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	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viking Manor Nursing Home	317 First Street Northwest 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to ensure nebulizer medications were administered safely for 1 of 1 resident (R16) who was observed to self administer a nebulizer and had not been assessed as safe to self administer medications. Findings include: R16's quarterly Minimum Data Set (MDS) dated [DATE], identified R6 had moderate cognitive impairment and had diagnoses which included Alzheimer's, chronic obstructive pulmonary disease (COPD) and anxiety disorder. Identified R16 received oxygen therapy and required staff assistance for self care and mobility. Review of R16's electronic health record (EHR) lacked documentation a Self Medication Administration (SAM) assessment has been completed. R16's Physician Telephone Orders dated 2/12/24, and signed 2/1/24, directed staff to administer Ipratropium-albuterol inhalation solution DuoNeb (medication used to relax the muscles in the airways and increase air flow to the lungs) two times daily (BID) and every four hours as needed for congestion. R16's Medication Administration Record dated 10/19/23 to 3/19/24, indicated R16 had been taking (DuoNeb) 0.5-2.5 3 milligrams (mg) per three milliliters (ml) two times per day. R16's care plan dated 11/12/23, indicated R16 had an activities of daily living (ADL) deficit related to activity intolerance and required staff assistance with self care. During an observation on 3/18/24 at 7:25 p.m., licensed practical nurse (LPN)-A opened R16's vial of Ipratropium-Albuterol inhalation solution and poured it into the nebulizer cup and attached the cup to the nebulizer mask. LPN-A applied the nebulizer mask onto R16's face, turned on the nebulizer machine, informed R16 she would return when the nebulizer was completed and exited the room. No staff were observed in R16's room. At 7:35 p.m., LPN-A returned to R16's room and R16 stated she had removed the mask and turned off the machine. During an interview on 3/18/24 at 7:40 p.m., R16 stated she had not been taught by the staff how to use the nebulizer machine however indicated she had taught herself how to use the machine. R16 verified staff did not remain in the room while the treatment was being administered. (continued on next page)

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.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/18/24 at 7:45 p.m., LPN-A verified she had placed the nebulizer treatment on R16 and exited the room. LPN-A stated she was unsure if a SAM assessment had been completed for R16. LPN-A stated her usual practice was to place the nebulizer mask on R16, leave the room and return once the nebulizer treatment was completed. LPN-A indicated sometimes R16 would remove the mask herself and sometimes LPN-A would remove the mask when the nebulizer was completed. During an interview on 3/19/24 at 2:16 p.m., registered nurse (RN)-A confirmed R16 did not have a SAM assessment completed for her nebulizer treatment. RN- stated her expectation was that a SAM assessment would have been completed for R16 or staff would have stayed in the room during the nebulizer treatment until an assessment had been completed to ensure R16 received the nebulizer treatment appropriately. During an interview on 3/19/24 at 10:50 a.m., director of nursing (DON) verified R16 did not have a SAM assessment completed. DON indicated her expectation was R16 would have had a SAM assessment completed or staff were expected to remain with the resident during the entire nebulizer treatment. Review of a facility policy titled Resident Self-Administration of Medication revised 2/2012, identified a resident may only self-administer medications after the facility's interdisciplinary team had determined which medications may be self-administered safely. Indicated if resdient was deemed safe to self administer a medication it would have been documented in the medical record and the care plan. Identified the decision for a resident to self- administer a medication was reassessed periodically based on changes in the resident's medical and/or decision making status.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to follow standards of practice related to medication administration of an inhalation medication for 1 of 1 resident (R16) observed for medication administration. Findings include: R16's quarterly Minimum Data Set (MDS) dated [DATE], identified R16 had moderate cognitive impairment and had diagnoses which included Alzheimer's, chronic obstructive pulmonary disease (COPD), and anxiety disorder. Identified R16 received oxygen therapy. R16's comprehensive care plan dated 1/31/24, identified R16 required staff assistance with dressing, hygiene and transfers. Indicated R16 had diagnosis of COPD, with goals which included would be free of respiratory infections and complications related to respiratory disease. R16's Order Summary Report signed 2/1/24, identified Breztri (steroid) inhalation Aerosol 160-9-4.8 microgram (MCG) 2 puffs orally two times a day for COPD. Rinse mouth after each use. During an observation on 3/18/24 at 7:38 p.m., R16 stood in her room holding onto her walker. Licensed practical nurse (LPN)-A entered R16's room and held an inhaler which included the Breztri medication up to R16's mouth and instructed R16 to take two puffs of the inhaler. R16 took two puffs of inhaler as instructed,. LPN-A then took the inhaler and exited the room. R16 was not observed to rinse her mouth out and LPN-A had not instructed R16 to rinse her mouth out as ordered after taking the Breztri inhaler. During an interview on 3/18/24 at 7:41 p.m., R16 indicated she received the Breztri inhaler twice a day. R16 confirmed she had not rinsed her mouth after just receiving the inhaler. R16 was not aware she was expected to rinse her mouth after using the inhaler and stated only once in a while staff would instruct her to rinse her mouth out however not every time she used the inhaler. During an interview on 3/18/24 at 7:46 p.m., LPN-A confirmed she had not instructed R16 to rinse her mouth after receiving the Breztri inhaler. LPN-A stated she had not seen the order instructions to rinse mouth after use. LPN-A indicated it was important to rinse the mouth after a steroid inhaler was received to prevent any infections. During a phone interview on 3/19/24 at 9:10 a.m., pharmacy consultant (PC)-A stated it was important to rinse the mouth after receiving Breztri inhaler because it was a steroid. PC-A indicated it could cause thrush, a fungal infection inside the mouth. PC-A stated it was her expectation nursing staff would instruct the resident to rinse their mouth after each use. During an interview on 3/19/24 at 10:50 a.m., director of nursing (DON) confirmed R16's Breztri inhaler label included instructions to rinse mouth after use. DON stated it was important for residents to rinse their mouth after use to prevent infections in the mouth. DON stated her expectation was for nursing staff to instruct R16 to rinse mouth after receiving the Breztri inhaler. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16's Breztri inhaler box instructions indicated take two puffs in the morning and two puffs in the evening and rinse mouth out after using the inhaler to reduce your chance of getting a fungal infection. Review of a facility policy titled Medication Administration revised 2/2013, indicated medications were administered by licensed nurses as ordered by the physician and in accordance with the professional standards of practice in a manner to prevent contamination or infections. Further indicated to administer medications in accordance with manufacturer's specifications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 37905 Based on observation, interview, and document review, the facility failed to ensure personal laundry was transported and delivered in a manner that prevented risk of contamination for 2 of 4 hallways observed for linen transportation. Findings include: Review of Centers for Disease Control (CDC) guidance, Appendix D - Linen and Laundry Management updated 5/4/23, identified linens must be sorted, packaged, transported, and stored in a manner that prevented risk of contamination by dust, debris, soiled linens or soiled items. During an observation on 3/19/24 at 1:10 p.m., housekeeper aide (HA)-A pushed the uncovered laundry rack to R27's room, removed clothing from the uncovered laundry rack, placed clothing into R27's closet, returned hangers to the rack and sanitized hands. HA-A pushed the uncovered laundry rack past the nurses' station where one staff member and one resident were located and proceeded down to the middle of the next hallway. HA-B joined HA-A, then HA-B delivered clothing from the uncovered laundry rack to R19's dresser and closet. HA-B removed R30's clothing from the rack, knocked, returned, placed the clothing back on the uncovered rack, removed clothing from the uncovered laundry rack and proceeded to deliver clothing to R17's room. HA-B did not sanitize hands during that time. HA-A delivered clothing to R16, R1, then to R30's room and sanitized hands. HA-A pushed the uncovered clothing rack with one pair of pants remaining back to the clean laundry room. During an interview on 3/19/24 at 1:28 p.m., HA-A confirmed the laundry rack was uncovered, stated they had never covered the personal laundry rack and had never been instructed to cover it. HA-A indicated was aware should sanitize hands after leaving each resident's room and indicated at times may have forgotten. During an interview on 3/19/24 at 1:34 p.m., DON indicated she would expect staff to sanitize their hands after they exited a resident's room if they touched items in the room such as drawers and closet handles. DON confirmed the personal laundry rack was not covered and stated was unaware it was required to be covered. During an interview on 3/19/24 at 1:47 p.m., administrator reviewed a page from the State Operations Manual (SOM) with surveyor and indicated they had been unaware the personal laundry rack should have been covered while laundry was transported and delivered and confirmed they had never covered it while transporting laundry in the facility. During an interview on 3/20/24 at 8:06 a.m., HA-B stated she was aware staff should sanitize hands after delivering laundry to resident's rooms and stated she had forgotten a few times on 3/19/24 while delivering laundry. HA-B indicated it was important to prevent the residents from getting sick. HA-B confirmed the laundry rack was uncovered while they delivered the laundry on 3/19/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled Laundry, revised 3/19/24, identified housekeeping staff would be in-serviced on handling linens and laundry on a regular basis. Indicated personal laundry would be placed on a cart with the resident's name and distributed to the resident's room. A hand written addition made and verified by the administrator on 3/19/24, included: clean laundry must be transported by methods that ensure cleanliness and protect from dust and soil during intra or inter facility loading, transport, and unloading. The facility policy titled Hand Hygiene undated, identified all staff would perform proper hand hygiene procedures to prevent the spread of infection to personnel, residents, and visitors. The policy identified that would apply to all staff working in all locations within the facility. The policy identified hand hygiene would be performed under the conditions listed to the attached hand hygiene table. The Hand Hygiene Table conditions included: after handling contaminated objects, before and after handling clean or soiled dressings, linens, etc, and when in doubt.