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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245559 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                      | (X3) DATE SURVEY COMPLETED<br><br>06/11/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Viking Manor Nursing Home |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>317 First Street Northwest<br>Ulen, MN 56585 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> R29's quarterly MDS dated [DATE], identified R29 was severely cognitively impaired and had diagnoses of Alzheimer's disease, dementia and depression. R29 needed total assistance with dressing, toileting and transfers.</p> <p>R29's care plan revised 3/31/25, identified R29 had an alteration in gastro intestinal status related to the presence of a cholecystectomy (gallbladder) tube and R29 was on EBP.</p> <p>R29's signed physicians orders dated 6/5/25, identified staff were to monitor the dressing to the biliary (gallbladder) draining daily and as needed (PRN). Further indicated staff were to change the dressing when soiled PRN.</p> <p>During an observation and interview on 6/9/25 at 4:30 p.m., NA-B and NA-C were in R29's room and transferred R29 into bed using a mechanical lift. NA-C grabbed two pairs of gloves from R29's bedside table and gave NA-B one pair. NA-C and NA-B applied gloves and removed R29's brief. NA-B provided R29 the urinal and R29 voided. RN-B removed the urinal and disposed the urine in the bathroom. NA-B returned to assist NA-C with cleaning R29's bottom and applying a new brief. NA-C and NA-B removed their gloves and transferred R29 back into the wheelchair with the mechanical lift. NA-B and NA-C did not wear gowns while providing cares to R29. NA-B and NA-C stated staff only needed to wear a gown when they were providing cares to R29's cholecystectomy tube. NA-B and NA-C confirmed they had not worn a gown when they were changing or transferring R29.</p> <p>During an interview on 6/11/25 at 9:28 a.m., director of nursing (DON) who also worked as the infection preventionist indicated staff should be wearing gowns when providing activities of daily living such as dressing, catheter care, transferring, and changing bedding. DON indicated wearing gowns was important to prevent the spread of possible infections to other residents.</p> <p>Review of facility policy titled Enhanced Barrier Precautions dated 2025, personal protective equipment (PPE) for enhanced barrier precautions was only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. High-contact resident care activities included dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC (peripherally inserted central catheter) lines, midline catheters.</p> <p>(continued on next page)</p> |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Based on observation, interview, and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn to prevent the spread of infection for 2 of 3 residents (R17, R29) observed for enhanced barrier precautions (EBP), (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities).</p> <p>Findings Include:</p> <p>Review of Centers for Disease Control (CDC) guidance dated 4/1/24, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for EBP included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing.</p> <p>R17's quarterly Minimal Data Set (MDS) dated [DATE], identified R17 was cognitively intact and had diagnoses of cerebral infarction (stroke), benign prostatic hyperplasia (prostate increasing in size making urination difficult), hemiplegia (paralysis), and hemiparesis (weakness on one side). R17 needed maximal assistance with upper body dressing and was dependent on staff for lower body dressing and toileting hygiene.</p> <p>R17's care plan revised on 2/14/24, identified that R17 required the assistance of one staff and a mechanical standing lift for toileting. R17 had a Foley catheter, and staff were to empty the urinary catheter as needed.</p> <p>R17's care plan revised on 5/10/25, identified staff needed to follow EBP when changing the Foley catheter, emptying the urinary drainage bag, performing peri care, and assisting the resident with bowel hygiene.</p> <p>R17's order summary report dated 6/5/25, identified staff needed to change the suprapubic catheter with 18 French once every 42 days and give the resident a new leg/bed catheter bag at bedtime every Sunday for catheter care.</p> <p>During an interview on 6/9/25 at 2:45 p.m., R17 indicated that staff typically did not wear a gown while providing care.</p> <p>During an observation on 6/11/25 at 7:21 a.m., nursing assistant (NA)-A applied gloves and did not apply a gown. NA-A took the mechanical standing lift into R17's room, applied R17's shoes and helped R17 sit on the side of the bed. NA-A assisted R17 with putting his feet on the standing mechanical lift. NA-A hooked R17's catheter bag on the mechanical lift and put the sling around R17. NA-A lifted R17 from the bed and transferred him to the bathroom and removed his brief and placed in the garbage. NA-A transferred R17 to the shower chair and brought R17 to the shower room down the hallway. At 8:11 a.m., NA-A came out of the shower room without a gown to grab the standing mechanical lift and brought the lift into the shower room.</p> <p>During an interview on 6/11/25 at 7:33 a.m., NA-A indicated staff would wear a gown when changing the catheter and switching the night bag to a leg bag. NA-A did not believe staff needed to wear a gown when getting R17 dressed or during a bath.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview on 6/11/25 at 8:55 a.m., licensed practical nurse (LPN)-A, indicated staff needed to wear a gown when changing the suprapubic catheter or the urine night bag to a leg bag. LPN-A did not think a gown would need to be worn when giving R17 a bath or dressing R17.</p> |   |  |

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| <p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review, the facility failed to ensure 2 of 6 residents (R40, R21) were offered or received pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations.</p> <p>Findings include:</p> <p>Review of the Pneumococcal Vaccine Timing for Adults, dated 10/24, from the CDC identified adults [AGE] years of age or older who had previously received the Pneumococcal 13-valent Conjugate Vaccine (PCV13) and the Pneumococcal Polysaccharide Vaccine 23 (PPSV23) should receive one dose of the 20-valent Pneumococcal Conjugate Vaccine (PCV20) or 21-valent Pneumococcal Conjugate Vaccine (PCV21).</p> <p>Review of R40's Minnesota Immunization Information Connection (MIIC) identified R40 had received the PPSV23 vaccination on 9/21/18. R40's medical record lacked documentation R40 had been offered or received the PCV20 or PCV21 vaccination. R40's medical record further revealed R40 had consented to receive the PCV20 or PCV21 vaccination on 5/6/25.</p> <p>Review of R21's MIIC identified R21 had received the PCV-13 vaccination on 2/25/16, and the PPSV23 vaccination on 10/1/09. R21's medical record lacked documentation R21 had been offered or received the PCV20 or PCV21 vaccination. R21's medical record further revealed R21's significant other consented for R21 to receive the PCV20 or PCV21 vaccination on 4/28/25.</p> <p>During an interview on 6/10/25 at 12:17 p.m., infection preventionist (IP) indicated she contacted the pharmacist via email on 6/9/25, requesting residents get caught up on their pneumococcal immunizations. IP did not specify R40 or R21 were included in the email.</p> <p>During a follow-up interview on 6/10/25 at 3:11 p.m., IP stated she was unaware why R40 did not receive the PCV20 or PCV21 vaccination. IP further stated the vaccinations were given by the pharmacist and it would only take one to two days after placing the order for the immunization to be available. IP confirmed R40 and R21 had consented to the PCV20 or PCV21 however, had not received the immunizations. IP further confirmed the pharmacist had not been contacted prior to the email on 6/9/25, to provide the immunizations to R40 and R21.</p> <p>During an interview on 6/11/25 at 9:35 a.m., director of nursing (DON) stated R40 and R21 should have received either the PCV20 or PCV21 immunizations. DON stated her expectations were every resident was to receive up to date immunizations following CDC guidelines.</p> <p>Review of facility policy titled, Pneumococcal Vaccine undated, indicated the facility would offer residents immunizations against pneumococcal disease in accordance with current CDC guidelines and recommendations.</p> |   |  |