will be utilized as able to decipter the cause of such everkly IDT and Falls Committee Meetings. Comprehensive assessments will be discusted on updates to R16's care plan din orker Monitoring will be the cause of such everkly IDT and Falls Committee Meetings. Comprehensive assessments will be discusted on updates to R16's care plan din orker who no monitoring will be that will be discusted on updates to R16's care plan beino	VIKING	MANOR NURSING HO	DME		ן ו	ULEN, MN 56585		
TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCE To THE APPROPRIATE DEFICIENCY       F 323     Continued From page 16 nurses' station or ensuring scheduled toileting. The care plan was not revised.     This system requires staff to carry a pager, along with a central monitoring station that will alert staff when an assigned resident has risen off of sensor.       Nursing notes on 7/24/14, at 8:30 a.m. and 9:40 a.m. described ongoing self transfers, At 7/24/14, the nursing note indicated a TABS alarm (electronic alarm) on the wheelchair was sounding because R16 had self transferred. The care plan did not address the use of a TABS alarm. Staff reminded R16 to use the call light.     Hendification and action for other VMNH resident with potential to be affected: All resident swith potential to be affected: All resident swith potential to be affected: All resident swith potential to be affected: All resident with potential to be affected: All resident weekly IDT and Falls Committee Meetings. Comprehensive assessments will be colleaved at not ause analysis will be utilized as able to decipher the care plan did not alor R128/14, at 10:30 p.m. indicated R16 was setting of the laser alarm but didn't want anything. There was no mention of a laser alarm on the care plan. On 7/28/14, at 1:015 p.m., the note indicated R16 had borken both the laser alarm and TABS alarm.     System Changes: All staff will be dicucated on updates to R16's care plan by 9/23/14, All staff will have signed a Fall Management Promise to Follow Agreement by 9/23/14, All staff will have signed a fall Management Promise to Follow Agreement by 9/23/14, at 1:40 then needing help, currently working with P-TOT (prysical therapy and occupational therapy), and to keep call light within reach.     Nursing notes on 8/1/14, at 1:45 p.m. indicated R16 was transferring self "multiple times tody." R16	(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
<ul> <li>F 323 Continued From page 16 nurses' station or ensuring scheduled toileting. The care plan was not revised.</li> <li>Nursing notes on 7/24/14, at 8:30 a.m. and 9:40 a.m. described ongoing self transfers. At 7/24/14, the nurseing note indicated a TABS alarm (electronic alarm) on the wheelchair was sounding because R16 had self transferred. The care plan did not address the use of a TABS alarm. Staff reminded R16 to use the call light.</li> <li>Nursing notes on 7/26/14 and 7/27/14 described additional self transfers with no interventions other than reminders to use the call light.</li> <li>Nursing notes on 7/26/14 and 7/27/14 described additional self transfers with no interventions other than reminders to use the call light.</li> <li>Nursing notes on 7/26/14 and 7/27/14 described additional self transfers with no interventions of a laser alarm on the care plan. On 7/28/14, at 1:0:30 p.m. the note indicated R16 had broken both the laser alarm and TABS alarm.</li> <li>Nursing notes on 81/1/4, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light within reach.</li> <li>Nursing notes on 83/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." R16 was transferring self without</li> </ul>						CROSS-REFERENCED TO THE APPROP		COMPLÉTION DATE
<ul> <li>nurses' station or ensuring scheduled toileting. The care plan was not revised.</li> <li>Nursing notes on 7/24/14, at 8:30 a.m. and 9:40 a.m. described ongoing self transfers. At 7/24/14, the nursing note indicated a TABS alarm (electronic alarm) on the wheelchair was sounding because R16 had self transferred. The care plan did not address the use of a TABS alarm. Staff reminded R16 to use the call light.</li> <li>Nursing notes on 7/26/14 and 7/27/14 described additional self transfers with no interventions other than reminders to use the call light.</li> <li>Nursing notes on 7/27/14, at 10:30 p.m. indicated R16 was setting off the laser alarm but didn't wart anything. There was no mention of a laser alarm on the care plan. On 7/28/14, at 1:10 p.m., the note indicated R16 was upset by the TABS alarm.</li> <li>Nursing notes on 8/1/14, at 1:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light within reach.</li> <li>Nursing notes on 8/1/14, at 1:15 p.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and fecommendations included removal of glider chair in room, continue to encourage resident to use call light within reach.</li> <li>Nursing notes on 8/1/14, at 1:145 p.m. indicated R16 was transferring self "multiple times today." R16 was educated and light use. On 8/6/14, at 7:20 p.m. R16 was transferring self "multiple times today." R16 was educated and call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self without</li> </ul>	F 323	Continued From pa	ao 16	( ·		This system requires staff to can	rry a pag	er,
<ul> <li>The care plan was not revised.</li> <li>Nursing notes on 7/24/14, at 8:30 a.m. and 9:40 a.m. described ongoing self transfers. At 7/24/14, the nursing note indicated a TABS alarm (electronic alarm) on the wheelchair was sounding because R16 had self transferred. The care plan di not address the use of a TABS alarm. Staff reminded R16 to use the call light.</li> <li>Nursing notes on 7/26/14 at 0:30 p.m. indicated R16 was uses on the care plan. On 7/28/14, at 3:10 p.m. the nurse's note indicated R16 had borken both the laser alarm and TABS alarm. the nurse's note indicated R16 had borken both the laser alarm and TABS alarm.</li> <li>Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage reaident to use call light within reach.</li> <li>Nursing notes on 8/3/14, at 1:145 p.m. indicated R16 was transferring self "multiple times today." R16 was educated abut call light use. On 8/6/14, at 7:20 p.m. R16 was educated abut call light within teach.</li> <li>Nursing notes on 8/3/14, at 1:145 p.m. indicated R16 have to an 0:3/14, at 1:145 p.m. indicated R16 was transferring self "multiple times today." R16 was seducated abut call light within teach.</li> <li>Nursing notes on 8/3/14, at 1:145 p.m. indicated R16 was transferring self "multiple times today." R16 was educated abut call light withint</li> </ul>	1 525	1 40		[ г.	523			
<ul> <li>Nursing notes on 7/24/14, at 8:30 a.m. and 9:40 a.m. described ongoing self transfers. At 7/24/14, the nursing note indicated a TABS alarm (electronic alarm) on the wheelchair was sounding because R16 had self transferred. The care plan did not address the use of a TABS alarm. Staff reminded R16 to use the call light.</li> <li>Nursing notes on 7/26/14 and 7/27/14 described additional self transfers with no interventions other than reminders to use the call light.</li> <li>Nursing notes on 7/27/14, at 10:30 p.m. indicated R16 was setting off the laser alarm on the care plan. On 7/28/14, at 10:30 p.m. the nurse's note indicated R16 was uset by the TABS alarm.</li> <li>Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 was used to the rhip fracture. On 7/29/14, at 1:10 p.m., the note indicated R16 had broken both the laser alarm and TABS alarm.</li> <li>Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light within reach.</li> <li>Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." R16 was educated abut call light use. On 8/6/14, at 7:20 p.m. R16 was stransferring self "multiple times today." R16 was educated abut call light use. On 8/6/14, at 7:20 p.m. R16 was fransferring self "multiple times today." R16 was educated abut call light use. On 8/6/14, at 7:20 p.m. R16 was fransferring self "multiple times today." R16 was educated abut call light use. On 8/6/14, at 7:20 p.m. R16 was fransferring self "multiple times today." R16 was educated abut call light use. On 8/6/14, at 7:20 p.m. R16 was fransferring self "multiple times today." R16 was educated abut call light use. On 8/6/14, at 7:20 p.m. R16 was fransferring self "multiple times today." R16 was elucated abut call light use. On 8/6/14, at 7:20 p.m. R16 was function the robay candid the more walked abut</li></ul>								
<ul> <li>Nursing notes on 7/24/14, at 8:30 a.m. and 9:40 a.m. described ongoing self transfers. At 7/24/14, the nursing notes on 7/86/14, at 13.30 a.m. and 9:40 the nursing notes on 7/86/14, at 13.30 p.m. indicated R16 was setting off the laser alarm on the care plan did nu d/127/14 (described additional self transfers with no interventions of other than reminders to use the call light.</li> <li>Nursing notes on 7/27/14, at 10:30 p.m. indicated R16 was setting off the laser alarm on the care plan. On 7/28/14, at 3:10 p.m. indicated R16 was setting off the laser alarm on the care plan. On 7/28/14, at 1:10 p.m., the nurse's note indicated R16 was used to R16/s alarm.</li> <li>Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 was transferring self multiple times today." Interventions and recommendations included removal of glider chair in room, continue to call light within reach.</li> <li>Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self multiple times today." R16 was transferring self multiple times today." R16 was ducated and used to many set in place and being followed. At 7:20 p.m. R16 was transferring self multiple times today." R16 was transferring self multiple times today."</li> </ul>		The care plan was	not revised.					
<ul> <li>a.m. described ongoing self transfers. At 7/24/14, the nursing note indicated a TABS alarm (electronic alarm) on the wheelchair was sounding because R16 had self transferred. The care plan did not address the use of a TABS alarm. Staff reminded R16 to use the call light.</li> <li>Nursing notes on 7/26/14 and 7/27/14 described additional self transfers with no intervention s other than reminders to use the call light.</li> <li>Nursing notes on 7/27/14, at 10:30 p.m. indicated R16 was setting off the laser alarm out didn't want anything. There was no mention of a laser alarm on the care plan. On 7/28/14, at 1:10 p.m., the note indicated R16 was upset by the TABS alarm.</li> <li>Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light within reach.</li> <li>Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." R16 was transferring self without</li> </ul>								
<ul> <li>the nursing note indicated a TABS alarm (electronic alarm) on the wheelchair was sounding because R16 had self transferred. The care plan did not address the use of a TABS alarm. Staff reminded R16 to use the call light. Nursing notes on 7/26/14 and 7/27/14 (described additional self transfers with no interventions other than reminders to use the call light.</li> <li>Nursing notes on 7/27/14, at 10:30 p.m. indicated R16 was setting off the laser alarm but didn't want anything. There was no mention of alaser alarm on the care plan. On 7/28/14, at 3:10 p.m. the nurse's note indicated R16 was upset by the TABS alarm.</li> <li>Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.</li> <li>Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self without</li> </ul>							ation	
(electronic alarm) on the wheelchair was sounding because R16 had self transferred. The care plan did not address the use of a TABS alarm. Staff reminded R16 to use the call light. Nursing notes on 7/26/14 and 7/27/14 described additional self transfers with no interventions other than reminders to use the call light.Identification and action for other YMNH resident suith potential to be affected: all resident suith potential to be affected: additional self transfers with no interventions other than reminders to use the call light.Nursing notes on 7/27/14, at 10:30 p.m. indicated R16 was setting off the laser alarm but didn't want anything. There was no mention of a laser alarm on the care plan. On 7/28/14, at 3:10 p.m. the note indicated R16 had beroken both the laser alarm and TABS alarm.Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical theray and occupational therapy), and to keep call light within reach.Identification and action for ofter VMNH resident suith and attion in detries. Comprehensive assessments will be addited randomly by DON and/or designee unit reviewed by Quality Assurance committee. All accident/falls interventions are in place and boing followed.Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self winthutIdentification and action for other VMNH escible additional settings. Comprehensive assessments will be addited randomly by DON and/or designee to ensure interventions are in place and boing followed.<						book and oral report.		
<ul> <li>sounding because R16 had self transferred. The care plan did not address the use of a TABS alarm. Staff reminder R16 had been found on the rknees on the floor in her com while holding onto her walker. Interventions and TABS alarm.</li> <li>Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and racommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.</li> <li>Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self without</li> </ul>						The standard for other MANU	г	
Care plan did not address the use of a TABS alarm. Staff reminded R16 to use the call light.Nursing notes on 7/26/14 and 7/27/14 described additional self transfers with no interventions other than reminders to use the call light.Nursing notes on 7/27/14, at 10:30 p.m. indicated R16 was setting off the laser alarm but didn't want anything. There was no mention of a laser alarm on the care plan. On 7/28/14, at 3:100 p.m. the nurse's note indicated R16 was upset by the TABS alarm and wheelchair, having forgotten about her hip fracture. On 7/29/14, at 1:10 p.m., the note indicated R16 had broken both the laser alarm and TABS alarm.Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.All resident fails and other unusual occurrences will be discussed at weekly DT and Falls committee. Maes the able to decipher the cause of such events. Nurses and IDT will continue to communication book, Kardex, and/or oral report.Nursing notes on 8/1/14, at 10:15 a.m. indicated removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self "multiple times today." R16 was ducated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self withoutAll resident fails and f							Ţ	
<ul> <li>alarm. Staff reminded R16 to use the call light.</li> <li>Nursing notes on 7/26/14 and 7/27/14 described additional self transfers with no interventions other than reminders to use the call light.</li> <li>Nursing notes on 7/27/14, at 10:30 p.m. indicated R16 was setting off the laser alarm on the care plan. On 7/28/14, at 3:10 p.m. the nurse's note indicated R16 was upset by the TABS alarm and wheelchair, having forgotten about her hip fracture. On 7/29/14, at 1:10 p.m., the note indicated R16 had broken both the laser alarm and TABS alarm.</li> <li>Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.</li> <li>Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." R16 was transferring self "multiple times today." R16 was transferring self without</li> </ul>							rences	
<ul> <li>Nursing notes on 7/26/14 and 7/27/14 described additional self transfers with no interventions other than reminders to use the call light.</li> <li>Nursing notes on 7/27/14, at 10:30 p.m. indicated R16 was setting off the laser alarm but didn't want anything. There was no mention of a laser alarm on the care plan. On 7/28/14, at 3:10 p.m. the nurse's note indicated R16 was upset by the TABS alarm and wheelchair, having forgotten about her hip fracture. On 7/29/14, at 1:10 p.m. the note indicated R16 had broken both the laser alarm and TABS alarm.</li> <li>Nursing notes on 8//14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.</li> <li>Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self without</li> </ul>								I.
<ul> <li>additional self transfers with no interventions other than reminders to use the call light.</li> <li>Nursing notes on 7/27/14, at 10:30 p.m. indicated R16 was setting off the laser alarm but didn't want anything. There was no mention of a laser alarm on the care plan. On 7/28/14, at 3:10 p.m. the nurse's note indicated R16 was upset by the TABS alarm and wheelchair, having forgotten about her hip fracture. On 7/29/14, at 1:10 p.m., the note indicated R16 had benches the talser alarm.</li> <li>Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encurage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.</li> <li>Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." R16 was transferring self without</li> <li>Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self without</li> <li>R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self without</li> </ul>			ç				,	
resident who sustains a fall. Root cause analysis will be utilized as able to decipher analysis will be utilized as able to decipher the cause of such events. Nurses and IDT will continue to communicate new interventions to staff via communication book, Kardex, and/or oral report. System Changes: All staff will be ducated on updates to R16's care plan by 9/23/14. All staff will have signed a Fall Management Promise to Follow Agreement by 9/23/14. All staff will have signed a Fall Management Promise to Follow Agreement by 9/23/14. An urse meeting will be held on 9/16/14 to review policies and educate staff on documentation of falls and fall investigation forms on 9/16/14 with all nursing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach. Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today."		•				Committee meetings. Completed for any	1	-
<ul> <li>analysis will be utilized as able to decipher</li> <li>analysis will be use on</li> <li>at as a being of unicated</li> <li>at as a</li></ul>						assessments will be completed for any		
Nursing notes on 7/27/14, at 10:30 p.m. indicated R16 was setting off the laser alarm but didn't want anything. There was no mention of a laser alarm on the care plan. On 7/29/14, at 3:10 p.m. the nurse's note indicated R16 was upset by the TABS alarm and wheelchair, having forgotten about her hip fracture. On 7/29/14, at 1:10 p.m., the note indicated R16 had broken both the laser alarm and TABS alarm.the cause of such events. Nurses and IDT will continue to communicate new interventions to staff via communication book, Kardex, and/or oral report.Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of gilder chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.Monitoring plan: R16's interventions and hourly rounding assessments have been audited daily for 2 weeks starting 8/15/14 and then weekly by DON and/or designee until reviewed by Quality Assurance committee. All accident/falls interventions will be audited randomly by DON and/or designee until reviewed by Quality Assurance committee. All accident/falls interventions will be audited randomly by DON and/or designee until reviewed to a trizop p.m. R16 was transferring self without		other than reminder	s to use the call light.				er	
<ul> <li>Nursing notes on 8/1/14, at 10:30 p.m.</li> <li>indicated R16 was setting off the laser alarm but didn't want anything. There was no mention of a laser alarm on the care plan. On 7/28/14, at 3:10 p.m. the nurse's note indicated R16 was upset by the TABS alarm and wheelchair, having forgotten about her hip fracture. On 7/29/14, at 1:10 p.m., the note indicated R16 had broken both the laser alarm and TABS alarm.</li> <li>Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.</li> <li>Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self without</li> </ul>								
staff via communication book, Kardex, and/or oral report. System Changes: All staff will be educated on updates to R16's care plan by 9/23/14. All staff will have signed a Fall Management Promise to Follow Agreement by 9/23/14. All staff will have signed a Fall Management Promise to Follow Agreement by 9/23/14. An urse meeting will be held on 9/16/14 to review policies and educate staff on documentation of falls and fall investigation forms on 9/16/14 with all nursing staff having completed education by 9/23/14. Mursing notes on 8/1/14, at 10:15 a.m. indicated removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach. Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self without						continue to communicate new interventio	ins to	
didn't Walk anything. There was no inferition of a laser alarm on the care plan. On 7/28/14, at 3:10 p.m. the nurse's note indicated R16 was upset by the TABS alarm and wheelchair, having forgotten about her hip fracture. On 7/29/14, at 1:10 p.m., the note indicated R16 had broken both the laser alarm and TABS alarm.oral report.Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self "multiple times today."Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self withoutNursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self inultiple times today."Nursing notes on 8/3/14, at 1:45 p.m. indicated R16/s interventions are in place and being followed. Results of monitoring will be reported to								
<ul> <li>System Changes:</li> <li>System Changes:</li> <li>All staff will be educated on updates to R16's care plan by 9/23/14. All staff will have signed a Fall Management Promise to Follow</li> <li>Agreement by 9/23/14. A nurse meeting will be held on 9/16/14 to review policies and educate staff on documentation of falls and fall investigation forms on 9/16/14 with all nursing staff having completed education by 9/23/14.</li> <li>Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker.</li> <li>Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.</li> <li>Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today."</li> <li>R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self without at 7:20 p.m. R16 was transferring self without</li> </ul>								
<ul> <li>the TABS alarm and wheelchair, having forgotten about her hip fracture. On 7/29/14, at 1:10 p.m., the note indicated R16 had broken both the laser alarm and TABS alarm.</li> <li>Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.</li> <li>Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today."</li> <li>Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today."</li> <li>R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self without</li> <li>All staff will be educated on updates to R16's care plan by 9/23/14. All staff will have signed a Fall Management Promise to Follow Agreement by 9/23/14. A nurse meeting will be held on 9/16/14 to review policies and educate staff on documentation of falls and fall investigation forms on 9/16/14 with all nursing staff having completed education by 9/23/14.</li> <li>Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today."</li> <li>R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self without</li> </ul>						orar report.		
All staff will be educated on updates to R16's care plan by 9/23/14. All staff will have signed a Fall Management Promise to Follow Agreement by 9/23/14. An urse meeting will be held on 9/16/14 to review policies and educate staff on documentation of falls and fall investigation forms on 9/16/14 with all nursing staff having completed education by 9/23/14.Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.Monitoring plan: R16's interventions and hourly rounding assessments have been audited daily for 2 weeks starting 8/15/14 and then weekly by DON and/or designee until reviewed by Quality Assurance committee. All accident/falls interventions will be audited randomly by DON and/or designee to ensure interventions are in place and being followed. Rsults of monitoring will be reported to						System Changes:		
<ul> <li>about her hip fracture. On //29/14, at 1:10 p.m., the note indicated R16 had broken both the laser alarm and TABS alarm.</li> <li>Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.</li> <li>Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self without</li> <li>care plan by 9/23/14. All staff will have signed a Fall Management Promise to Follow Agreement by 9/23/14. A nurse meeting will be held on 9/16/14 to review policies and educate staff on documentation of falls and fall investigation forms on 9/16/14 with all nursing staff having completed education by 9/23/14.</li> <li>Monitoring plan: R16's interventions and hourly rounding assessments have been audited daily for 2 weeks starting 8/15/14 and then weekly by DON and/or designee to ensure interventions are in place and being followed. Results of monitoring will be reported to</li> </ul>		the TABS alarm and	l wheelchair, having forgotten			All staff will be educated on updates to R	16's	
<ul> <li>the note indicated R16 had broken both the laser alarm and TABS alarm.</li> <li>Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker.</li> <li>Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.</li> <li>Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today."</li> <li>Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self without</li> <li>a Fall Management Promise to Follow Agreement by 9/23/14. A nurse meeting will be held on 9/16/14 to review policies and educate staff on documentation of falls and fall investigation forms on 9/16/14 with all nursing staff having completed education by 9/23/14.</li> <li>Monitoring plan:</li> <li>R16's interventions and hourly rounding assessments have been audited daily for 2 weeks starting 8/15/14 and then weekly by DON and/or designee until reviewed by Quality Assurance committee. All accident/falls interventions will be audited randomly by DON and/or designee to ensure interventions are in place and being followed.</li> <li>Results of monitoring will be reported to</li> </ul>		about her hip fractu	re. On 7/29/14, at 1:10 p.m.,					
alarm and TABS alarm.Agreement by 9/23/14. A nurse meeting will be held on 9/16/14 to review policies and educate staff on documentation of falls and fall investigation forms on 9/16/14 with all nursing staff on documentation of falls and fall investigation forms on 9/16/14 with all nursing staff on documentation of falls and fall investigation forms on 9/16/14 with all nursing staff on documentation of falls and fall investigation forms on 9/16/14 with all nursing staff on documentation of falls and fall investigation forms on 9/16/14 with all nursing staff on documentation of falls and fall investigation forms on 9/16/14 with all nursing staff on documentation by 9/23/14.Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.Monitoring plan: R16's interventions and hourly rounding assessments have been audited daily for 2 weeks starting 8/15/14 and then weekly by DON and/or designee until reviewed by Quality Assurance committee. All accident/falls interventions will be audited randomly by DON and/or designee to ensure interventions are in place and being followed. Results of monitoring will be reported to		the note indicated R	16 had broken both the laser				-8	
Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.held on 9/16/14 to review policies and educate staff on documentation of falls and fall investigation forms on 9/16/14 with all nursing staff having completed education by 9/23/14.Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self withoutMonitoring plan: R16/3 interventions and hourly rounding assessments have been audited daily for 2 weeks starting 8/15/14 and then weekly by DON and/or designee until reviewed by Quality Assurance committee. All accident/falls interventions will be audited randomly by DON and/or designee to ensure interventions are in place and being followed. Results of monitoring will be reported to		alarm and TABS ala	ırm.				will be	
Nursing notes on 8/1/14, at 10:15 a.m. indicated R16 had been found on her knees on the floor in her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.staff on documentation of falls and fall investigation forms on 9/16/14 with all nursing staff having completed education by 9/23/14.Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self withoutMonitoring plan: R16's interventions and hourly rounding assessments have been audited daily for 2 weeks starting 8/15/14 and then weekly by DON and/or designee until reviewed by Quality Assurance committee. All accident/falls interventions will be audited randomly by DON and/or designee to ensure interventions are in place and being followed. Results of monitoring will be reported to								
her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.staff having completed education by 9/23/14.Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self withoutstaff having completed education by 9/23/14.Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self withoutMonitoring plan: R16/3 interventions and hourly rounding assessments have been audited daily for 2 weeks starting 8/15/14 and then weekly by DON and/or designee until reviewed by Quality Assurance committee. All accident/falls interventions will be audited randomly by DON and/or designee to ensure interventions are in place and being followed. Results of monitoring will be reported to		Nursing notes on 8/	1/14, at 10:15 a.m. indicated 🛛					
her room while holding onto her walker. Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.staff having completed education by 9/23/14.Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self withoutstaff having completed education by 9/23/14.Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self withoutMonitoring plan: R16 was transferring self without		R16 had been found	on her knees on the floor in			investigation forms on 9/16/14 with all nu	irsing	
Interventions and recommendations included removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.Monitoring plan: R16's interventions and hourly rounding assessments have been audited daily for 2 weeks starting 8/15/14 and then weekly by DON and/or designee until reviewed by Quality Assurance committee. All accident/falls interventions will be audited randomly by DON and/or designee to ensure interventions are in place and being followed. Results of monitoring will be reported to		her room while hold	ing onto her walker.					
removal of glider chair in room, continue to encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.Monitoring plan: R16's interventions and hourly rounding assessments have been audited daily for 2 weeks starting 8/15/14 and then weekly by DON and/or designee until reviewed by Quality Assurance committee. All accident/falls interventions will be audited randomly by DON and/or designee to ensure interventions are in place and being followed. Results of monitoring will be reported to		Interventions and re	commendations included			/		
encourage resident to use call light when needing help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.R16's interventions and hourly rounding assessments have been audited daily for 2 weeks starting 8/15/14 and then weekly by DON and/or designee until reviewed by Quality Assurance committee. All accident/falls interventions will be audited randomly by DON and/or designee to ensure interventions are in place and being followed. Results of monitoring will be reported to	1					Monitoring plan:		
help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.assessments have been audited daily for 2 weeks starting 8/15/14 and then weekly by DON and/or designee until reviewed by Quality Assurance committee. All accident/falls interventions will be audited randomly by DON and/or designee to ensure interventions are in place and being followed. Results of monitoring will be reported to						R16's interventions and hourly rounding		
call light within reach.DON and/or designee until reviewed by Quality Assurance committee. All accident/falls interventions will be audited randomly by DON and/or designee to ensure interventions are in place and being followed.Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self withoutDON and/or designee until reviewed by Quality Assurance committee. All accident/falls interventions will be audited randomly by DON and/or designee to ensure interventions are in place and being followed. Results of monitoring will be reported to		help, currently working with PT/OT (physical therapy and occupational therapy), and to keep call light within reach.			Ì			
call light within reach.DON and/or designee until reviewed by Quality Assurance committee. All accident/falls interventions will be audited randomly by DON and/or designee to ensure interventions are in place and being followed.Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today." R16 was educated about call light use. On 8/6/14, 								
Nursing notes on 8/3/14, at 1:45 p.m. indicated R16 was transferring self "multiple times today."Assurance committee. All accident/falls interventions will be audited randomly by DON and/or designee to ensure interventions are in place and being followed. Results of monitoring will be reported to								
R16 was transferring self "multiple times today."and/or designee to ensure interventions are in place and being followed.R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self withoutand/or designee to ensure interventions are in place and being followed.Results of monitoring will be reported to							-	
R16 was transferring self "multiple times today."and/or designee to ensure interventions are in place and being followed.R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self withoutand/or designee to ensure interventions are in place and being followed.Results of monitoring will be reported to						interventions will be audited randomly by	DON	
R16 was educated about call light use. On 8/6/14, at 7:20 p.m. R16 was transferring self without place and being followed. Results of monitoring will be reported to						and/or designee to ensure interventions are	e in	
at 7:20 p.m. R16 was transferring self without Results of monitoring will be reported to								
						Administrator and Quality Assurance Con	mittee	

.

Facility ID: 00075

PRINTED: 09/01/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245559	B. WING		08	/15/2014	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	for staff for help. Nursing notes on 8, R16 was noted to h bathroom from w/c wheeled walker. Sta and walked R16 ba walker. R16 was no instructed to use the Nursing notes on 8, R16 transferred her shoes on. Staff rem to wear stocking fee call light to get staff to have said, "I know Nursing notes from indicated R16 was f next to window. The stated she was tryin Staff found a recline R16 and the recline next to bed." The re occupational therap recliner with the call a.m., one hour prior indicated the therap in the wheelchair at a.m., and the fall. Th assistant assigned to admitted not having a.m. and the fall so independently. The	/9/14, at 1:15 p.m. indicated lave "walked per self" to (wheelchair). R16 used aff assisted R16 for toilet use ck to bed with gait belt and oted to be unsteady and was e call light. On /10/14, at 7:40 a.m. indicated rself to the bathroom without inded R16 that it was unsafe et and showed R16 how to use assistance. R16 was quoted w but I just forget." 8/11/14, at 10:10 a.m. found in room, flat on back e incident report indicated R16 ng to get back into recliner. er arm cover on floor next to r was "pushed up against wall	F 323		onitoring, ursing or	9/23/14	
	On 8/12/14, at 1:20 seated in a wheelch	p.m. R16 was observed air in her room. R16 propelled g her legs from the middle of	Far	cility ID: 00075 if coi	ntinuation sheet F	Page 18 of 25	

.

CENTER	KS FOR MEDICARE	& MEDICAID SERVICES				IVID INO.	0920-0291		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245559	B. WING			08/	08/15/2014		
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
VIKING MANOR NURSING HOME				317 FIRST STREET NORTHWEST ULEN, MN 56585					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 323	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	323					

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

Facility ID: 00075

If continuation sheet Page 19 of 25

STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245559	B. WING			08/	15/2014
	PROVIDER OR SUPPLIER	) ME		3	STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST JLEN, MN 56585		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX }	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	8/12/14, at 3:00 p.n R16 during night sh fewer episodes of s because her needs On 8/12/14, at 3:03 and stated R16 wor help with transfers button for help. NA- R16 when she was bedroom so she co doing. On 8/12/14, at 3:15 (DON) stated the a R16's fall on 7/22/1 of PRN (as needed medication). The D dementia but was u that R16 thought sh that attempted inter TABS alarm and la alarms were not ad discontinued when DON further stated PT/OT, staff were f whereabouts, and t DON verified the la related to potential falls or attempted in of injury from falls. On 8/13/14, at 9:02 stated that attempt fall included the call to use the call light.	Ige 19 NA)-B was interviewed on h. and described caring for hifts. NA-B stated R16 had belf-transfers and falling were anticipated and met. p.m. NA-A was interviewed uld forget that she needed and also forgot to use call -A stated she tried to follow observed on her way to her uld check on what R16 was p.m. the director of nursing ssessment of causal factors of 4, may have been the addition ) oxycodone (narcotic pain ON also stated R16 had used to being independent and he still was. The DON stated rventions included the use of a ser alarm. She verified the lded to the care plan and were R16 had broken them. The R16 was being followed by requently monitoring R16's the furniture was changed. The ck of documented assessment causative factors related to herventions to reduce the risk ca.m. registered nurse (RN)-A ed interventions after the first ll light within reach, reminders a laser alarm to the bed and e wheelchair. R16 was upset	F	323			

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

Facility ID: 00075

If continuation sheet Page 20 of 25

PRINTED: 09/01/2014 FORM APPROVED OMB NO: 0938-0391

.

STATEMEN	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 Y /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245559	B. WING			08/	15/2014
	PROVIDER OR SUPPLIER			3'	TREET ADDRESS, CITY, STATE, ZIP CODE 17 FIRST STREET NORTHWEST ILEN, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	verified R16 was n assistance per PT/ R16 had dementia interventions includ call light. RN-A furt assessment to det to reduce the risk of interventions. On 8/13/14, at 12:3 (PT)-A stated R16 balance and safety attempts self-trans "spoken to daily." standing and did n added R16 did not was not safe to sel On 8/13/14, at 12:3 self-transfers "ever According to NA-O but did not work. N to use the call light When interviewed DON stated sugge hourly rounds, how because R16 was On 8/14/14, at 9:00 affixed her initials t R16's care plan on safety checks. On 8/14/14, at 9:15 was conducted wit who stated R16 ha four times during F	destroyed them both. RN-A ot independent and required /OT evaluation. RN-A stated and was forgetful, but ded to "educate" R16 to use ther verified there was no ermine potential interventions of falls and there were no new 30 p.m. physical therapist was working on endurance, v issues. PT-A verified R16 fers despite having been PT-A stated R16 had difficulty ot use wheelchair brakes. PT-A understand instructions and f-transfer. 57 p.m. NA-C stated R16 ry time you turn around." C, a laser alarm was attempted IA-C stated R16 was reminded	F:	323			

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

Facility ID: 00075

If continuation sheet Page 21 of 25

PRINTED: 09/01/2014 FORM APPROVED OMB NO. 0938-0391

	NO FOR MEDICARE	& MEDICAID SERVICES	r		0	VID NO.	0920-0291	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245559	B. WING			08/	15/2014	
	PROVIDER OR SUPPLIER	) ME		STREET ADDRESS, CITY, STATE, ZIP 317 FIRST STREET NORTHWEST ULEN, MN 56585	CODE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	n Should E Appropf	BE	(X5) COMPLETION DATE	
F 323	incident reports reg 7/22/14, 8/1/14, 8/1 verified the docume was accurate and la or interventions. The Treatment/Ma undated Falls - Clin "identify pertinent in subsequent falls an consequences of fa assessment of a pr Monitoring and Foll fall continues, staff situation and the "c interventions." The facility's Manag revised on 12/2007 additional or differe despite initial interve The facility's Fall Pr directed "primary R resident's care plan prevent the likely ho The immediate jeop 8/15/14, at 12:20 p. reviewed and asses identified interventions. In included hourly safe ambulation and act pharmacy reviews of physician was upda were initiated. Staff related to the updat	p.m. the DON reviewed the larding R16's falls on 7/16/14, 1/14 and 8/12/14. The DON entation on the incident reports acked evidence of assessment nagement section of facility's lical protocol, directed staff to nerventions to try to prevent d to address risks of serious alling" following the evious fall. In addition, the ow-Up section indicated that if would re-evaluate the ontinued relevance of current ging Falls and Fall Risk policy , directed staff to implement nt interventions if falling recurs	. F 3					
FORM CMS-25	667(02-99) Previous Versions	Obsolete Event ID: RXQ511	1	Facility ID: 00075	continuatio	on sheet f	Page 22 of 25	

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245559	B. WING			08/	15/2014
	Provider or Supplier Manor Nursing HC	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 317 FIRST STREET NORTHWEST ULEN, MN 56585			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	iD PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323 F 386 SS=C	understanding of th plan included chang were documented, monitored. Compre were completed for of falls. 483.40(b) PHYSICI CARE/NOTES/ORI The physician must program of care, ind treatments, at each of this section; write notes at each visit; with the exception of polysaccharide vace administered per ph policy after an asse This REQUIREMEN by: Based on interview resident facility adm not include languag following from 483.4 F386-residents' phy the resident's total p included medication and dated orders wit Findings include: On 8/14/14, at 3:23 for the extended sur for review. Included	e plan for R16. The removal ges in the way resident falls assessed, and outcomes hensive falls assessments all residents identified at risk AN VISITS - REVIEW DERS review the resident's total cluding medications and visit required by paragraph (c) e, sign, and date progress and sign and date all orders of influenza and pneumococcal cines, which may be hysician-approved facility ssment for contraindications. IT is not met as evidenced and document review the hission agreement policy did e which identified the 40 (b): sician responsibility to review program of care which is and treatments, and signed		323	It is the policy of VMNH to assure that the physician reviews a resident's total program of care, as required by law and regulation. Corrective action for identified residents: The survey findings do not identify any speciresident who has not had his/her physician review the total program of care. It is VMNF position that it is in compliance with 42 CFR 483.40(b) and that its physicians are providin the required total program review as required by law and regulation. Survey findings indicated that facility admission policy and orders "lack identification of physician responsibilities for review of residents' programs of care." Neith the cited regulation nor the CMS <i>State Operat Manual's</i> Interpretive Guidelines on F386 me a need for admission orders identifying this responsibility. As provided for in law and regulation, VMNH is requesting informal dispresolution to question this deficiency. Identification and action for other VMNH resision dorders to assure that the resident's primar physician has been reviewing the resident's primar physician has been reviewing the resident's nor program of care. In its review of these finding the Administrator has noted that the VMNH Admission Packet includes a resident handboo with the Admission Agreement. Under Minnesota state law, all materials and docume given to a resident at admission are considered admission contract. VMNH's resident handboo includes brief explanations of many facility policies for residents and their families. One of these policies is <i>Medical Care</i> that describes the resident's physician will visit every 30 day for the first 90 days and every 60 days thereaft in between visits, as needed for immediate me	I's § g ate ter tions ntion oute <u>idents</u> <u>ge:</u> ing care y tal iss, k nts the pok ok of nat s s er.	

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

Facility ID: 00075

If continuation sheet Page 23 of 25

PRINTED: 09/01/2014 FORMAPPROVED OMB NO: 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		245559	B. WING			08/	15/2014	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>		
	MANOR NURSING HO	ME			17 FIRST STREET NORTHWEST			
VINING				L	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 APPROPN DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 386 F 387 SS=C	at 8:57 a.m. The facility policy tit dated 8/6/13, includ which included prov for the immediate ca covered at least: typ and routine care orc lacked identification for review of resider On 8/15/14, at 12:30 administrator confirr Admissions to the F current policy and in any additional langu as the policy had be 483.40(c)(1)-(2) FRI OF PHYSICIAN VIS The resident must b once every 30 days admission, and at le thereafter. A physician visit is c not later than 10 day required. This REQUIREMEN by: Based on interview resident facility adm	lity administrator on 8/15/14, led, Admissions to the Facility, led direction for the physician rision of information needed are of the resident which be of diet, medication orders, ders. However the policy of physician responsibilities nts' programs of care. 0 p.m., the facility med the policy titled, acility, dated 8/6/13, was the ndicated he was not aware of tage that would be necessary, een reviewed frequently. EQUENCY & TIMELINESS SIT be seen by a physician at least for the first 90 days after east once every 60 days onsidered timely if it occurs ys after the date the visit was IT is not met as evidenced and document review the ission agreement policy did e which identified the			attention; and that the physician will keep resistention; and that the physician will keep resistention; and birector of Nursing have consulted with Medical Director regarding F386 findings and reviewed regulation and CMS State Operation Manual's Interpretive Guidelines on F386 to assure that physicians continue to review a resident's total plan of care. Monitoring plan: The DON and/or designee will perform random audits monthly of admission orders ongoing of total program of care Audit findings will be reviewed at quarterly Quality Assurance meet The Quality Assurance committee will determ direction for future compliance monitoring, at and training. Administrator or designee is resp for compliance.	xpect strator d ms om care lent's ings. in	ts s ul	

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

Facility ID: 00075

If continuation sheet Page 24 of 25

PRINTED: 09/01/2014 FORM APPROVED OMB NO: 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1				E SURVEY IPLETED
		245559	B. WING	;		08/	15/2014
	PROVIDER OR SUPPLIER	DME		3	STREET ADDRESS, CITY, STATE, ZIP CODE 117 FIRST STREET NORTHWEST JLEN, MN 56585		<del></del>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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 387	contact, every 30 da every 60 days there Findings include: On 8/14/14, at 3:23 for the extended su Included in the requ admission orders. T facility administrator The facility policy tit dated 8/6/13, includ which included prov for the immediate ca covered at least: typ and routine care ord lacked identification for physician's visits On 8/15/14, at 12:30 administrator confir Admissions to the F current policy and ir any additional langu	nust be seen with face to face ays for the first 90 days and eafter. p.m., facility policies required rvey process were requested. lest was a policy for resident The policy was provided by the r on 8/15/14, at 8:57 a.m. led, Admissions to the Facility, ed direction for the physician rision of information needed are of the resident which be of diet, medication orders, ders. However the policy of physician responsibilities with face to face contact.	F		the physician will keep resident informed your medical condition we expect would the total plan of care. It is VMNH's position that it is in compl 42 CFR § 483.40(c) and that its resident seen in a timely manner by their physic: required by law and regulation. Survey indicate that facility admission policy di include language about residents being a their physicians as required in F387. Ne cited regulation nor the CMS <i>State Open</i> <i>Manual's</i> Interpretive Guidelines on F38 mention a need for the admission agreer include such language. VMNH's admission packet that is provided to every resident admission included information about the physician visits. As provided for in law a regulation, VMNH is requesting informat dispute resolution to question this deficie. Administrator and Director of Nursing h consulted with Medical Director regardint findings and reviewed regulation and C. <i>State Operations Manual's</i> Interpretive Guidelines on F387 to assure that reside continue to be seen 1:1 by their physiciar a timely manner as required by law and Administrator is consulting with legal co regarding revisions to the Resident Hance policy to. <u>Monitoring plan:</u> The DON and/or designee will perform re audits monthly of admission orders ongo care to assure that physicians are review resident's total program of care Audit fin will be reviewed at quarterly Quality Ass meetings. The Quality Assurance commit determine direction for future compliance.	include iance wi s are ians, as findings d not seen by ither the rations on upon le and l ency. ave mg F387 MS nts is in regulation unsel lbook andom ing a dings urance tee will etter the results are to ion the state of the state of the st	th

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

Event ID: RXQ511

Facility ID: 00075

If continuation sheet Page 25 of 25

	MENT OF HEALTH				359023	Printed: 08/ FORM APP OMB NO. 093	PROVED
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			PLE CONSTRUCTION G 01 - 1965 BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245559		B. WING		08/12/20	14
	ROVIDER OR SUPPLIER MANOR NURSING H	IOME	317 FIF		STATE, ZIP CODE ET NORTHWEST 5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE CON	(X5) MPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
	FIRE SAFETY 01 Main Building						
	Minnesota Departm time of this survey, 01 Main Building wa compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	Survey was conduct lent of Public Safety. Viking Manor Nursin as found in substant requirements for pa id at 42 CFR, Subpa ty from Fire, and the Fire Protection Assoc 1, Life Safety Code Health Care.	At the g Home cial articipation art 2000 ciation				
	without a basement different times. The constructed in 1965 Type II (000) constr west was constructed determined to be Ty separated from the fire barrier. A connecting 1994 to the north en the facility to an apa connecting link was south of the west w clinic. Both building existing nursing hor 2003 a 24 foot by 4 constructed to the s Type II(000) constri- basement.	ype V (111) construct original building with ecting link was const and of the east wing to artment building and constructed in 1998 ing to connect the fa s are separated from ne with 2-hour fire b 2 foot, PT addition w couth of the east wing ction, 1-story without	five s d to be of to the tion and is a 2-hour tructed in o connect a b to the cility to a n the arriers. In ras g that is t a	5			9
	automatic fire sprin accordance with NF	is protected with a co kler system installed PA 13 Standard for	in the				DATE
LABORATO	RY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESE	NIATIVE'S SIG	NATURE	TITLE	(X6) D	AIE

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.

Printe DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR CENTERS FOR MEDICARE & MEDICAID SERVICES OMB N								
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - 1965 BUILDING 01		(X3) DATE S COMPLE	URVEY	
		245559		B. WING		08/1	2/2014	
	PROVIDER OR SUPPLIER MANOR NURSING I	HOME	317 FIF		STATE, ZIP CODE ET NORTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCII " BE PRECEDED BY FULL I INTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 000	Installation of Sprin The facility has a fin 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 detec system in accordan Fire Code 2007 edi The facility has a ca census of 42 at the The facility was sur	kler Systems 1999 e re alarm system with ridor system and in o uilding, with sleeping the 1981 addition ar are on the fire alarm nce with NFPA 72 "T Code" 1999 edition. onitored for automatic tion. Hazardous area ctors that are on the ice with the Minneso tion.	smoke common g room hd the system The fire c fire as have fire alarm ta State nd had a	K 000				

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

	MENT OF HEALTH			73559022 FORM AP OMB NO. 09			08/15/2014 APPROVED 0.0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 0202		(X3) DATE SURVEY COMPLETED	
		245559		B. WING		08/1	2/2014
	ROVIDER OR SUPPLIER MANOR NURSING H	IOME	317 FIR		STATE, ZIP CODE ET NORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S		K 000			
	FIRE SAFETY						
	02 PT Addition						
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Viking Manor Nursing Home 02 PT Addition was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care.				νώ. -		
8	without a basement different times. The constructed in 1965 Type II (000) constru- west was constructed determined to be Ty separated from the fire barrier. A connect 1994 to the north er the facility to an apa connecting link was south of the west wi clinic. Both buildings existing nursing hor 2003 a 24 foot by 42 constructed to the s Type II(000) construc- basement.	rpe V (111) construct original building with ecting link was const and of the east wing to artment building and constructed in 1998 ing to connect the fail s are separated from ne with 2-hour fire ba 2 foot, PT addition we outh of the east wing ction, 1-story without	five s d to be of o the ion and is a 2-hour ructed in o connect a to the cility to a the arriers. In as g that is a				e E
	automatic fire sprink	s protected with a co der system installed PA 13 Standard for t	in				
LABORATOR	RY DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESE	NTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

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

STATE DEAT OF DEFICIENCIES AND PLANOP CORRECTION       INIT PROVIDERS UPPLIER UDENTIFICATION NUMBER       INIT PLANOP CORRECTION A BUILDING 0202       INIT COMPLETE COMPLETED         NAME OF PROVIDER OR SUPPLIER VIKING MANOR NURSING HOME       ISTREET ADDRESS. CITY. STATE. 2IP CODE 317 FIRST STREET NORTHWEST ULLEN.NN 36595       INIT COMPLETED       08/12/2014         VIKING PREFIX TRG       SUMMANY STATEMENT OF DEFICIENCIES OR LSC IDENTIFYING MODE/INTERCENT OF DEFICIENCIES TRG       PROVIDERS PLANOP CORRECTION (EACH CORRECTIVE ACTIONS PARATOP CORRECTION CEASE CORRECTIVE ACTIONS PARATOP CORRECTIVE ACTIONS PARATOP CEASE CORRECTIVE ACTION PARATOP CEASE CORRECTIVE ACTIONS PARATOP CEASE			FORM	Printed: 08/15/2014 FORM APPROVED OMB NO. 0938-0391				
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         VIKING MANOR NURSING HOME       317 FIRST STREET NORTHWEST ULEN, MN 56585         (X4) ID PREFIX       SUMMARY STATEMENT OF DEFICIENCIES OR LSC IDENTIFYING INFORMATION       ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PROCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACT								
VIKING MANOR NURSING HOME       317 FIRST STREET NORTHWEST ULEN, MN 56585         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES OR LSC IDENTIFYING INFORMATION       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETION DATE         K 000       Continued From page 1 Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detectors in the 1985 building, with sleeping room smoke detectors in the 1981 addition and the 1965 building that are on the fire alarm system installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The facility has a capacity of 45 beds and had a census of 42 at the time of the survey.       The facility has a capacity of 45 beds and had a census of 42 at the time of the survey.         The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is       Survey and survey as an one survey.			245559		B. WING		08/1	2/2014
ULEN, MN 56585       (X4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     COMPLETION DATE       K 000     Continued From page 1 Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detectors in the 1965 building, with sleeping room smoke detectors in the 1981 addition and the 1965 building that are on the fire alarm system installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The facility has a capacity of 45 beds and had a census of 42 at the time of the survey.     The facility has a capacity of 45 beds and had a census of 42 at the time of the survey.     The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is								
PREFX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETION DATE         K 000       Continued From page 1 Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridor system and in common areas in the 1965 building, with sleeping room smoke detectors in the 1981 addition and the 1965 building that are on the fire alarm system installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition.       The facility has a capacity of 45 beds and had a census of 42 at the time of the survey.         The facility was surveyed as one building.       The requirement at 42 CFR, Subpart 483.70(a) is	VIKING	MANOR NURSING I	HOME					Ť
Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridor system and in common areas in the 1965 building, with sleeping room smoke detectors in the 1981 addition and the 1965 building that are on the fire alarm system installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 45 beds and had a census of 42 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is	PRÉFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
	K 000	Installation of Sprin The facility has a fir detection in the corr 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 detect system in accordan Fire Code 2007 edi The facility has a ca census of 42 at the The facility was sur The requirement at	kler Systems 1999 e re alarm system with ridor system and in o uilding, with sleeping the 1981 addition ar are on the fire alarm nce with NFPA 72 "T Code" 1999 edition. Onitored for automatic tion. Hazardous area ctors that are on the ce with the Minneso tion. apacity of 45 beds ar time of the survey.	smoke common g room d the system The fire c fire as have fire alarm ta State d had a g.	K 000			

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

.

If continuation sheet Page 2 of 2

....



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7013 2250 0001 6357 2147

August 28, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5559022

Dear Mr. Kjos:

The above facility was surveyed on August 11, 2014 through August 15, 2014 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.

# 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:

Gail Anderson, Unit Supervisor Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota 56537-3858

Phone: (218) 332-5140 Fax: (218) 332-5196

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 Gail Anderson at the number noted 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 Meeth

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

cc: Original - Facility Licensing and Certification File