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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UP5E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00075

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/01/16** (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

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):

17. SURVEYOR SIGNATURE — Date :
Gail Anderson, Unit Supervisor — 04/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 05/16/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/22/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245559

May 5, 2016

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 March 21, 2016 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

April 5, 2016

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

RE: Project Number S5559024

Dear Mr. Kjos:

On March 2, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 18, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On April 1, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 17, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 18, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 21, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 18, 2016, effective March 21, 2016 and therefore remedies outlined in our letter to you dated March 2, 2016, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245559	A. Building B. Wing	4/1/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 03/21/2016	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 03/21/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 03/21/2016
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 (INITIALS) GA/mm	DATE 04/05/2016	SIGNATURE OF SURVEYOR 28034	DATE 04/01/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/18/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245559 Y1	A. Building 01 - 1965 BUILDING 01 B. Wing Y2	3/17/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0048	03/01/2016	LSC K0050	03/01/2016	LSC K0052	03/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0062	03/01/2016	LSC K0069	03/07/2016	LSC K0076	03/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0144	03/01/2016	LSC K0154	03/01/2016	LSC K0155	03/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	04/05/2016	36536	03/17/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 2/17/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245559 Y1	A. Building 03 - BUILDING 0202 B. Wing Y2	3/17/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0048	03/01/2016	LSC K0050	03/01/2016	LSC K0062	03/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0144	03/01/2016	LSC K0154	03/01/2016	LSC K0155	03/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL / mm	04/05/16	36536	03/17/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/17/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UP5E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00075

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/18/2016** (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):

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NEII 03/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 03/22/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 0151

March 2, 2016

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

RE: Project Number S5559024

Dear Mr. Kjos:

On February 18, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 29, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 29, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit to acknowledge your receipt of the 2567, your review and your PoC submission.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC

must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 18, 2016 (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 August 18, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC 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 electronic 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

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

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 _____	02/18/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Received via email 3/10/16	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document interview, the facility failed to ensure oral care assistance was provided as directed by the care plan for 1 of 3 residents (R55) reviewed for activities of daily living (ADLs). Findings include: R55's care plan, dated 10/28/15, identified R55 had problems of dementia, impaired mobility and inability to communicate needs. R55's care plan indicated R55 had an upper denture and a lower partial, and directed staff to brush teeth, partial and denture twice a day and as needed. The care plan also indicated R55 would refuse to	F 282	On 2/17/16, staff did go back and provided Oral cares to R55. Care plans were reviewed to reflect current oral cares for each resident. All staff educated on the importance of oral cares. Current policy on Oral Cares was reviewed and education was provided to staff on 3/10/16. Education included that it is expected that staff offer oral cares according to each resident's plan of care. DON or designee will do random audits to ensure oral cares are being offered to all residents according to their plan of care. Audit findings will be brought to QA. All education will be completed by 3/21/16. 3/14/16 OK JP	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jodee Kiss — Administrator — 3/16/2016

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

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F 282	Continued From page 1 wear the denture/partial at times, and staff were to reapproach as needed. On 2/17/16, from 7:36 p.m. until 7:46 p.m. R55's personal cares were observed. Nursing assistant (NA)-A and NA-B were observed performing personal hygiene on R55, and transferring R55 to bed. During the observation R55 was not offered or provided oral cares by NA-A or NA-B during this time. On 2/17/16, at 7:54 p.m. NA-B verified oral cares had not been done, and confirmed oral cares had not been offered to R55. NA-B stated "[NA-A] had already done oral cares, I think." On 2/17/16, at 7:56 p.m. NA-A verified oral cares had not been done for R55, and confirmed oral cares had not been offered to R55. NA-A stated "I should have but I didn't, I forgot." On 2/17/16, at 7:58 p.m. the director of nursing (DON) was interviewed and stated "I would expect them to offer oral hygiene every morning and at evening cares." DON also confirmed R55's care plan and stated "I would expect staff to follow the nursing assistant care plan." The facility policy titled Care Plans, revised 8/06, directed an individualized comprehensive care plan included measurable objectives and timetables to meet the residents medical, nursing, mental and psychological needs is developed for each resident.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312		

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F 312	Continued From page 2 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document interview, the facility failed to provide the necessary care and services to maintain oral hygiene for 1 of 3 residents (R55) reviewed for activities of daily living (ADLs). Findings include: R55's quarterly Minimum Data Set (MDS) dated 1/19/16, identified R55 had diagnoses which included dementia, hip fracture and history of falls. The MDS identified R55 had severe cognitive impairment, and totally dependent on staff to perform personal hygiene including oral hygiene. R55's care plan, dated 10/28/15, identified R55 had problems of dementia, impaired mobility and inability to communicate needs. R55's care plan indicated R55 had an upper denture and a lower partial, and directed staff to brush teeth, partial and denture twice a day and as needed. The care plan also indicated R55 would refuse to wear the denture/partial at times, and staff were to reapproach as needed. R55's Oral/Dental Assessment, dated 10/22/15, indicated R55 had upper full dentures and a lower partial denture with some natural teeth. The assessment indicated staff would assist R55	F 312	On 2/17/16, staff did go back and provided Oral cares to R55. Care plans were reviewed to reflect current oral cares for each resident. All staff educated on the importance of oral cares. Current policy on Oral Cares was reviewed and education was provided to staff on 3/10/16. Education included that it is expected that staff offer oral cares according to each resident's plan of care. DON or designee will do random audits to ensure oral cares are being offered to all residents according to their plan of care. Audit findings will be brought to QA. All education will be completed by 3/21/16.	

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F 312	Continued From page 3 with oral hygiene each morning and evening. On 2/17/16, from 7:36 p.m. until 7:46 p.m. R55's personal cares were observed. Nursing assistant (NA)-A and NA-B were observed performing personal hygiene on R55, and transferring R55 to bed. During the observation R55 was not offered or provided oral cares by NA-A or NA-B during this time. On 2/17/16, at 7:54 p.m. NA-B verified oral cares had not been done, and confirmed oral cares had not been offered to R55. NA-B stated "[NA-A] had already done oral cares, I think." On 2/17/16, at 7:56 p.m. NA-A verified oral cares had not been done for R55, and confirmed oral cares had not been offered to R55. NA-A stated "I should have but I didn't, I forgot." On 2/17/16, at 7:58 p.m. the director of nursing (DON) was interviewed and stated "I would expect them to offer oral hygiene every morning and at evening cares." DON also confirmed R55's care plan and stated "I would expect staff to follow the nursing assistant care plan." The facility policy titled Care Plans, revised 8/06, directed an individualized comprehensive care plan included measurable objectives and timetables to meet the residents medical, nursing, mental and psychological needs is developed for each resident.	F 312		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		

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F 441	Continued From page 4 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 441	Staff involved were re-educated on how to properly handle dirty and soiled linen. Linen handling expectations re-educated with all staff. Personnel must handle, store, process and transport linens so as to prevent the spread of infection. DON or designee will do random audits to ensure that dirty linen is being passed, brought out of the rooms and properly stored to prevent cross contamination. Audit findings will be brought to QA. All education will be completed by 3/21/16.	

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F 441	Continued From page 5	F 441		

review, the facility failed to implement infection control practices in an appropriate manner to prevent the potential for cross contamination with soiled linen during observation or personal cares for 1 of 3 residents(R55) reviewed for activies of daily living.

Findings include:

R55's quarterly Minimum Data Set (MDS) dated 1/19/16, identified R55 had diagnoses which included dementia, hip fracture and history of falls. The MDS identified R55 had severe cognitive impairment, required extensive assistance from staff for bed mobility and dressing and was totally dependent on staff for assistance with toilet use and personal hygiene. Further, the MDS identified R55 was always incontinent of bladder and bowel.

R55's care plan, dated 10/28/15, identified R55 had problems of dementia, impaired mobility and inability to communicate needs. R55's care plan listed various interventions which included total assist with transferring, repositioning, and personal hygiene. Further, R55's care plan identified R55 was incontinent of bladder and bowel, and directed staff to provide perineal care twice a day and wash, rinse and dry perineum after each incontinence episode.

On 2/17/16, at 7:36 p.m. R55's personal cares were observed on R55. Nursing assistant (NA)-A washed R55's face, and NA-B entered the room with a mechanical lift. NA-A continued to wash and dry R55's face while NA-A waited for her to finish. NA-A and NA-B proceeded to transfer R55 from his wheelchair to the bed (using a

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F 441	Continued From page 6	F 441		

mechanical lift), removed the lift sheet, and placed R55 in a semi-sitting position on his bed. NA-A and NA-B removed R55's visibly soiled sweater and shirt. NA-B placed the soiled clothing in R55's wheelchair and and dressed R55 in a gown and laid him down on the bed. At 7:40 p.m. NA-B removed R55's shoes, and both NA-A and NA-B removed R55's pants. NA-B threw the soiled clothing in R55's wheelchair. NA-B walked into the bathroom and obtained a container of wet wipes and returned to R55's bedside. NA-A and NA-B both donned gloves, and proceeded to loosen R55's incontinent brief. NA-B began cleaning R55's perineal area with the wet wipes, while NA-A dried R55's perineal area with a towel. NA-A proceeded by rolling R55 to his right side while NA-B wiped R55's buttocks with wet wipes, then dried his buttocks area using the same towel. NA-A and NA-B proceeded to remove the soiled incontinent brief and applied a fresh brief. NA-A and NA-B removed their gloves. NA-B continued to clean up supplies while NA-A placed a pillow under R55's feet, covered R55 up with blanket and placed the call light within reach.

At 7:44 p.m. NA-A grabbed the soiled white linens with ungloved hands off the bed side table. NA-A held the linen against her left mid-waist area against her uniform, walked across the room to the bathroom, and proceeded to bend over with the soiled linen touching her chest area, waist area, and upper left leg area. NA-A retrieved a clear plastic bag out of the bed side table, then placed the soiled linen inside the bag. NA-A walked back over to R55's wheelchair, grabbed the soiled clothing, and held the linen against her left mid-waist area against her

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F 441	Continued From page 7	F 441		

uniform, walked back into the bathroom, and proceeded to bend over with the soiled linen touching her chest area, waist area, and upper left leg area. NA-A retrieved a clear plastic bag out of the bed side table, then placed the soiled linen inside the bag. NA-B lowered R55's bed and left the room. At 7:46 p.m. NA-A gathered up the soiled linen in the bags and proceeded to transport them to the dirty utility room.

On 2/17/16, at 7:47 NA-A confirmed she carried the soiled linen against her uniform and stated "I just had a huge pile of it." NA-A indicated the usual facility practice for handling soiled linen was to carry the soiled linen away from you, out in front of you and not against your clean uniform.

On 2/17/16, at 7:54 p.m. NA-B confirmed the usual facility practice was, soiled linen should not be carried next to your uniform, it should be bagged, and taken to the dirty utility room. NA-B stated "I would carry it [soiled linen] away from my uniform."

On 2/17/16, at 7:58 p.m. the director of nursing (DON) confirmed the current facility policy and verified staff should carry soiled linen away from their bodies, soiled linen should be bagged and removed to the dirty utility room. The DON stated "Carrying linen against their uniforms is not proper protocol."

The facility policy and procedure titled Laundry and Linen revised on 4/07, directed staff should not allow linen, clean or soiled, to touch clothing or uniform, and handle all soiled linen as though it is potentially infectious.

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

F5559025

PRINTED: 03/02/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245559	A. BUILDING 01 - 1965 BUILDING 01 B. WING	02/17/2016

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Viking Manor Nursing Home 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101		K 000 APPROVED By Tom Linhoff at 2:38 pm, Mar 15, 2016 RECEIVED MAR 15 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 3/10/2016

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

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K 000	Continued From page 2 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 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 40 at the time of the survey. The facility was surveyed as two buildings. The requirement at 42 CFR, Subpart 483.70(a) is not met.	K 000		
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a complete Fire Safety Plan that included all 8 items listed in the Life Safety Code 2000 addition, section 19.7.2.2. This deficient practice could jeopardize the efficient	K 048	We have updated our Fire and Evacuation Plan to cover all items listed in LSC 19.7.22. Completion Date 3/1/16	

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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
K 048	Continued From page 3 evacuation of all 40 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:00 am to 12:30 pm on 02/17/2016 documentation review revealed that the fire safety plan did not cover all the items listed in the LSC 19.7.2.2. This was confirmed by the Maintenance Supervisor and the facility Administrator	K 048		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 40 residents and undetermined amount of staff and visitors	K 050	A grid which shows fire drills for each quarter and each shift will be monitored more closely to ensure their will be a fire drill each month of the quarter. The Administrator will be responsible to monitor times of fire drills. Completion Date 3/1/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245559	A. BUILDING **01 - 1965 BUILDING 01** B. WING _____	02/17/2016

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

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K 050	Continued From page 4 Findings Include: On the facility tour between 9:00 am to 12:30 pm on 02/17/2016 documentation review revealed that a fire drill was missed on the overnight shift in November. This deficient condition was verified by the Maintenance Supervisor and the facility Administrator	K 050		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the facility. Findings Include: On the facility tour between 9:00 am to 12:30 pm on 02/17/2016 observations revealed that a	K 052	The smoke detector in the Food Service Supervisors Office has been moved so it is not within 36 inches of a diffuser. Completion Date 3/1/16	

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K 052	Continued From page 5 smoke detector in the Food Supervisor office was within 36 inches of a diffuser. This was confirmed by the Maintenance Supervisor and the facility Administrator	K 052		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 40 residents, staff and visitors. Findings include: On the facility tour between 9:00 am to 12:30 pm on 02/17/2016 observations and documentation review revealed the following items not in compliance with NFPA 13. 1. There was no documentation of quarterly sprinkler system tests. 2. There was no documentation for the 5 year gauge calibration/replacement. 3. In the activity room storage, plastic bins were	K 062	Our sprinkler system was tested on March 1, 2016 by Summit Fire Protection. This included the quarterly sprinkler test and the 5 year gauge calibration/replacement. The activity room storage shelves were lowered so they are no longer obstructing sprinkler heads. Activity staff have also been instructed of proper storage so that sprinkler heads are not restricted should their use be necessary. Completion Date 3/1/16	

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K 062	Continued From page 6 blocking the sprinkler heads. This deficient practice was verified by the Maintenance Supervisor and the facility Administrator.	K 062		
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility has failed to ensure that 1 of 2 semi-annual inspections of the kitchen hood ventilation and fire suppression system have been completed. NFPA 96 8-3.1 per table 8-3.1, states that for moderate-volume cooking operations, the hood system and components shall be inspected and maintained semiannually by a properly trained, qualified, and certified company or person. This deficient practice could affect all 40 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:00 am to 12:30 pm on 02/17/2016 documentation review revealed that there was only one inspection, (5/28/2015) for the kitchen hood system in the past 12 months. This deficient practice was verified by the Maintenance Supervisor and the facility Administrator	K 069	Our kitchen hood ventilation and fire Suppression system was cleaned and inspected March 7, 2016. The administrator will insure that inspections will be completed on a semi-annual basis. Completion Date 3/7/16	
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 076		

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K 076	Continued From page 7 Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to store oxygen cylinders in accordance with NFPA 99 (99) section 4-3.1.1.2 in a manner to prevent tipping over. This deficient practice could affect 12 of the 40 residents and an undtermined amount of staff and visitors. On the facility tour between 9:00 am to 12:30 pm on 02/17/2016 observations revealed an unsecured oxygen cylinder in the 02 storage room. This deficient practice was verified by the Maintenance Supervisor and the facility Administrator.	K 076	The oxygen cylinder in the oxygen storage room has be secured. The Director of Nursing will audit compliance to ensure all oxygen cylinders are stored appropriately. Completion Date 3/1/16	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110, 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements	K 144	Our generator log has been modified to Include a record of the cool down. Documentation will me maintained by our Maintenance Supervisor. An emergency light has be installed which luminates the generator. Completion Date 3/1/16	

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K 144	Continued From page 8 of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 40 residents, staff, and visitors. Findings include: On the facility tour between 9:00 am to 12:30 pm on 02/17/2016 observations and documentation review revealed the following: 1. The generator log did not have a record of the cool down. 2. The generator location did not have an emergency light. This deficient practice was verified by the Maintenance Supervisor and the facility Administrator.	K 144		
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a review of documentation and an interview with staff it was determined that the facility staff does not have a written out of service policy for the automatic sprinkler system in accordance with NFPA 101 (LSC) 2000 edition sections 19.3.4.5.1 and 9.7.6.1. This deficient practice could negatively impact all 40 of the residents if the system is out of service and no alternative method of containing a fire is provided.	K 154	A policy for the sprinkler system out of service has been written and placed in our Fire and Evacuation Plan. Implementation of this policy rests with the facility Administrator. Completion Date 3/1/16	

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K 154	Continued From page 9 Findings Include: On the facility tour between 9:00 am to 12:30 pm on 02/17/2016 documentation review revealed that there was no policy for the sprinkler system out of service. This deficient practice was verified by the Maintenance Supervisor and the facility Administrator.	K 154		
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a review of documentation and an interview with staff it was determined that the facility does not have a written out of service policy for the fire alarm system in accordance with NFPA 101 (LSC) 2000 edition sections 19.3.4.5.1 and 9.6.1.8. This deficient practice could negatively impact all 40 of the residents if the system is out of service and no alternative method of discovering a fire is provided. Findings Include: On the facility tour between 9:00 am to 12:30 pm on 02/17/2016 documentation review revealed that there was no policy for the fire alarm system out of service.	K 155	A policy for the fire alarm system out of service has been written and placed in our Fire and Evacuation Plan. Implementation of this policy rests with the facility Administrator. Completion Date 3/1/16	

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K 155	Continued From page 10 This deficient practice was verified by the Maintenance Supervisor and the facility Administrator	K 155		

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

F5559025

PRINTED: 03/02/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245559	A. BUILDING 03 - BUILDING 0202 B. WING	02/17/2016

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Viking Manor Nursing Home 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101		K 000 APPROVED By Tom Linhoff at 2:40 pm, Mar 15, 2016 RECEIVED MAR 15 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator | 3/10/2016

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

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K 000	Continued From page 2 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 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 40 at the time of the survey. The facility was surveyed as two buildings. The requirement at 42 CFR, Subpart 483.70(a) is not met.	K 000		
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a complete Fire Safety Plan that included all 8 items listed in the Life Safety Code 2000 addition, section 19.7.2.2. This	K 048	We have updated our Fire and Evacuation Plan to cover all items listed in LSC 19.7.22. Completion Date 3/1/16	

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K 048	Continued From page 3 deficient practice could jeopardize the efficient evacuation of all 40 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:00 am to 12:30 pm on 02/17/2016 documentation review revealed that the fire safety plan did not cover all the items listed in the LSC 19.7.2.2. This was confirmed by the Maintenance Supervisor and the facility Administrator	K 048		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 40 residents and undetermined amount of staff and visitors	K 050	A grid which shows fire drills for each quarter and each shift will be monitored more closely to ensure their will be a fire drill each month of the quarter. The Administrator will be responsible to monitor times of fire drills. Completion Date 3/1/16	

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K 050	Continued From page 4 Findings Include: On the facility tour between 9:00 am to 12:30 pm on 02/17/2016 documentation review revealed that a fire drill was missed on the overnight shift in November. This deficient condition was verified by the Maintenance Supervisor and the facility Administrator	K 050		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 40 residents, staff and visitors. Findings Include: On the facility tour between 9:00 am to 12:30 pm on 02/17/2016 observations and documentation review revealed the following items not in compliance with NFPA 13.	K 062	Our sprinkler system was tested on March 1, 2016 by Summit Fire Protection. This included the quarterly sprinkler test and the 5 year gauge calibration/replacement. The activity room storage shelves were lowered so they are no longer obstructing sprinkler heads. Activity staff have also been instructed of proper storage so that sprinkler heads are not restricted should their use be necessary. Completion Date 3/1/16	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
K 062	Continued From page 5 1. There was no documentation of quarterly sprinkler system tests. 2. There was no documentation for the 5 year gauge calibration/replacement. This deficient practice was verified by the Maintenance Supervisor and the facility Administrator.	K 062		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 40 residents, staff, and visitors. Findings include: On the facility tour between 9:00 am to 12:30 pm on 02/17/2016 observations and documentation review revealed the following: 1. The generator log did not have a record of the cool down. 2. The generator location did not have an emergency light. This deficient practice was verified by the Maintenance Supervisor and the facility	K 144	Our generator log has been modified to Include a record of the cool down. Documentation will me maintained by our Maintenance Supervisor. An emergency light has be installed which luminates the generator. Completion Date 3/1/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245559	A. BUILDING **03 - BUILDING 0202** B. WING	02/17/2016

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K 144	Continued From page 6 Administrator.	K 144		
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1. This STANDARD is not met as evidenced by: Based on a review of documentation and an interview with staff it was determined that the facility staff does not have a written out of service policy for the automatic sprinkler system in accordance with NFPA 101 (LSC) 2000 edition sections 19.3.4.5.1 and 9.7.6.1. This deficient practice could negatively impact all 40 of the residents if the system is out of service and no alternative method of containing a fire is provided. Findings include: On the facility tour between 9:00 am to 12:30 pm on 02/17/2016 documentation review revealed that there was no policy for the sprinkler system out of service. This deficient practice was verified by the Maintenance Supervisor and the facility Administrator.	K 154	A policy for the sprinkler system out of service has been written and placed in our Fire and Evacuation Plan. Implementation of this policy rests with the facility Administrator. Completion Date 3/1/16	
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified,	K 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245559	A. BUILDING **03 - BUILDING 0202** B. WING	02/17/2016

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K 155	Continued From page 7 and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a review of documentation and an interview with staff it was determined that the facility does not have a written out of service policy for the fire alarm system in accordance with NFPA 101 (LSC) 2000 edition sections 19.3.4.5.1 and 9.6.1.8. This deficient practice could negatively impact all 40 of the residents if the system is out of service and no alternative method of discovering a fire is provided. Findings include: On the facility tour between 9:00 am to 12:30 pm on 02/17/2016 documentation review revealed that there was no policy for the fire alarm system out of service. This deficient practice was verified by the Maintenance Supervisor and the facility Administrator	K 155	A policy for the fire alarm system out of service has been written and placed in our Fire and Evacuation Plan. Implementation of this policy rests with the facility Administrator. Completion Date 3/1/16	