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

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245559**

2. STATE VENDOR OR MEDICAID NO. (L2) **734040100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **09/30/2014** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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

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

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE: Tammy Williams, HFE NEII — Date: 10/13/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL: Mark Meath, Enforcement Specialist — Date: 10/13/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 10/22/2014 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **09/24/2014** (L33)

DETERMINATION APPROVAL

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 deficienceis 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, 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.

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,

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245559	A. Building B. Wing	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 qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	09/23/2014	ID Prefix F0314 Reg. # 483.25(c) LSC	09/23/2014	ID Prefix F0323 Reg. # 483.25(h) LSC	09/23/2014
ID Prefix F0386 Reg. # 483.40(b) LSC	09/23/2014	ID Prefix F0387 Reg. # 483.40(c)(1)-(2) LSC	09/23/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/MM	10/13/2014	32603	09/30/2014
CMS RO				

Followup to Survey Completed on: 8/15/2014

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

AH Form Approved

10/9/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00075	A. Building B. Wing	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) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp. 4** LSC	Correction Completed **09/23/2014**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **09/23/2014**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	Correction Completed **09/23/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/mm	10/13/2014	32603	09/30/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/15/2014

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

Protecting, Maintaining and Improving the Health of Minnesotans

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: RXQ5
Facility ID: 00075

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245559**

2. STATE VENDOR OR MEDICAID NO. (L2) **734040100**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/15/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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

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

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Miriam Thornquist, HFE NEII 09/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/23/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

CCN: 24-5559

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:

> **Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;**
>
> **No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);**
>
> **Substandard Quality of Care - 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;

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

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

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

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

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)

- 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. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

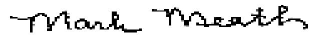
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

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

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

Sincerely,



Mark Meath, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245559	A. BUILDING ______ B. WING ______	08/15/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On August 11, 12, 13, 14 and 15, 2014, surveyors of this department's staff visited the above provider and the following federal deficiencies are issued. An extended survey was conducted by the Minnesota Department of Health on 8/11/14, through 8/15/14. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to comprehensively assess and implement interventions for R16 who was at risk for falls. The IJ began on 7/22/14, at 3:32 p.m., and was removed on 8/15/14, at 12:20 p.m.; however, non-compliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that was not immediate jeopardy. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	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, at admission, quarterly, and more frequently if needed. Corrective action for identified residents: 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:	9/15/14 OK [handwritten initials]

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

RECEIVED
SEP 11 2014
MN Dept of Health
Fergus Falls

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F 280 Continued From page 1

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation , interview and document review the facility failed to revise the care plan for 1 of 3 residents (R16) reviewed for accidents; and for 1 of 4 residents (R46) reviewed for pressure ulcers.

Findings include:
R16's 5-day Medicare assessment Minimum Data Set (MDS) dated 7/31/14, identified R16 had diagnoses which included hip fracture, osteoporosis, osteoarthritis and dementia.
R16's falls Care Area Assessment (CAA) dated 4/3/14, was a checklist of risk factors with no documented assessment to indicate the affect on falls for R16. The CAA indicated falls would be addressed in the care plan but did not include suggested interventions.
R16's current care plan, last revised on 7/29/14, indicated R16 had dementia nd was "low risk" for falls. The care plan identified R16 required assistance with transfers, utilized a gait belt and

F 280 (Provider's Plan of Correction)

- Receiving Hospice care because she had refused to participate in 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 cares;
- Reminders to use call light;
- Offering the bathroom every 2-3 hours.

At its regularly scheduled Falls Meeting on 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 include:

- Laser alarm and TABS unit

On 7/24/14, family and nursing staff noted resident's continued desire for independence in her familiar setting, so the following were noted on her care plan:

- Hospice care was discontinued; and
- Physician orders for PT/OT were obtained. Evaluation was conducted and OT and PT began working with R16 on strength, balance, and safety.

On 7/29/14, both alarms were discontinued and removed from care plan due to causing increased agitation to R16.

After R16's fall on 8/1/14 from the glider chair in her room, the following interventions were added to her care plan:

- The glider chair was removed with the family's permission; and
- Auto lock brakes were requested for her wheelchair and applied on 8/4/14.

On 8/11/14, R16 said she fell from her recliner when trying to get back into recliner. One of the removable arm chair covers noted on the floor next to her. The care plan was updated to include removal of recliner arm covers from room, so she could securely grasp the chair arm if she stood on her own.

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

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F 280		F 280		

F 280 Continued From page 2

walker, repositioning every 2 hours, offer toileting every 2 to 3 hours and as needed. Further, the care plan directed staff to place call light within reach, encourage to use call light for assistance as needed and to be prompt in responding to all requests for assistance.
On 7/16/14, at 4:45 a.m. R16 was found on floor at the hallway, lying on right side. The report indicated R16 had stated her "hip broken." R16's left shoe lace had been untied and was not using her walker at the time of fall. R16 was sent to the hospital and required surgical repair of the left hip fracture on 7/17/14.

R16 returned from the hospital on 7/22/14 at 12:15 p.m.. There had been no update to the care plan to reflect changes related to R16's post-operative status. At 7:15 p.m. R16 was found on the bathroom floor and still no revision to the care plan. Despite multiple falls the care plan was not revised to include interventions to reduce the risk of injury due to falls.

On 8/12/14, at 3:15 p.m. the director of nursing (DON) stated that attempted interventions included a laser alarm and tabs alarm; physical therapy; and frequent monitoring of R16's whereabouts. The care plan was not updated.

The facility's Fall Prevention Policy (undated), directed "primary RN will re-evaluate and revise resident's care plan and/or facility practice to prevent the likely hood [sic] of another fall."

Pressure Ulcer

R46's quarterly MDS dated 8/6/2014, identified severe cognitive impairment, needed extensive

F 280 (Plan of Correction)

After surveyors notified VMNH of the immediate jeopardy on 8/13/14, R16 was assessed. This assessment included:

- Consultation with her family who are satisfied with the interventions that support her continued independence and understand her risk for falls;
- Consultation with VMNH consulting pharmacist who recommended that her thyroid level could be drawn now, instead of as scheduled in September; Consultation and evaluation by her primary physician.

The following interventions were added to the care plan:

- Hourly rounding safety checks with staff asking R16 about bathroom/food/water/repositioning /pain relief is needed.
- Signs posted in her room to remind R16 to call for help;
- Call light within reach.

The following interventions were continued:

- Auto lock wheelchair brakes,
- PT,
- OT,
- Offering ambulation three times per day.

Since survey, staff continue to assess R16 in consultation with her family and primary physician. Her care plan has been updated as follows:

- Night light in bathroom Trialing laser alarm set to silent but does link to call light.
- Wireless and silent alarm system. Staff assigned to care for R16 will carry a pager that links to system, immediately alerting staff if R16 has risen off of sensor.

R 46 continues to receive routine evaluation and treatment from the Sanford Wound Clinic that she first visited on 6/10/14. Prior to survey, R46 visited the Wound Clinic on 6/18/14, 6/25, 7/2, 7/9, 7/22, and 8/5, 2014. VMNH staff will continue to work with R46 and R46's family to accommodate R46's resistance and concerns about disrupting R46's sleep in order to carry on pressure relieving measures and treatment when R46 is asleep. VMNH staff have included recommendations and orders from the Wound Clinic on R46's care plan. VMNH staff completed a comprehensive assessment for R46 on 8/15/14, and reviewed her care plan to assure that it included the

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F 280 Continued From page 3

assist with all ADL's and had two unstageable (known pressure ulcer but not stageable due to coverage of wound bed in slough or eschar tissue) pressure ulcers with most severe tissue type of eschar (black, yellow brown tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin and is not evidence of healing).

R46's care plan revised 8/4/14, identified R46 was at risk for pressure ulcer development related to decreased mobility. However, the care plan did not identify R46 had current pressure ulcers. The care plan listed various interventions which included: to reposition R46 every 2-3 hours, notify nurse of any concerns, document and report any new pressure areas. Further the care plan directed staff to utilize foot rests and keep both pedals up to help with pain when R46 utilized a wheelchair. The care plan lacked interventions to promote healing of unstageable ulcers to both heels.

On 8/13/14, at 8:43 a.m. confirmed R46's current care plan and confirmed the care plan lacked interventions to float heels at all times.

The DON, interviewed on 8/13/14, 10:10 a.m. verified a comprehensive skin assessment had not been completed after R46 developed the pressure ulcers, and verified R46's care plan had not been updated to reflect interventions for the bilateral unstageable pressure ulcers.

F 314 SS=G 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident

F 280 (Provider's plan of correction)

following interventions:

- Floating of heels at all times while in bed;
- Arginade (protein supplement) twice a day;

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:
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.
All resident care plans will be reviewed quarterly at care conferences and updated with any changes 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

System Changes:
All staff will receive education to be completed by 9/23/14 related to revision of care plans, how to determine need for assessment and policy review related to care planning.

Monitoring Plan:
QA staff are conducting compliance monitoring related to survey findings and determinations, including repositioning and fall prevention at least weekly. Results of monitoring will be reported to Administrator and Quality Assurance Committee at its next meeting on October 2, 2014 for direction of future compliance monitoring, audits and training.
Director of Nursing or designee is responsible for compliance.

Completion date: 9/23/14

F 314

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F 314	Continued From page 4 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to timely identify, comprehensively assess, and implement appropriate interventions for 1 of 1 resident (R46) reviewed for unstagable pressure ulcers. This deficient practice resulted in actual harm for R46. Findings include: R46's admission Minimum Data Set (MDS) dated 2/27/2014, identified R46 had diagnosis which included dementia, failure to thrive and altered mental status. Their was no assessment of R46's cognitive status or presence of delirium. The MDS identified R46 was at risk for development of pressure ulcers, required extensive assist with all activities of daily living (ADL's) and had no current pressure ulcers. R46's Pressure Ulcer Care Area Assessment (CAA) dated 2/27/2014, listed R46 had risk factors for development of pressure ulcers which included requiring extensive assist in bed mobility and urinary incontinence, antipsychotic and antianxiety medication use, and newly admitted. The CAA identified R46's care plan would address R46's needs.	F 314	It is the policy of VMNH to ensure that any resident having pressure sores receives necessary treatment and service to promote healing, prevent infection and prevent new sores from developing. Corrective Action for identified resident: R 46 continues to receive routine evaluation and treatment from the Sanford Wound Clinic that she first visited on 6/10/14. Prior to survey, R46 visited the Wound Clinic on 6/18, 6/25, 7/2, 7/9, 7/22, and 8/5, 2014. VMNH staff will continue to work with R46 and R46's family to accommodate R46's resistance and concerns about disrupting R46's sleep in order to carry on pressure relieving measures and treatment when R46 is asleep. (NA)I and other staff report that R46 moves independently in bed and shifts the pillow that they have placed under her heels. VMNH staff have included recommendations and orders from the Wound Clinic on R46's care plan. VMNH staff completed a comprehensive assessment for R46 on 8/15/14, and reviewed her care plan to assure that it included the	

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F 314 Continued From page 5

A quarterly MDS dated 8/6/2014, identified R26 had severe cognitive impairment, needed extensive assist with all ADL's and had two unstagable (known pressure ulcer but not stagable due to coverage of wound bed in slough or eschar tissue) pressure ulcers with most severe tissue type of eschar (black, yellow brown tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin and is not evidence of healing). The MDS also indicated skin and ulcer treatments, including a turning and repositioning program, nutritional intervention, pressure ulcer care and dressings to feet were provided for R46.

R46's care plan revised 8/4/14, identified R46 was at risk for pressure ulcer development related to decreased mobility. However, the care plan did not identify R46 had current pressure ulcers. The care plan listed various interventions which included: to reposition R46 every 2-3 hours, notify nurse of any concerns, document and report any new pressure areas. Further the care plan directed staff to utilize foot rests and keep both pedals up to help with pain when R46 utilized a wheelchair. The care plan lacked interventions to promote healing of unstagable ulcers to both heels.

On 8/12/14, at 3:00 p.m. registered nurse (RN)-B and licensed practical nurse (LPN)-A were observed to provide wound care for R46 to a left lower leg wound, and to both unstageable pressure ulcers to the heels. After wound care was completed for the left leg wound, wound care was provided for bilateral unstagable pressure ulcers to both heels. RN-B removed the dirty dressing from the resident's right heel. The entire pressure ulcer to the right heel measured 2.0

F 314 following interventions:

- Floating of heels at all times while in bed;
- Arginade (protein supplement) twice a day;

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:

To ensure other residents of VMNH will receive necessary treatment and services to promote healing, prevent infection and prevent new sores from developing,

- 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.
- RRAs (nursing assistants) will continue to

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F 314	Continued From page 6 centimeters (cm) by 2.0 cm with an open area in the middle of the ulcer measuring 2 cm by 0.8 cm. The pressure ulcer was black in color and hard to the touch indicating eschar tissue. Then the dirty foam dressing was removed from the left heel. The unstagable pressure ulcer measured 7.1 cm by 3.0 cm, was black in color and hard to the touch indicating eschar tissue was present in wound. Both pressure ulcers were cleansed with normal saline and fresh foam dressings were applied and wrapped with gauze. RN-B then applied tubigrips (elastic stretch band stocking type devices) to both feet covering the heels. RN-B placed a pillow under each calf and elevated R46's heels off the bed. On 8/13/14, 6:56 a.m. R46 was observed in bed lying on her back. One pillow had been placed under both knees, keeping the resident's knees at a 45 degree angle. Beige tubigrip stockings were observed on both heels with both heels resting directly on the surface of the mattress. During continuous observation from 6:56 a.m. to 8:30 a.m. R46 remained lying in bed with both heels directly on the mattress. At 8:30 a.m. at surveyors request, nursing assistant (NA)-I entered R46's room and confirmed R46's heels were resting on the mattress with the pillow under R46's knees. NA-I verified R46 had not been repositioned from 6:56 a.m. to 8:30 a.m. (a total of 1 hour and 36 minutes in which R46's heels were resting on the mattress.) NA-I revealed R46's heels should not have been resting on the mattress as R46 had pressure ulcers to both heels. NA-I exited the room at 8:35 a.m., without having offered, or attempted, to reposition R46's heels off of the mattress. On 8/13/14, at 8:43 a.m. R46 remained lying in	F 314	document every shift on skin observations in the Point Click Care-Point of Care charting system for all residents. • RRAs will continue to alert nurse to any skin breakdown/ redness/ abnormalities. • Nurses will continue to conduct Braden assessments upon admission and quarterly, • Nurses will conduct Tissue Tolerance assessments upon admission and annually, and also if any skin breakdown occurs, and • Pressure Sore Risk assessments will be added and completed with every admission and quarterly.	

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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 on her heels at any time due to presence of the pressure ulcers. She confirmed R46's current care plan and confirmed the care plan lacked interventions to float heels at all times. 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. 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. No further assessments were documented for R46. 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 progress	F 314	• Care plans will be updated quarterly and PRN per assessment data collected. • Weekly charting will continue to address skin assessment and treatment if any. 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. <u>System changes:</u> 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. <u>Monitoring plan:</u> The DON and/or designee will perform random audits weekly of • Skin breakdown interventions to	

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F 314	Continued From page 8 notes from 6/5/14 to 8/14/14, revealed the following: -6/5/14, the note indicated a bath aid had reported R46 had pressure areas to both heels. The note indicated the back of the left heel had an unstagable dark purple ulcer which measured 10 cm by 10 cm. The note further identified there was another pressure ulcer to R46's right heel which presented as dark purple, was unstagable, and measured 6 cm by 5 cm. In addition, the note identified R46 had a stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed, without slough, may also present as an intact or open blister) pressure ulcer to the left ankle measuring 3 cm by 3 cm. The progress note directed to refer to the care plan for plan of care. The note further indicated a referral had been made to the wound care clinic at that time. - 6/6/14, revealed education to resident regarding use of pressure relieving boots due to pressure ulcers on both heels, but that R46 had declined use of pressure relieving boots. However, the note indicated R46 had agreed to have her heels off of the mattress with a pillow under her lower legs. - 6/8/14, R46 had gone on an outing with her daughter who had called the facility to inform the staff that R46 was being taken to the emergency room due to wound on left lower leg and blister to the right heel. R46 returned to the facility after evaluation from the emergency room with orders including: "no pressure on heels, set up wound nurse clinic". - 6/20/14, R46's right heel had been weeping,	F 314	ensure interventions are in place and being followed; • Assessment forms for completion; and • Weekly charting on skin condition. Audit findings will be reviewed at weekly IDT meetings and quarterly Quality Assurance meetings. The Quality Assurance committee will determine direction for future compliance monitoring, audits and training. Director of Nursing or designee is responsible for compliance.	9/23/14

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

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F 314	Continued From page 9 area was covered with gauze and wraps, message left for RN. - 6/21/14, R46's right heel blister was open, area measured 6 cm long, no width or depth measurements. - 6/22/14, R46's right heel was bleeding, area cleansed and redressed. - 6/23/14, notification to physician regarding right heel condition, dressing change to right heel with bloody drainage. - 6/26/14, daughter was using two plastic grocery bags filled with rolled up plastic bags one under each of R46's feet. The note indicated staff provided R46 with elevated foot rests to keep pressure off of R46's feet. -6/29/14, dressing change to right heel and also revealed that R46 had a reddened area to coccyx 3 cm x 2 cm red/pink area which was not open. - 7/1/14, stage one pressure ulcer noted to coccyx, measured 2 cm by 1.5 cm red area, non blanchable. - 7/3/14, small bloody drainage form right heel, dressing changed. -7/6/14, dressing change to right heel, drainage was noted on dirty dressing consisting of blood and purulent (greenish/yellowish indicative of infection). The pressure ulcer measured 6 cm by 5.3 cm, purple area above right heel. - 7/10/14, dressing change completed to right heel which measured 5.2 cm by 6.5 cm, peeling	F 314		

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F 314	Continued From page 10 skin, dark purple in color. However, at the wound base there was an opening in the pressure ulcer wound bed which measured 3 cm by 2 cm . Black necrotic (dead tissue) was noted at the wound bed. A further note revealed daughter requested to have staff educated to keep R46's heels off of the foot pedals. - 7/14/14, dressing change to left heel, ulcer area was soft and "mushy" with "bruised" center. The ulcer measured 4 cm by 2 cm. The right heel was noted to be scaly in appearance and measured 7 cm by 4.5 cm with 2.1 cm by 1 cm of necrotic tissue noted. - 7/16/14, order to discontinue foam dressing to right heel per daughters request, ordered Vitamin E to right heel daily and to leave area open to air. - 7/17/14, vitamin E discontinued and dressing change with foam was re-ordered. -7/21/14, left heel measured 8 cm by 4 cm with a 4 cm by 1.2 cm dark purple area in the middle of the ulcer. The right heel measured 8 cm by 4 cm with a 2 cm by 2 cm necrotic area in the center of the ulcer bed. -7/25/14, left heel measured 8 cm by 4 cm with a 3.5 cm by 1.0 cm dark purple area in the middle of the ulcer. The right heel measured 8 cm by 4 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.	F 314		

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F 314	Continued From page 11 - 8/2/14, left heel measured 7 cm by 3 cm, dark purple in color and hard to the touch. The right heel measured 2.1 cm by 2 cm and was black in color. Review of weekly pressure ulcer progress notes from 6/5/14 to 8/12/14, reveled the measurements of the wounds as noted in the progress notes. The weekly pressure ulcer progress notes did not include comprehensive assessment of R46's skin condition. Review of physician order's from 6/10/14 to 7/22/14 revealed the following: -6/10/14, ensure no pressure on heels, keep heels floated at all times with boots or pillows under calves. -6/18/14, keep heels floated at all times, use pillows under calves to float heels, do not need boots if using pillow. - 6/25/14, discontinue heel boots, okay to elevate legs with pillows. -7/2/14, continue with preventative management - 8/5/14, continue with preventative management, please avoid putting pressure on the heels. During interview on 8/12/14, 1:30 p.m. director of nursing (DON) verified R46 had been considered at risk for development of pressure ulcers and that she expected R46's skin would have been checked weekly on bath day, with documentation of such in the resident's chart. The DON also stated she expected R46's skin to be observed daily with cares and any concerns reported to the	F 314		

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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 those identified at risk for pressure ulcer development.

Review of the facility's policy titled Pressure Ulcer Treatment revised 12/28/09, revealed the staff were to assess the resident's pressure ulcer,

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F 314	Continued From page 13 manage tissue loads, provide pressure ulcer care and provide education and quality improvement. Review of the facility's policy titled Pressure Ulcers/Skin Breakdown - Clinical Protocol revised 12/28/09, revealed staff were supposed to assess and recognize those at risk for pressure ulcers, determine cause, provide treatment, and provide management and monitoring of pressure ulcers.	F 314		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess residents at risk for falls and failed to ensure appropriate interventions were implemented to minimize risk for falls for 1 of 3 (R16) residents reviewed for falls. This deficient practice resulted in an immediate jeopardy situation for R16. Findings include: The immediate jeopardy began on 7/22/14 when findings revealed R16 had not been comprehensively assessed for root cause of self-transfers leading to falls. The facility administrator and the director of nursing (DON) were notified of the immediate jeopardy on	F 323	It is the policy of VMNH to ensure the resident environment remains as free from accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. Corrective action for identified residents: 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: • Receiving Hospice care because she had refused to participate in 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 cares; • Reminders to use call light; • Offering the bathroom every 2-3 hours. At its regularly scheduled Falls Meeting on 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 include: • Laser alarm and TABS unit	

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F 323	Continued From page 14 8/13/14, at 3:39 p.m. The immediate jeopardy was removed at 12:20 p.m. on 8/15/14, after the facility submitted an acceptable removal plan, but noncompliance remained at the lower scope and severity level of D which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. R16's 5-day Medicare Minimum Data Set (MDS) dated 7/31/14, identified diagnoses which included hip fracture, osteoporosis, osteoarthritis and dementia. The MDS identified R16 had severe cognitive impairment, required extensive assistance with bed mobility, transfers, walk in room, walk in corridor, locomotion on unit, dressing, toilet use and personal hygiene. R16 was not steady during transitions (moving from seated to standing position, turning around and facing opposite direction, moving on and off toilet, transfer between bed and chair) or walking. R16 used walker and wheelchair as mobility devices. Further, the MDS identified R16 had fallen and sustained a fracture prior to admission, and had fallen since admission with no injury. R16's Care Area Assessment (CAA) dated 4/3/14, indicated R16 was forgetful, had memory loss and confusion at times, mood decline, communication problems, and received psychoactive medications. The CAA identified R16 had risk factors for falls that included osteoporosis, arthritis, cognitive impairment, depression, and hearing impairments. The Fall CAA identified R16 was at high risk for falls related to use of psychotropic medications and required use of assistive device and indicated interventions would be implemented in an attempt to prevent or minimize further falls. R16's Fall Assessment form dated 7/30/14, identified R16 was at moderate risk for falls due to history of falls. The assessment identified R16	F 323	On 7/24/14, family and nursing staff noted resident's continued desire for independence in her familiar setting, so the following were noted on her care plan: • Hospice care was discontinued; and • Physician orders for PT/OT were obtained. Evaluation was conducted and OT and PT began working with R16 on strength, balance, and safety. On 7/29/14, both alarms were discontinued and removed from care plan due to causing increased agitation to R16. After R16's fall on 8/1/14 from the glider chair in her room, the following interventions were added to her care plan: • The glider chair was removed with the family's permission; and • Auto lock brakes were requested for her wheelchair and applied on 8/4/14. On 8/11/14, R16 said she fell from her recliner when trying to get back into recliner. One of the removable arm chair covers noted on the floor next to her. The care plan was updated to include removal of recliner arm covers from room, so she could securely grasp the chair arm if she stood on her own. It is VMNH's position that its assessment and care of R16 was in compliance with 42 CFR § 483.25(h) and that no immediate jeopardy situation existed regarding R16. As provided for in law and regulation, VMNH is requesting informal dispute resolution to question this deficiency. After surveyors notified VMNH of the immediate jeopardy on 8/13/14, R16 was assessed. This assessment included:	

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had a recent hip fracture, occasional incontinence of bladder and bowel, some agitated behaviors, was not able to stand independently, required assist of one with gait belt for transfers, and used walker for mobility.

R16's current care plan, last revised on 7/29/14, identified R16 had dementia, and was at "low risk" for falls. The care plan indicated R16 required assistance with transfers with a gait belt and walker, repositioning every 2 hours, and offer toileting every 2 to 3 hours and as needed. Further, the care plan directed staff to place call light within reach, encourage to use call light for assistance as needed and to be prompt in responding to all requests for assistance.

Review of R16's incident reports from 7/16/14 to 8/12/14 revealed the following:

-On 7/16/14, at 4:45 a.m. R16 was found on floor in the hallway, lying on right side. The report indicated R16 stated she had a "hip broken." The report indicated R16's left shoe lace had been untied and R16 was not using her walker at the time of fall. R16 had been sent to the hospital and had required surgical repair of the left hip fracture on 7/17/14.

-On 7/22/14, at 7:15 p.m. R16 was found on the bathroom floor, yelling "Help!" R16 had just been re-admitted to the facility after the hip fracture at 12:15 p.m. on 7/22/14, (7 hours prior to this fall). A Root Cause Analysis Tool dated 7/22/14, indicated R16 had been alone in the room, there was no documentation regarding the last time she'd been to the bathroom, staff should have kept close to nursing station, and also identified the resident did not use call light. There was no evidence of actions taken to reduce the risk of additional falls such as keeping R16 close to the

F 323 (Plan of correction)

- Consultation with her family who are satisfied with the interventions that support her continued independence and understand her risk for falls;
- Consultation with VMNH consulting pharmacist included:
  - Review of pain medication to
  - note no correlation between medications and falls;
  - Orthostatic blood pressure measurements that noted no

  correlation between blood pressure changes and falls
  - Thyroid level drawn now, instead of as scheduled in September, and Synthroid level adjusted.
- Consultation and evaluation by her primary physician.

The following interventions were added to the care plan:

- Hourly rounding safety checks with staff asking R16 about bathroom/ food/water/repositioning/pain relief is needed.
- Signs posted in her room to remind R16 to call for help;
- Call light within reach.

The following interventions were continued:

- Auto lock wheelchair brakes,
- PT,
- OT,
- Offering ambulation three times per day.

Since survey, staff continue to assess R16 in consultation with her family and primary physician. Her care plan has been updated as follows:

- On 9/3/14, a wireless and silent alarm system was purchased for use with R16 and any other resident having multiple falls and/or unsafe self-transferring.

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nurses' station or ensuring scheduled toileting. The care plan was not revised.

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. 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 3:10 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.

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 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 asking for assistance and was reminded to wait

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.
Nurses and IDT communicated R16 care plan changes to direct care staff via communication book and oral report.

Identification and action for other VMNH residents with potential to be affected:
All resident falls and other unusual 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 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 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.

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 Administrator and Quality Assurance Committee

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F 323	Continued From page 17 for staff for help. Nursing notes on 8/9/14, at 1:15 p.m. indicated R16 was noted to have "walked per self" to bathroom from w/c (wheelchair). R16 used wheeled walker. Staff assisted R16 for toilet use and walked R16 back to bed with gait belt and walker. R16 was noted to be unsteady and was instructed to use the call light. On Nursing notes on 8/10/14, at 7:40 a.m. indicated R16 transferred herself to the bathroom without shoes on. Staff reminded R16 that it was unsafe to wear stocking feet and showed R16 how to use call light to get staff assistance. R16 was quoted to have said, "I know but I just forget." Nursing notes from 8/11/14, at 10:10 a.m. indicated R16 was found in room, flat on back next to window. The incident report indicated R16 stated she was trying to get back into recliner. Staff found a recliner arm cover on floor next to R16 and the recliner was "pushed up against wall next to bed." The report indicated the occupational therapist had assisted R16 into the recliner with the call light within reach at 9:00 a.m., one hour prior to the falls. The report indicated the therapist had observed R16 seated in the wheelchair at some point between 9:00 a.m., and the fall. The report indicated nursing assistant assigned to care for R16 at that time admitted not having re-positioned R16 between a.m. and the fall so R16 was transferring independently. The intervention implemented was removal of arm protectors from the recliner. On 8/12/14, at 1:20 p.m. R16 was observed seated in a wheelchair in her room. R16 propelled the wheelchair using her legs from the middle of	F 323	at its next meeting on October 2, 2014 for direction of future compliance monitoring, audits and training. Director of Nursing or designee is responsible for compliance.	9/23/14

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 18	F 323		

the room to the window briefly then back to the middle of the room. A blue cloth covered recliner was observed near the window in the room.

Nursing notes on 8/12/14, at 3:00 p.m. indicated R16 was found in room, sitting on buttocks with her back up against the bed. The report indicated R16 was, "Trying to get something out of her drawer." The recommendations/interventions section of the report indicated R16 had dementia and did not realize the need for, "More assistance with cares, transfers, & ambulation." The report did not indicate interventions aside from, "Continue to monitor," and no changes to be implemented at that time.

On 8/13/14, at 7:24 a.m. R16 was observed seated in a wheelchair in her room. R16 propelled her wheelchair with her legs toward the bathroom, reached out and opened up the door and wheeled herself up to the toilet stool. R16 stood up and slowly walked a step forward, pulled her slacks and underwear down, turned around and sat on the toilet seat. R16 did not lock the wheelchair brakes or use the call light to summon assistance for staff prior to self-transferring. At 7:27 a.m. R16 grabbed the bars on toilet seat and slowly stood up, pulled up her underwear and pants, walked a step forward, turned and sat in the wheelchair. Staff were unaware of R16's activities.

On 8/15/14 at 9:42 a.m. R16 was seated in the wheelchair in her room and there were antilock brakes observed on wheelchair. There were signs on wall next to bed, on edge of dresser and at the foot of bed that warned R16 to remember to call for help. When R16 was asked about the sign, R16 smiled and said, "Oh here and there."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245559	A. BUILDING ____ B. WING ____	08/15/2014

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

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F 323	Continued From page 19 Nursing assistant (NA)-B was interviewed on 8/12/14, at 3:00 p.m. and described caring for R16 during night shifts. NA-B stated R16 had fewer episodes of self-transfers and falling because her needs were anticipated and met. On 8/12/14, at 3:03 p.m. NA-A was interviewed and stated R16 would forget that she needed help with transfers and also forgot to use call button for help. NA-A stated she tried to follow R16 when she was observed on her way to her bedroom so she could check on what R16 was doing. On 8/12/14, at 3:15 p.m. the director of nursing (DON) stated the assessment of causal factors of R16's fall on 7/22/14, may have been the addition of PRN (as needed) oxycodone (narcotic pain medication). The DON also stated R16 had dementia but was used to being independent and that R16 thought she still was. The DON stated that attempted interventions included the use of a TABS alarm and laser alarm. She verified the alarms were not added to the care plan and were discontinued when R16 had broken them. The DON further stated R16 was being followed by PT/OT, staff were frequently monitoring R16's whereabouts, and the furniture was changed. The DON verified the lack of documented assessment related to potential causative factors related to falls or attempted interventions to reduce the risk of injury from falls. On 8/13/14, at 9:02 a.m. registered nurse (RN)-A stated that attempted interventions after the first fall included the call light within reach, reminders to use the call light, a laser alarm to the bed and a TABS alarm to the wheelchair. R16 was upset	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245559	A. BUILDING ______ B. WING ______	08/15/2014

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F 323	Continued From page 20 by the alarms and destroyed them both. RN-A verified R16 was not independent and required assistance per PT/OT evaluation. RN-A stated R16 had dementia and was forgetful, but interventions included to "educate" R16 to use call light. RN-A further verified there was no assessment to determine potential interventions to reduce the risk of falls and there were no new interventions. On 8/13/14, at 12:30 p.m. physical therapist (PT)-A stated R16 was working on endurance, balance and safety issues. PT-A verified R16 attempts self-transfers despite having been "spoken to daily." PT-A stated R16 had difficulty standing and did not use wheelchair brakes. PT-A added R16 did not understand instructions and was not safe to self-transfer. On 8/13/14, at 12:57 p.m. NA-C stated R16 self-transfers "every time you turn around." According to NA-C, a laser alarm was attempted but did not work. NA-C stated R16 was reminded to use the call light but would forget. When interviewed on 8/13/14, at 2:00 p.m. the DON stated suggested interventions included hourly rounds, however, rounds were not initiated because R16 was getting physical therapy. On 8/14/14, at 9:00 a.m. RN-A verified and affixed her initials to signify she just updated R16's care plan on 8/13/14, to include hourly safety checks. On 8/14/14, at 9:19 a.m. a telephone interview was conducted with R16's family member (FM)-A, who stated R16 had attempted to self-transfer four times during FM-A's visit on 8/13/14. FM-A stated R16 was resistant to using a nurse call light.	F 323		

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F 323	Continued From page 21 On 8/14/14, at 1:20 p.m. the DON reviewed the incident reports regarding R16's falls on 7/16/14, 7/22/14, 8/1/14, 8/11/14 and 8/12/14. The DON verified the documentation on the incident reports was accurate and lacked evidence of assessment or interventions. The Treatment/Management section of facility's undated Falls - Clinical protocol, directed staff to "identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling" following the assessment of a previous fall. In addition, the Monitoring and Follow-Up section indicated that if fall continues, staff would re-evaluate the situation and the "continued relevance of current interventions." The facility's Managing Falls and Fall Risk policy revised on 12/2007, directed staff to implement additional or different interventions if falling recurs despite initial interventions. The facility's Fall Prevention Policy (undated), directed "primary RN will re-evaluate and revise resident's care plan and/or facility practice to prevent the likely hood [sic] of another fall." The immediate jeopardy was removed on 8/15/14, at 12:20 p.m. when the facility had reviewed and assessed R16's falls and had identified interventions to reduce the risk of injury from falls. The care plan was updated to reflect the interventions. Immediate interventions included hourly safety checks, scheduled ambulation and activities. Physical Therapy and pharmacy reviews were completed. The physician was updated and medication changes were initiated. Staff were provided education related to the updated care plan. Staff interviews and observations were completed to verify staff	F 323		

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F 323	Continued From page 22 understanding of the plan for R16. The removal plan included changes in the way resident falls were documented, assessed, and outcomes monitored. Comprehensive falls assessments were completed for all residents identified at risk of falls.	F 323		
F 386 SS=C	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and document review the resident facility admission agreement policy did not include language which identified the following from 483.40 (b): F386-residents' physician responsibility to review the resident's total program of care which included medications and treatments, and signed and dated orders with each visit. Findings include: On 8/14/14, at 3:23 p.m., facility policies required for the extended survey process were requested for review. Included in the request was the policy for resident admission orders. The policy was	F 386	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. <u>Corrective action for identified residents:</u> The survey findings do not identify any specific resident who has not had his/her physician review the total program of care. It is VMNH's position that it is in compliance with 42 CFR § 483.40(b) and that its physicians are providing the required total program review as required by law and regulation. Survey findings indicate that facility admission policy and orders "lacked identification of physician responsibilities for review of residents' programs of care." Neither the cited regulation nor the CMS *State Operations Manual's* Interpretive Guidelines on F386 mention a need for admission orders identifying this responsibility. As provided for in law and regulation, VMNH is requesting informal dispute resolution to question this deficiency. <u>Identification and action for other VMNH residents with potential to be affected and System Change:</u> At monthly care plan review, Director of Nursing or designee reviewed each resident's plan of care and orders to assure that the resident's primary physician has been reviewing the resident's total program of care. In its review of these findings, the Administrator has noted that the VMNH Admission Packet includes a resident handbook with the Admission Agreement. Under Minnesota state law, all materials and documents given to a resident at admission are considered the admission contract. VMNH's resident handbook includes brief explanations of many facility policies for residents and their families. One of these policies is *Medical Care* that describes that the resident's physician will visit every 30 days for the first 90 days and every 60 days thereafter. It also explains that the physician will be notified in between visits, as needed for immediate medical	

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F 386	Continued From page 23 provided by the facility administrator on 8/15/14, at 8:57 a.m. The facility policy titled, Admissions to the Facility, dated 8/6/13, included direction for the physician which included provision of information needed for the immediate care of the resident which covered at least: type of diet, medication orders, and routine care orders. However the policy lacked identification of physician responsibilities for review of residents' programs of care. On 8/15/14, at 12:30 p.m., the facility administrator confirmed the policy titled, Admissions to the Facility, dated 8/6/13, was the current policy and indicated he was not aware of any additional language that would be necessary, as the policy had been reviewed frequently.	F 386	attention; and that the physician will keep resident informed about your medical condition we expect would include the total plan of care. Administrator and Director of Nursing have consulted with Medical Director regarding F386 findings and reviewed regulation and CMS *State Operations 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 care to assure that physicians are reviewing a resident's total program of care Audit findings will be reviewed at quarterly Quality Assurance meetings. The Quality Assurance committee will determine direction for future compliance monitoring, audits and training. Administrator or designee is responsible for compliance.	9/23/14
F 387 SS=C	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on interview and document review the resident facility admission agreement policy did not include language which identified the following from 483.40 (c):	F 387	It is the policy of VMNH to assure that a resident is seen by their physician in a timely manner, as required by law and regulation. Corrective action for identified residents: The survey findings do not identify any specific resident who has not seen his/her physician in a timely manner, as required by law and regulation. Identification and action for other VMNH residents with potential to be affected and System Change: In its review of these findings, the Administrator has noted that the VMNH Admission Packet includes a resident handbook with the Admission Agreement. Under Minnesota state law, all materials and documents given to a resident at admission are considered the admission contract. VMNH's resident handbook includes brief explanations of many facility policies for residents and their families. One of these policies is *Medical Care* that describes that the resident's physician will visit every 30 days for the first 90 days and every 60 days thereafter. It also explains that the physician will be notified in between visits, as needed for immediate medical attention; and that	

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	245559	A. BUILDING ______ B. WING ______	08/15/2014

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

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F 387	Continued From page 24 F387-the resident must be seen with face to face contact, every 30 days for the first 90 days and every 60 days thereafter. Findings include: On 8/14/14, at 3:23 p.m., facility policies required for the extended survey process were requested. Included in the request was a policy for resident admission orders. The policy was provided by the facility administrator on 8/15/14, at 8:57 a.m. The facility policy titled, Admissions to the Facility, dated 8/6/13, included direction for the physician which included provision of information needed for the immediate care of the resident which covered at least: type of diet, medication orders, and routine care orders. However the policy lacked identification of physician responsibilities for physician's visits with face to face contact. On 8/15/14, at 12:30 p.m., the facility administrator confirmed the policy titled, Admissions to the Facility, dated 8/6/13, was the current policy and indicated he was not aware of any additional language that would be necessary, as the policy had been reviewed frequently.	F 387	the physician will keep resident informed about your medical condition we expect would include the total plan of care. It is VMNH's position that it is in compliance with 42 CFR § 483.40(c) and that its residents are seen in a timely manner by their physicians, as required by law and regulation. Survey findings indicate that facility admission policy did not include language about residents being seen by their physicians as required in F387. Neither the cited regulation nor the CMS *State Operations Manual's* Interpretive Guidelines on F387 mention a need for the admission agreement to include such language. VMNH's admission packet that is provided to every resident upon admission included information about the physician visits. As provided for in law and regulation, VMNH is requesting informal dispute resolution to question this deficiency. Administrator and Director of Nursing have consulted with Medical Director regarding F387 findings and reviewed regulation and CMS *State Operations Manual's* Interpretive Guidelines on F387 to assure that residents continue to be seen 1:1 by their physicians in a timely manner as required by law and regulation. Administrator is consulting with legal counsel regarding revisions to the Resident Handbook policy to. <u>Monitoring plan:</u> The DON and/or designee will perform random audits monthly of admission orders ongoing care to assure that physicians are reviewing a resident's total program of care Audit findings will be reviewed at quarterly Quality Assurance meetings. The Quality Assurance committee will determine direction for future compliance monitoring, audits and training. Administrator or designee is responsible for compliance.	9/23/14

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	245559	A. BUILDING **01 - 1965 BUILDING 01** B. WING	**08/12/2014**

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

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

01 Main Building

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Viking Manor Nursing Home 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

Viking Manor Nursing Home is a 1-story building without a basement and constructed at five different times. The original building was constructed in 1965 and was determined to be of Type II (000) construction. An addition to the west was constructed in 1981 that was determined to be Type V (111) construction and is separated from the original building with a 2-hour fire barrier. A connecting link was constructed in 1994 to the north end of the east wing to connect the facility to an apartment building and a connecting link was constructed in 1998 to the south of the west wing to connect the facility to a clinic. Both buildings are separated from the existing nursing home with 2-hour fire barriers. In 2003 a 24 foot by 42 foot, PT addition was constructed to the south of the east wing that is Type II(000) constriction, 1-story without a basement.

The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the

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

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	245559	A. BUILDING **01 - 1965 BUILDING 01** B. WING	**08/12/2014**

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

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K 000	Continued From page 1 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 two buildings. The requirement at 42 CFR, Subpart 483.70(a) is Met.	K 000		

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	245559	A. BUILDING 03 - BUILDING 0202 B. WING	08/12/2014

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K 000	INITIAL COMMENTS 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. Viking Manor Nursing Home is a 1-story building without a basement and constructed at five different times. The original building was constructed in 1965 and was determined to be of Type II (000) construction. An addition to the west was constructed in 1981 that was determined to be Type V (111) construction and is separated from the original building with a 2-hour fire barrier. A connecting link was constructed in 1994 to the north end of the east wing to connect the facility to an apartment building and a connecting link was constructed in 1998 to the south of the west wing to connect the facility to a clinic. Both buildings are separated from the existing nursing home with 2-hour fire barriers. In 2003 a 24 foot by 42 foot, PT addition was constructed to the south of the east wing that is Type II(000) constriction, 1-story without a basement. The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the	K 000		

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

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	245559	A. BUILDING **03 - BUILDING 0202** B. WING ______	**08/12/2014**

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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 MET.	K 000		

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

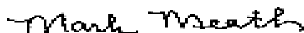
We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at the number noted above.

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,



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Licensing and Certification File

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