Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 28, 2022

Administrator
Victory Health & Rehabilitation Center
512 49th Avenue North
Minneapolis, MN 55430

RE: CCN: 245544
Cycle Start Date: December 2, 2021

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On December 19, 2021, we informed you of imposed enforcement remedies.

On February 10, 2022, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility continues to not to be in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. remove this sentence if not SQC and IJ. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On February 9, 2022, the situation of immediate jeopardy to potential health and safety cited at F678 was removed. However, continued non-compliance remains at the lower scope and severity of D.

As a result of the survey/revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 3, 2022, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 3, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 3, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of December 19, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 3, 2022.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Victory Health & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 3, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to

determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

If an acceptable ePoC 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).

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

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 June 2, 2022 (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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an

explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING ______ B. WING ______	C 02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY HEALTH & REHABILITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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
E 000	Initial Comments On 2/7/22, 2/8/22, 2/9/22, and 2/10/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/7/22, 2/8/22, 2/9/22, and 2/10/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED, however, NO deficiencies were cited due to actions implemented by the facility prior to survey: H5544291C (MN80457) H5544293C (MN80295) H5544298C (MN78969) The following complaint was found to be SUBSTANTIATED: H5544301C (MN78078) with a related deficiency cited at F744. The following complaints were found to be UNSUBSTANTIATED: H5544292C (MN80389), H5544294C (MN79726),	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 03/03/2022

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 000	Continued From page 1 H5544295C (MN79545), H5544296C (MN79288), H5544297C (MN79201), H5544299C (MN78490), H5544300C (MN78337), H5544302C (MN78064), H5544303C (MN77969), H5544304C (MN75790), and H5544305C (MN78024). The survey resulted in an Immediate Jeopardy (IJ) to resident health and safety. An IJ at F678 began on 2/8/22, when R1's Provider Orders for Life-Sustaining Treatment (POLST) identified R41 had an active do-not-resuscitate order, however, the electronic health record (EHR) indicated R41's was to be administered CPR. The administrator was notified of the IJ at 3:30 p.m. on 2/8/22. The IJ was removed on 2/9/22, at 10:56 a.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted from 2/9/22 to 2/10/22. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and	F 552		3/12/22

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F 552	Continued From page 2 participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to allow a resident to participate in treatment decisions for 1 of 1 resident (R27) reviewed for hospice. Findings include: R27's Admission Record dated 2/10/22, lacked indication R27 had a legal guardian or durable Power of Attorney (DPOA). R27's diagnoses included unspecified dementia without behavioral disturbance. R27's significant change Minimum Data Set (MDS) dated 12/21/21, indicated R27 was moderately cognitively impaired and received hospice services. R27's care plan dated 12/15/21, indicated R27 received hospice care with a listed intervention to	F 552	F 552 R 27 met with hospice liaison and facility social worker regarding hospice services. R 27 Agreed to continue Hospice services and remain a DNR. A new POLST and Hospice agreement were signed by the resident. The MD all other residents receiving hospice services their hospice consent for services was reviewed and have the appropriate signature from resident or resident representative. Future residents who desire hospice services after admission to the facility will meet with resident and/or resident representative and hospice liaison and the appropriate signatures will be present. The Interdisciplinary Team was in-serviced on Appointing Resident Representative policy with emphasis that resident can appoint as resident	

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F 552	Continued From page 3 respect resident's rights to make decisions. R27's Provider Orders for Life-Sustaining Treatment (POLST) dated 12/14/21, indicated R27 had a do-not-resuscitate (DNR) order, however, the document was not signed by R27. The document was signed by family member (FM)-A. A document titled Hospice Transaction Form was signed by FM-A on 12/14/21. A corresponding document titled Admission Consent (hospice) had a box marked with an "x" to the immediate left of wording "Patient unable to sign due do to" with a hand written note which indicated "increased confusion." The document was also signed by FM-A. R27's medical record was reviewed and lacked evidence had a legal guardian or DPOA paperwork. Additionally, R27's medical record lacked evidence a licensed physician or court had determined R27 lacked the capacity to make her own decisions. Upon interview on 2/7/22, at 6:04 p.m. R27 stated, "I don't want to be on hospice, nor did I sign any paperwork to be on hospice." Additionally, "I don't want to be a DNR" Upon interview on 2/8/22, at 10:25 a.m. the administrator stated R27 was sent to the hospital on a previous date for an emergent situation. Further, the administrator stated he initiated a DNR request for R27. Upon a second interview on 2/10/22, at 8:48 a.m. R27 again confirmed she did not want hospice care and stated, "I want the staff to do everything	F 552	representative and the resident will be given opportunities to participate in the plan of care. The Social Service and/or designee will be responsible for compliance. Audits on resident/representative participating in plan of care for hospice services will begin weekly x 4 weeks then monthly to ensure compliance. All audits will be reviewed by the Administrator and the Administrator will present the audit results to QAPI for review and recommendation.	

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F 552	Continued From page 4 possible to keep me alive and make me better." Upon interview on 2/8/22, at 2:34 p.m. the assistant director of nursing (ADON) stated R27 had threw a hospice worker out of her room when approached about hospice services. Due to the incident, the hospice worker was asked to come back at a later time to conduct an evaluation and complete admission paperwork. R27 was again approached by facility staff and a hospice worker and R27 was "fairly agreeable" for hospice care. The ADON verified R27 was her own decision maker. The ADON was unable to explain why FM-A had signed R27's POLST and hospice admission paperwork. Upon interview on 2/9/22, at 1:15 p.m. a hospice manager stated R27 initially refused hospice services. Further, hospice normally verified an individual had a DPOA prior to a representative signing. During an interview on 2/9/22, at 3:25 p.m. hospice registered nurse, (RN)-E stated they assessed R27 on 12/14/21 and noted R27 was "alert and oriented." Further, when RN-E explained they were from hospice, R27 repeatedly stated "nope" so RN-E had left R27's room. RN-E stated FM-A had already signed R27's hospice admission paperwork and verified R27 did not sign documentation (consent), however, had later verbally agreed. Upon interview on 2/9/22, at 3:55 p.m. FM-A stated she signed a POLST and hospice admission paperwork on behalf of R27. FM-A verified she was not a guardian or DPOA for R27. FM-A stated hospice affiliates explained a POLST and paperwork needed to be signed for R27 to be	F 552		

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F 552	Continued From page 5 eligible for hospice services. Further, the facility explained R27 would get extra help when signed on for hospice services. Upon interview on 2/10/22, at 9:36 a.m. the social services director (SSD) stated if a resident was able to make their own decisions, a family member should not sign any of their paperwork. Upon a second interview on 2/10/22, at 10:50 a.m. the hospice manager stated, hospice RN-F initially went to the facility on 11/19/21 to conduct an assessment on R27. R27 had verbalized she did not want hospice services at that time. The hospice manager stated he also went to the facility and spoke with R27 at an unknown time and date and R27 said "okay" to services, however, stated R27 was confused at the time of the visit. Subsequently, the ADON again called and asked for hospice to return review hospice services again with R27 [on 12/14/21]. The hospice manager verified R27's POLST and hospice admission paperwork was sent to FM-A to sign due to his previous assessment of R27 being too confused to sign paperwork. A policy regarding guardianship and DPOA was requested, however, not provided.	F 552		
F 569 SS=B	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and	F 569		3/12/22

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F 569	Continued From page 6 (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure remaining personal fund account balances were distributed to the estate in a timely manner for 4 of 4 residents (R62, R63, R64, R60) reviewed who had been discharged and/or expired. Findings include: A provided Victory Health and Rehabilitation Center Funds Balance Report, printed 2/10/22, identified a list of all residents with open, active personal fund accounts with the nursing home. The listing included both currently admitted and discharged residents, and the list identified the following: R62 had a balance of $817.01 with dictation present reading, "01/05/2022 Admitted to Another Facility." R63 had a balance of $30.00 with dictation	F 569	F 569 R 62, R 63, R 64 and R 60 have all been discharged from the facility. Individual checks were issued to each of the receiving party and/or estate. From survey exit until present, resident funds were disbursed per facility policy. All discharged/deceased resident accounts were reviewed and reconciled. There is currently a zero balance. Future residents who expire or transfer to another facility, the resident funds will be disbursed in 30 days per facility policy. The Business Office Manager was in-serviced on the Refunds Policy and Procedure with focus on item #2 that upon discharge and/or resident death, resident funds will be issued within 30 days. Administrator and/or designee is responsible for compliance. Audits on resident fund issuance after discharge or death will begin weekly x 2	

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F 569	Continued From page 7 present reading, "12/09/2020 Discharge to Home." R64 had a balance of $419.00 with dictation present reading, "10/22/2021 Admitted to Another Facility." R60 had a balance of $769.03 with dictation present reading, "12/17/2021 Expired." On 2/10/22 at 12:40 p.m., the business office manager (BOM) was interviewed and explained the nursing home used a third-party company to help manage the resident fund accounts. BOM verified the accounts outlined for discharged or expired residents had positive balances which were still under the nursing home' third-party funds and control; however, was unable to provide more detail until she consulted with the third-party company. During subsequent interview on 2/10/22 at 2:47 p.m., BOM explained she had received notification from the third-party company and verified the funds had not been returned to paid back to the resident or their estates' thus far. BOM stated she just learned the funds should have been re-paid or distributed back within 30 days and voiced the nursing home would have to work with the third-party company to ensure timely distribution going forward. A corresponding electronic mail message (i.e., e-mail) was provided from the third-party company which outlined, "these [the accounts with remaining funds] are in the process of being closed, a check will be sent to the resident/financial rep [representative] asap [as soon as possible]."	F 569	weeks then monthly to ensure compliance. All audits will be reviewed by the Administrator and the Administrator will present the audit results to QAPI for review and recommendation.	

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F 569	Continued From page 8 A facility' policy on personal fund accounts and fund distribution upon death or discharge was requested, however, none was received.	F 569		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		3/12/22

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F 580	Continued From page 9 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to notify the medical provider and/or resident representative of a new wound or need to alter treatment due to the unavailability of a prescribed antibiotic for 2 of 3 residents (R55, R28) reviewed for change of condition. Findings include: Stage II pressure ulcer: partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissue is not visible. Granulation tissue, slough and eschar, are not present. R55's quarterly Minimum Data Set (MDS) dated 1/29/22, indicated R55 was severely cognitively impaired and lacked indication of any skin issues.	F 580	F 580 R 55 and R 28 both had risk management incidents created, the MD and family representative notified of new pressure injury, their response documented in the resident electronic medical record. R28 risk management was completed for delay in antibiotic therapy, the MD and family representative were notified. The care plans and treatments were reviewed and updated as needed for R27 and 28. All other residents were reviewed and there was no resident change in condition that warranted resident and/or family response. Future residents who experience pressure injuries, the MD and family representative will be notified, and their response will be recorded. Nursing staff will be in-serviced on Acute Change in Condition policy with emphasis on notifying the MD and resident	

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F 580	Continued From page 10 R55's care plan dated 5/24/21, indicated R55 had the potential to develop a pressure ulcer due to immobility and diagnoses. R55 goal was for their skin to be intact, free from redness, blisters, or discoloration. The care plan listed several interventions to help R55 meet their goal which including monitoring/documenting/reporting changes in skin status. A progress note dated 1/26/22, at 11:36 p.m. indicated R56 had, "a blister of size smaller than a dime was noted on the left buttock." R55's medical record was reviewed and lacked any evidence the newly developed area had been communicated to the physician despite the area being identified on 1/26/22. During interview on 2/10/22, at 10:06 a.m. licensed practical nurse (LPN)-E explained a clear, fluid-filled blister was noted on R55's coccyx area (1/26/22) and verified R55's representative, nor the doctor was notified of the skin alteration. On 2/10/22, at 10:10 a.m. R55's personal care was observed with nursing assistant (NA)-A and LPN-B. At this time, a Stage II pressure ulcer on R55's left buttocks was observed. The wound bed was pink and moist with a small amount of drainage. The Stage II pressure ulcer measured 0.5 centimeters (cm) x 1 cm. LPN-B verified the wound was a Stage II pressure ulcer. During interview on 2/10/22, at 10:25 a.m. the director of nursing (DON) stated the R55's representative and the physician should had been notified of the skin alteration to obtain a treatment	F 580	responsible parties of the resident change and recording the response in the resident electronic medical record. The Director of Nursing and/or designee will be responsible for compliance. Audits on acute change in condition notification will begin weekly x 2 weeks then monthly to ensure compliance. All audits will be reviewed by the Administrator and the Administrator will present the audit results to QAPI for review and recommendation.	

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F 580	Continued From page 11 order. R28's Admission Record printed 2/10/22, indicated he had diagnoses including cancer, cirrhosis (liver damage), dementia, and respiratory failure. R28's significant change Minimum Data Set (MDS) dated 12/21/21, indicated R28 was moderately cognitively impaired. R28's physician orders printed 2/10/22, indicated R28 had a toe infection to his right side and was prescribed cefuroxime axetil (antibiotic) 500 milligrams by mouth twice daily for 10 days starting on 1/18/22, at 8:00 p.m. Review of R28's Orders - Administration Notes revealed the following: - 1/18/22, at 8:10 p.m. the pharmacy could not deliver today (cefuroxime axetil) today due to billing reasons. The medication was to be delivered the following day. - 1/19/22, at 8:32 a.m. cefuroxime axetil was not available. - 1/19/22, at 7:50 p.m. cefuroxime axetil was not available. - 1/20/22, at 11:18 a.m. R28 was transferred to the hospital. Review of R28's medical record lacked evidence the facility notified the physician R28 did not receive and/or administer antibiotics as ordered 1/18/22, through 1/20/22. A progress note dated 1/20/22, at 1:34 p.m. indicated the facility received a call from the hospital informing them R28 was admitted due to cellulitis of the right leg.	F 580		

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F 580	Continued From page 12 During interview on 2/10/22, at 12:43 p.m. the director of nursing (DON) confirmed the facility did not administer R28's prescribed antibiotic. During interview on 2/10/22, at 3:23 p.m. nurse practitioner (NP)-C stated she was not informed R28's antibiotics were not administered. She expected facility staff to update her and it was unacceptable not do do so. The Change in a Resident's Condition or Status policy dated 2/2021, indicated, "The nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition."	F 580		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information	F 585		3/12/22

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F 585	Continued From page 13 on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F 585		

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F 585	Continued From page 14 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to make prompt efforts to resolve grievances for 6 of 6 residents (R158, R52, R59, R101, R102, and R3) reviewed for grievances.	F 585	F 585 R 158 was discharged from the facility. R 52 grievance was responded to 3/4 R 59 was discharged from the facility.	

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F 585	Continued From page 15 Findings include: Review of the facility Grievance Log revealed: - R158 voiced concerns related to infection control practices, pain management, and call light response times on 10/22/21. Follow-up was requested, however, not documented. - R52 voiced a concern related to call light response times on 10/25/21, and bathing preferences on 11/2/21. Follow-up was requested, but not documented. - R59 voiced a concern related to call light response times on 11/5/21. A corresponding Grievance Form dated 11/5/21, contained a summary of the concern, but did not include documentation of a complaint resolution. - R101 voiced a concern related to call light response times on 11/17/21. Follow-up was requested, but not documented. - R102 voiced a concern related to her roommate's disruptive behavior on 12/1/21. A corresponding Grievance Form dated 12/1/21, contained a summary of the concern, but did not include documentation of a complaint resolution. - R3 voiced a concern related to podiatry services and pain management on 12/12/21. A corresponding Grievance Form dated 12/13/21, contained a summary of the concern, but did not include documentation of a complaint resolution. During an interview on 2/9/22, at 12:44 p.m. the administrator stated all grievances should be reviewed during the daily interdisciplinary team (IDT) meeting. The assigned department head should address the concern and bring a completed Grievance Form with a documented resolution to the daily IDT meeting. The facility social worker was responsible for maintaining the	F 585	R 101 grievance was responded to 3/4 R 102 grievance was responded to on 3/4 R 3 grievance was responded to on 3/4 All other grievances from survey exit to present have been reviewed and resolved. Future grievance will be recorded, and resolution will be recorded per facility policy The IDT team will be in-serviced on the Grievance Policy with emphasis on providing resident resolution within 5 days of receipt of concern. Resident and/or family resolution will be recorded on the grievance form. Pending grievances that require more than the policy timeframe, the resident/representative will be notified, and their response will be recorded on the grievance form. The Social Services Director and/or designee will be responsible for compliance. Audits on timely grievance response will begin weekly x 4 weeks then monthly to ensure compliance. All audits will be reviewed by the Administrator and the Administrator will present the audit results to QAPI for review and recommendation.	

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F 585	Continued From page 16 completed Grievance Forms. The administrator added all grievances should have a resolution within 5-days of the verbalized concern. The administrator stated Grievance Forms for R158, R52, and R101 were "missing." Further, he did not know if the concerns in which R59, R102, and R3 were addressed/resolved. During an interview on 2/9/22, at 3:40 p.m. social worker (SW)-A stated all concerns voiced by residents should have investigative steps and a resolution documented on a Grievance Form. R158, R59, R101, and R102 had discharged and were unable to be interviewed. R52 was unavailable for interview and R3 refused to be interviewed. Facility policy titled Grievance/Complaints, Filing dated 2/14/21, directed, "The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative." "Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) workings days of receiving the grievance and/or complaint." "The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems." "The results of all grievances files [sic] investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision."	F 585		

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F 656	Continued From page 17	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		3/12/22

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F 656	Continued From page 18 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a comprehensive care plan was developed to reflect assessed and identified needs to promote continuity of care for 2 of 4 residents (R57, R17) reviewed for dental and oxygen use. Findings include: R57's quarterly Minimum Data Set (MDS), dated 2/2/22, identified R57 had moderate cognitive impairment, demonstrated no rejection of care behavior(s), and required extensive assistance to complete his personal hygiene needs. On 2/7/22 at 1:10 p.m., R57 was observed laying in bed in his room. R57 was interviewed and expressed he had sustained several falls which led to several chipped teeth. R57 stated he had discussed fixing them with the staff, however, no further action had been taken so far to get his teeth and hygiene care addressed. R57's Hennepin County Medical Center Nursing Home Visit - Progress Note, dated 10/26/21, identified R57 was seen at the nursing home after being hospitalized. The note included a section labeled, "Physical Exam," which outlined, "Poor dentition." Further, a section labeled, "Assessment and Plan," identified R57's various medical complications which included, "11. Broken teeth ... Oral surgery appointment was	F 656	F 656 R 57 care plan and group sheet was updated to include dental cares. R 57 will be placed on the list to be seen by the dentist. R 17 care plan for oxygen use was created and the group sheets was reviewed and updated as needed. R 17's MDS was modified to include oxygen use. Existing residents who utilize oxygen their care plans were reviewed and updated as needed. Existing residents who need dental services their care plan was reviewed, and appointments were scheduled as needed. Upon admission resident comprehensive care plans will be created per facility policy. Nursing staff was in-serviced on the Care Plan, Comprehensive policy with focus that the care plan is developed to address treatment concerns and appropriate interventions are initiated to enhance optimal resident functioning. The Director of Nursing and/or designee will be responsible for compliance. Audits on resident comprehensive care plan addressing areas of concern will begin weekly x 4 weeks then monthly to ensure compliance. All audits will be reviewed by the Administrator and the Administrator will present the audit results to QAPI for review and recommendation.	

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F 656	Continued From page 19 missed ... NH [nursing home] staff was asked to follow up to ensure appointment is rescheduled." When interviewed on 2/9/22 at 9:44 a.m., nursing assistant (NA)-C stated she routinely cared for R57 and provided morning cares to him, if he allowed them. NA-C explained R57 had several missing teeth and would often refuse oral cares with a toothbrush. So, as a result, NA-C stated she would just provide him some mouth wash adding, "I always make sure we use the mouthwash." NA-C stated she believed all staff were doing R57's oral care and hygiene in this manner adding, "they should [be]." However, R57's care plan, dated 2/9/21, lacked any identified problem statements, goal(s), or specific interventions for R57's oral hygiene or care despite having been identified as missing several teeth and often refusing oral care with a tooth brush resulting in the use of strictly mouth wash for hygiene. On 2/9/22 at 10:53 a.m., the acting director of nursing (DON) was interviewed and reviewed R57's care plan and medical record. The DON verified the care plan lacked any guidance or interventions for R57's oral hygiene or dentition and stated it "should be" added. The DON expressed he was unaware the staff were only using mouthwash to provide oral hygiene to R57. Further, the DON reviewed the pre-printed NA "assignment sheets" (used as a pocket reference for care guide) and verified it lacked information or interventions on R57's oral hygiene or dentition needs. The DON stated the care plan and assignment sheets should be updated with R57's dentition and oral hygiene interventions to help reduce the risk of bacteria growth in R57's mouth.	F 656		

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F 656	Continued From page 20 R17's admission Minimum Data Set (MDS) dated 12/3/21, indicated R17 was cognitively intact and had diagnoses of an acute fracture of the lower extremity and acute respiratory failure. R17 required assistance to support and balancing when walking. The MDS lacked indication of oxygen use. R17's hospital discharge orders dated 11/26/21, indicated R17 had oxygen at 2 liters (L) nasal cannula ordered at bedtime. R17's Order Summary Report dated 12/1/21, indicated R17 was non weight bearing on their right lower extremity. However, R17's care plan dated 12/2/21, and corresponding nursing assistant care sheet dated 1/14/22, lacked evidence of goal(s), or specific interventions related to R17's mobility and oxygen needs. During an interview on 2/9/22, at 10:23 a.m. nursing assistant (NA)-B stated she did not usually work with R17 and was unaware of any specific mobility needs R17 had. During an interview on 2/9/21, at 10:51 a.m. licensed practical nurse (LPN)-B stated R17's mobility was limited and R17 worked with therapy. LPN-B confirmed R17 was received oxygen when he was in bed, however, this was not addressed on R17's care plan. During an interview on 2/10/21, at 12:27 p.m. the director of nursing (DON) verified R17's care plan lacked indication of R17's oxygen needs and mobility. The DON stated the information needed	F 656		

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F 656	Continued From page 21 to be included on R17's care plan to ensure R17's needs were met. Facility policy titled Care Plan, Comprehensive Person-Centered revised 2016, indicated a comprehensive care plan that meets the resident's physical, psychosocial, and functional needs was developed for each resident.	F 656		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a do-no-resuscitate (DNR) order was accurately reflected throughout the medical record for 1 of 2 residents (R41) reviewed for advanced directives. This resulted in an immediate jeopardy (IJ) for R41 who would had received cardiopulmonary resuscitation (CPR), contrary to their wishes, in the absence of a pulse or respirations. The IJ began on 2/8/22, at 3:30 p.m. when R1's Provider Orders for Life-Sustaining Treatment (POLST) identified R41 had an active do-not-resuscitate order, however, the electronic health record (EHR) indicated R41's was to be administered CPR. The administrator was notified of the IJ at 3:30 p.m. on 2/8/22. The IJ was removed on 2/9/22, at 10:56 a.m. but non-compliance remained at the lower scope and	F 678	F 678 R 41 code status was updated to reflect POLST and the care plan reviewed and updated. Existing resident code status order, POLST and care plan for advanced directives were reviewed and updated as needed. Future residents will have their code status order and POLST will be reviewed upon admission, readmission, significant change, quarterly and as needed and will be matched against the medical record for accuracy. Nursing and IDT team members were in-serviced on the Advanced Directive Policy updated on 3/9/22 with emphasis on review of the resident code status, POLST and care plan upon admission, readmission, significant change, quarterly and as needed and that this information is	3/12/22

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F 678	Continued From page 22 severity level of D, isolated with no actual harm but potential to cause more than minimal harm. Findings include: R41's Admission Record printed 2/11/22, indicated R41 had diagnoses of heart failure, acute respiratory failure with hypoxia (low oxygen issues in the tissues), morbid obesity, cardiomyopathy (disease of the heart muscle), and obstructive sleep apnea. R41's significant change Minimum Data Set (MDS) dated 1/8/22, indicated R41 was cognitively intact. R41's physician orders reviewed on 2/7/22, at 4:10 p.m. included R41 was Full Code (CPR) dated 6/16/21. R41's care plan dated 7/13/21, indicated R41 was Full Code, with a goal of "Resident's Advanced Directives will be honored." Staff were directed to review R41's code status on a quarterly basis and as needed. R41's POLST signed by and R41 and the medical provider on 11/5/21, indicated DNR. R41's Care Conference Summary 1 - V2 dated 12/1/21 and 1/25/22, indicated R41's code status was Full Code. R41's Social Service Note dated 1/25/22, at 3:43 p.m. identified R41's code status was Full Code. During interview on 2/7/22, at 2:15 p.m. registered nurse (RN)-A stated both the EHR and paper chart would be reviewed (in the event a	F 678	matched to the medical record. The Social Services Director and/or designee will be responsible for compliance. Audits on resident code status, POLST and advanced directive care plan accuracy will begin 2x week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. All audits will be reviewed by the Administrator and the Administrator will present the audit results to QAPI for review and recommendation.	

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F 678	Continued From page 23 resident did not have a pulse or respirations). If the information did not match CPR would be initiated. During interview on 2/7/22, at 2:17 p.m. licensed practical nurse (LPN)-A stated in the event of cardiac arrest, both the EHR and paper chart would be reviewed. If a discrepancy existed CPR would be initiated. During interview on 2/7/22, at 2:18 p.m. LPN-B stated in the event of cardiac arrest, both the EHR and paper chart would be reviewed. If a discrepancy existed CPR would be initiated. R41's EHR banner observed on 2/7/22, at 4:10 p.m. indicated R41 was Full Code; athough R41's POLST identiifed DNR. During interview on 2/7/22 at 4:13 p.m. R41 confirmed his code status was DNR and he had signed the appropriate forms. During interview on 2/7/22, at 4:14 p.m. RN-B stated he reviewed the both EHR banner and the signed POLST in the paper chart to determine whether to provide CPR. If there was a discrepancy, he would initiate CPR. RN-B confirmed R41's EHR banner indicated Full Code and R41's POLST indicated DNR. RN-B stated the electronic documentation should have been changed when R41's new POLST was completed, or staff would perform CPR on him when he did not want it. During interview on 2/7/22, at 4:39 p.m. director of nursing (DON) verified the EHR indicated R41 was identified as Full Code, however, the signed POLST in the paper chart indicated R41 was	F 678		

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F 678	Continued From page 24 DNR. The DON stated the discrepancy existed for approximately three months and he would have treated R41 as a Full Code. He re-affirmed if there was any doubt he would "save the life." During interview on 2/8/22, at 8:51 a.m. director of social services (DSS) stated if a resident wanted to change a POLST she would meet with the provider, a nurse, and the resident (or resident representative), fill out the POLST, and have the resident (or representative) sign it. Once completed she gave a copy to the resident and placed the document in the paper chart. She communicated any changes in code status verbally at a daily team meeting, and a nurse or a social worker changed the care plan. She did not change the banner or the physician order in the EHR but thought nursing staff would change it right away. If she noticed a conflict, she would check with the nurse manager, but expected staff would proceed with a Full Code. During interview on 2/8/22, at 9:14 a.m. social worker (SW)-A stated she typically was not involved in the POLST process, however, recalled reviewing the POLST with R41 and, after he signed it, she gave it to the DON. She stated if the code status in the paper chart and the EHR didn't match she anticipated staff would have performed CPR because of the lack of clarity, but it would have been against R41's wishes. During interview on 2/8/22, at 10:25 a.m. administrator stated when the POLST was completed the order should have been changed in the EHR and the banner updated. He stated he did not know why R41's code status was not updated in the EHR, but when the physician placed the order, it should had been changed.	F 678		

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F 678	Continued From page 25 During interview on 2/8/22, at 11:49 a.m. physician (MD)-A stated code status must be addressed at each resident admission and re-admission, and he expected any change in status to be accurately communicated with staff. He stated the POLST must reflect the resident's choice, and staff must respect the resident's decision. He stated once a POLST was signed by the resident and the physician he gave it to the facility staff to put into the chart, and he considered the POLST a physician order. His expected staff to follow the orders on the paper copy of the POLST to ensure resident's wishes were respected. During interview on 2/8/22, at 1:38 p.m. R41 stated he changed his code status a few months ago after a visit with the provider, and the social worker at the time had him sign a form. He verified his understanding of DNR versus Full Code by stating DNR meant "if your heart stops, they make no attempt to get it going again, and full code is when they do what they can to get you going." He further stated he changed his code status because he "didn't want to have any chance of being brain damaged." The facility Advance Directives policy updated 1/9/19, indicated resident's code status would be obtained either verbally from the resident, hospital medical record or resident advanced directive documents. This information would be entered into the Electronic Medical Record for physician review and signature. Social Services reviews and updates the Advance Directives upon readmission and as needed but at least quarterly in conjunction with the plan of care. POLST information would be added to all resident charts	F 678		

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F 678	Continued From page 26 upon admission. The policy Emergency Procedure - Cardiopulmonary Resuscitation revised 2/2018, identified if the resident's DNR status was unclear, CPR would be initiated until it was determined that there was a DNR or a physician's order not to administer CPR. The IJ was removed on 2/9/22, at 10:56 a.m. when the facility developed and implemented a systemic removal plan which was verified by interview and document review. - All residents records were reviewed to ensure the electronic banner, physician orders, and advance directive care plans reflected the most current POLST and orders on 2/9/22. - Seven LPNs and five RNs were educated on POLST completion, order entry and facility policy on 2/8/22, as evidenced by the Education Sign In Sheet. - A process was implemented to ensure all other nurses completed mandatory education prior to the start of their next shift on 2/8/22, which included notification of required mandatory education via signage at the time clock and via phone/text. - On 2/9/22, LPN-A, LPN-B, DON, and DSS were interviewed and verified they received education regarding POLST completion, order entry, and policy. - The policy for advanced directives was reviewed and updated to include the POLST will be reviewed upon admit, quarterly, and with change in condition by the IDT (interdisciplinary team) and matched against the medical record for accuracy.	F 678		
F 684 SS=G	Quality of Care	F 684		3/12/22

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F 684	Continued From page 27 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, an document review, the facility failed to comprehensively assess/reassess a newly identified wound and implement antibiotic therapy as ordered by the physician for 1 of 1 resident (R28) reviewed for hospitalizations. This resulted in actual harm for R28 who was hospitalized for worsening cellulitis and required intravenous (IV) antibiotics. Findings include: R28's Admission Record printed 2/10/22, indicated R28 had diagnoses which included cancer, cirrhosis (liver damage), and dementia. R28's significant change Minimum Data Set (MDS) dated 12/21/21, indicated R28 was moderately cognitively impaired, independent with transfers, and required extensive assistance of one staff with dressing and personal hygiene. The MDS indicated R28 did not have a history of refusing cares. R28's care plan dated 2/4/22, indicated he had the potential for impaired skin integrity.	F 684	F 684 R 28 had a risk management incident created and thoroughly investigated for root cause along with a new wound assessment, skin care plan review, review of wound treatment orders and the MDS reviewed for pressure injury accuracy. R 28 s MD was notified that the oral antibiotic medication was not administered as ordered and the wound was not relayed to the MD. The MD s response will be recorded in the resident s electronic medical record. Existing resident who have wounds, their wound assessments, orders and care plans were reviewed and updated as needed. Existing resident orders whether verbal/telephone/prescriber written from survey exit until present will be reviewed and updated as needed. Future residents who require treatment, orders will be obtained from the MD and implemented per facility policy. Nursing staff were in-serviced on Medication Treatment Order policy with emphasis of recording orders into the	

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F 684	Continued From page 28	F 684		

A Weekly Skin Check dated 12/29/21, lacked any indication of open areas on R28's skin. Subsequently, the electronic health record (EHR) lacked documentation of R28's Weekly Skin Check which was scheduled for 1/6/22.

Review of R28's Progress Notes included the following:
- 1/13/22, at 1:01 a.m. R28, "sent himself to the hospital" at 8:00 p.m. on 1/12/22 to request pain medication.
- 1/13/22, at 2:43 a.m. licensed practical nurse (LPN)-F documented R28 returned from the hospital with an antibiotic order. Corresponding Hospital Discharge Instructions dated 1/12/22, at 11:02 p.m. directed R28 to take cefuroxime axetil (Ceftin; an antibiotic) 500 milligrams (mg) tablet, 1 tablet by mouth 2 times daily for 10 days for a toe infection on his right foot. Further, R28 was to seek medical care if his pain or swelling for the infection did not improve within 2 days.

R28's Weekly Skin Check dated 1/13/22, identified R28 had intact skin, no open areas, and no new skin concerns despite previously being diagnosed with a toe infection on 1/13/22.

R28's physician orders received on 1/18/22, at 3:00 p.m. (five days after the initial order after a facility initiated call to the provider) indicated R28 had a toe infection of the right leg. Staff were instructed to clean the wound with wound cleanser, apply an absorbent dressing, and change the dressing twice daily. The orders also indicated R28 was prescribed Ceftin 500 mg by mouth twice daily for 10 days starting on 1/18/22, at 8:00 p.m. for the toe infection.

Review of R28's Medication Administration

Provider's Plan of Correction (F 684, continued):

resident medical record when received and on the Pressure Injury Skin Breakdown Policy with emphasis of notifying the physician for new areas of skin breakdown and completion of weekly skin assessments.
The Director of Nursing and/or designee will be responsible for compliance.
Audits on timely notification to the MD on treatment delays and new pressure injuries and resident order implementation will begin 2x week x 2 weeks, weekly x 4 weeks then monthly to ensure compliance.
All audits will be reviewed by the Administrator and the Administrator will present the audit results to QAPI for review and recommendation.

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F 684	Continued From page 29	F 684		

Record dated 1/1/22, through 1/31/22, lacked evidence Ceftin was administered after hospital discharge on 1/13/22.

Subsequent review of R28's Progress Notes revealed:
- 1/18/22, 8:10 p.m. the pharmacy could not deliver today (Ceftin) for billing reasons. Medication was coming tomorrow and the doses would be rescheduled.
- 1/19/22, at 8:32 a.m. and 7:50 p.m. indicated Ceftin was not available.
- 1/20/22, at 11:18 a.m. R28 was transferred to the hospital.
- 1/20/22, at 1:34 p.m. the facility received a call from the hospital and was informed R28 was admitted for cellulitis of the right leg.
- 1/21/22, at 9:40 a.m. R28 remained in the hospital and received IV antibiotics.
- 1/22/22, at 9:37 p.m. R28 was readmitted to the facility.

R28's medical record lacked indication R28's physician was notified Ceftin was not administered as ordered.

A Hospital Interagency Transfer Form dated 1/22/22, indicated R28 was prescribed Ceftin for outpatient antibiotic therapy to treat an ulcer on his right second toe during a previous visit on 1/12/22, and had "recently failed outpatient antibiotic therapy." During admission on 1/20/22, R28 was found to have an ulcer over his right second toe with discharging puss, swelling, and redness which extended up his right ankle.

R28's electronic health record (EHR) lacked documentation of R28's wound from 1/13/21 (when R28 initially returned from the hospital)

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F 684	Continued From page 30 until 1/30/22 when a Weekly Skin Check identified R28 had an open area to his right second toe. The Weekly Skin Check lacked measurements and wound characteristics. Subsequently, a Weekly Skin Check dated 2/5/22, identified R28's right toe continued to be slightly red and swollen with an open area which measured 0.5 centimeters (cm) by 0.7 cm, however, additional wound characteristics were not documented. During interview on 2/7/22, at 1:04 p.m. R28 stated he was in the hospital two to three weeks ago for a sore on his foot due to an ill-fitting shoe. He stated he had a "little nick" on his right second toe which kept getting bigger. The swelling increased to four inches above his ankle. R28 stated he was placed on IV antibiotics at the hospital and was observed to be wearing a walking boot on his right foot. During an observation on 2/10/22, at 10:40 a.m. R28's right second toe was red, swollen, had had multiple shallow scabs with flaky skin over the top surface. During interview on 2/10/22, at 10:45 a.m. registered nurse (RN)-A stated skin checks were completed weekly with showers and all skin issues were documented. He stated staff may not have documented R28's wound because he had orders for it to be cleaned and only new skin concerns were documented during weekly skin checks. If a new wound was found, staff completed a risk management form, assessed the wound, and reported it to the nurse practitioner (NP). The NP then assessed the wound or referred the resident to the wound nurse. Whenever staff completed a dressing	F 684		

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F 684	Continued From page 31 change drainage and wound characteristics should be documented. He stated it was important to document skin assessments to show the progress of each wound and whether interventions were successful or if additional interventions were required. During interview on 2/10/22, at 12:43 p.m. the director of nursing (DON) stated R28 went to the hospital on 1/12/22, for a toe issue and returned very early in the morning on 1/13/22. He stated there was a "breakdown" upon R28's return (1/13/22) and the nurse should had faxed R28's antibiotic order to the pharmacy and the medication would had arrived to the facility within the day. Due to the "lapse" R28 did not receive his medication. The DON confirmed the facility did not administer any antibiotics from 1/13/22, through R28's hospital admission on 1/20/22. The DON stated the antibiotic would had been helpful to stop the progression of the infectious process. Further, nurses should had evaluated the wound when doing dressing changes and he expected to see wound assessment documentation to follow the wound progression. The DON verified R28's medical record lacked wound documentation. During an interview on 2/10/22, at 3:23 p.m. nurse practitioner (NP)-C reviewed R28's EHR and stated the facility called the nurse line on 1/18/22, to request an order for an antibiotic to treat R28's toe which was described as red, inflamed, warm, and had discharge. The on-call provider instructed the facility to check on R28's antibiotic order from the emergency department on 1/12/22. The facility stated they were unable to locate R28's antibiotic order. The on-call provider then gave the facility another order for Ceftin and wound treatment. She stated the expectation was	F 684		

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F 684	Continued From page 32 for the facility to assess a wound and update the provider and it was unacceptable not to do so. NP-C also stated she was not informed R28's antibiotic was not started on 1/18/22 (second order provided) and the hospitalization could had been avoided had R28 not gone eight days without being administered the antibiotic. During an interview on 2/10/22, at 4:21 p.m. the administrator agree had R28 received the prescribed antibiotic, as ordered, on 1/12/22, he likely would had avoided hospitalization. On 2/10/22, at 9.32 a.m. and 12:29 p.m. a telephone interview with LPN-F, who documented receiving the antibiotic order on 1/13/22, was attempted and message left. No return call was received. Facility policy titled Pressure Ulcers/Skin Breakdown - Clinical Protocol dated 4/18, indicated the nurse shall described and document/report a full assessment of pressure sores including location, stage, length, width, and depth, presence of exudates (drainage), or necrotic tissue.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		3/12/22

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F 686	Continued From page 33 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and implement timely interventions to promote healing and reduce the risk of complications for a newly developed State II pressure ulcer for 1 of 3 residents (R55) reviewed for pressure ulcers. Findings include: Stage II pressure ulcer: partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissue is not visible. Granulation tissue, slough and eschar, are not present. R55's quarterly Minimum Data Set (MDS) dated 1/29/22, indicated R55 was severely cognitively impaired and required extensive assistance of one staff for bed mobility and toileting. The MDS lacked indication of any skin issues. R55's care plan dated 5/24/21, indicated R55 had the potential to develop a pressure ulcer due to immobility and diagnoses. R55 had a goal of maintaining intact skin, being free from redness, blisters, and discoloration. The care plan identified several interventions to help R55 meet the goal which included monitoring/documenting/reporting changes in	F 686	F 686 R 55 had a new weekly skin measurement completed, a risk management incident initiated and investigated, the care plan updated and treatment orders reviewed and updated as needed. Existing residents who have wounds orders, weekly assessments and care plan was reviewed and updated as needed. Future residents, the MD will be notified of new skin concern and treatment orders received and implemented per order. Nursing staff were in-serviced the Pressure Injury Skin Breakdown Policy with emphasis of notifying the physician for new areas of skin breakdown and accurately documenting the size, location, presence of exudate or necrotic tissue and completion of the wound assessment weekly. The Director of Nursing and/or designee will be responsible for compliance. Audits on notification to the MD of new pressure injuries and completion of weekly wound assessments will begin 2x week x 2 weeks, weekly x 4 weeks then monthly to ensure compliance. All audits will be reviewed by the Administrator and the Administrator will present the audit results to QAPI for review and recommendation.	

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F 686	Continued From page 34	F 686		

skin status. The care plan lacked indication of any active skin conditions.

R55's progress notes dated 1/26/22, at 11:36 p.m. indicated, "a blister of size smaller than a dime was noted on the left buttock." Despite documentation of the skin condition, R55's most recent Weekly Skin Check dated 2/5/22, indicated R55's skin was intact.

R55's medical record was reviewed and lacked evidence treatment orders had been sought or a comprehensive wound assessment/reassessment was completed for the wound identified on 1/26/22.

During interview on 2/10/22, at 10:06 a.m. licensed practical nurse (LPN)-E explained a clear, fluid-filled blister was noted on R55's left coccyx area. LPN-E verified R55's treatment was not sought for the newly identified skin condition.

On 2/10/22, at 10:10 a.m. R55's personal care was observed with nursing assistant (NA)-A and LPN-B. At this time, a Stage II pressure ulcer was seen on R55's left buttock. The wound bed was pink and moist with a small amount of sanguineous drainage. The wound measured 0.5 centimeters x 1 cm. LPN-B verified the open area was a State II pressure ulcer.

During interview on 2/10/22, at 10:25 a.m. the director of nursing (DON) stated the LPN should document the size and characteristics of a wound on the wound assessment form in the electronic medical record (EMR). The DON verified facility protocol was not implemented for R55's skin condition.

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F 686	Continued From page 35 A provided Pressure Ulcers/Skin Breakdown Clinical Protocol dated April 2018, indicated,"The nurse shall describe and document/report the following: 1. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue 2. Pain assessment 3. Resident's mobility status 4. Current treatments, including support surfaces 5. All active diagnoses	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to perform a comprehensive root cause analysis which identified individualized risk factors to reduce the likelihood of subsequent falls for 1 of 1 resident (R56) reviewed for accidents. Findings include: R56's Admission Record indicated he had diagnoses of cirrhosis (liver damage) and diabetes. R56's admission Minimum Data Set (MDS) dated	F 689	F 689 R 56 fall incidents from 1/29 until present were all reviewed, a root cause identified, a new fall and pain assessment created, and the care plan updated to reflect R 56's status and current fall interventions. Existing residents from survey exit until present, their fall assessment and care plan interventions were reviewed and updated as needed. Future resident falls, a risk management incident will be created, thoroughly investigated and the fall care plan interventions initiated. IDT and the nursing staff will be	3/12/22

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F 689	Continued From page 36 12/27/21, indicated R56 required supervision with transfers, ambulation, toilet use, and personal hygiene. R56 was not steady when turning around or when facing the opposite direction while walking. R56's Falls Care Area Assessment (CAA) dated 1/5/22, indicated R56 was unsteady when walking and turning the opposite direction, but able to stabilize. A subsequent Falls CAA dated 2/2/22, identified R56 received narcotic, anti-anxiety, and insulin which could lead to weakness and unsteadiness. The CAA directed to review the care plan for corresponding interventions. Review of R56's progress notes revealed: - On 1/14/22, at 12:00 a.m. staff met R56 sitting by the west unit medication cart. It was noted R56's left knee and the right side of his lower leg was bleeding. R56 indicated he slipped on the slippery ground in the smoking area and fell on his stomach. R56 sustained a bruise and minor skin break to the right side of his lower leg. - 1/29/22, at 10:33 p.m. R56 was feeling weak, tripped, and fell backwards as he was walking. He leaned on the wall near the social workers office. Bleeding was noted to R56's right knee. - 2/9/22, at 4:22 p.m. R56 stated he fell outside at 7:00 a.m. when he went outside to smoke. The fall was unwitnessed and no injury was noted. Review of R56's care plan dated 12/20/21, indicated R56 was at low risk for falls with a documented goal of, "Resident will be free of falls through the review date." Despite R56's falls on 1/14/22 and 1/29/22, R56's care plan was not reviewed and/or updated until 2/10/22. During an interview on 2/7/22, at 12:08 p.m. R56	F 689	in-serviced on Assessing Falls and Causes policy with emphasis on identifying root cause and patterns along with effective interventions. The Director of Nursing and/or designee will be responsible for compliance. Audits on root cause analysis and fall interventions will begin 2x a week for 2 weeks, then 1x a week x 4 weeks then monthly to ensure compliance. All audits will be reviewed by the Administrator and the Administrator will present the audit results to QAPI for review and recommendation	

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F 689	Continued From page 37 stated a few weeks ago, he went outside to have a cigarette and fell in the smoking area. R56 stated staff did not put salt down and his feet came out from under him. During interview on 2/9/22, at 1:28 p.m. R56 stated he did not take pain medications at the time of his first fall (1/14/22) and did not feel medications impacted his balance. R56 stated he did not feel the staff salted the sidewalks or patios at the facility. R56 stated he, "fell outside today" because he was unable to see ice on the sidewalk in front of the building. During interview on 2/10/22, at 11:24 a.m. registered nurse (RN)-A stated staff opened a risk management form, called the nurse practitioner (NP), informed the supervisor, and updated family when a resident fell. A root cause analysis was conducted for every fall to determine why it happened and to populate appropriate interventions to prevent the fall from happening again. RN-A reviewed R56's electronic health record (EHR) and confirmed there were no additional interventions identified after R56's falls on 1/14/22 and 1/29/22. A fall demanded a risk assessment every time and no risk assessments completed after each of R56's falls. During interview on 2/10/22, at 12:43 p.m. the director of nursing (DON) stated when a resident fell, staff conducted an assessment, updated the provider, completed a risk management form, and updated the care plan to prevent re-occurrence. The DON stated R56 went outside to smoke wearing slippers and fell on icy concrete. After the fall, staff put salt out on the concrete on the patio area. The DON reaffirmed there should had been an updated care plan for	F 689		

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F 689	Continued From page 38 every fall R56 had and verified there were no new interventions added to R56's care plan after falls on 1/14/22 and 1/29/22. During interview on 2/10/22, at 4:09 p.m. the administrator stated all falls were reviewed during the morning clinical standup meeting. A root cause analysis was completed and interventions were added to the care plan. The administrator stated R56 did not have an unsteady gait and the cause of R56's falls was related to too much medication. Review of R56's EHR lacked Fall Incident Reports / Root Cause Analysis for falls on 1/14/22 and 1/29/22. Facility policy titled Falls and Fall Risk, Managing dated 3/18, identified staff, with input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. Further, the policy identified if falling occurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.	F 689		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 744	F 744	3/12/22

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F 744	Continued From page 39	F 744		

review, the facility failed to comprehensively reassess and develop individualized interventions to address exhibited behaviors of dementia for 1 of 1 resident (R35) who had soiled nails and refused hygiene assistance.

Findings include:

R35's quarterly Minimum Data Set (MDS) dated 1/3/22, indicated R35 had a severe cognitive impairment, had no physical or verbal behaviors, and no refusal of cares. The MDS further indicated R35 required extensive assistance with personal hygiene and bathing. R35's diagnoses included Alzheimer's disease with early onset and dementia with behavioral disturbance.

R35's care plan updated 1/19/22 indicated, R35 had behaviors of crawling/laying on the floor, self-transferring and disrobing in the bedroom/public places. Also, R35 was noted to smear stool on the walls and his clothing. R35 was noted to refuse cares, including, but not limited to, personal hygiene, nail care, repositioning, grooming, and bathing. Staff were to monitor behavioral episodes and attempt to determine underlying causes when considering the location, time of day, persons involved, and situations.

Despite the facility having recognized R35 had ongoing refusals of care, R35's medical record lacked indication of a comprehensive reassessment and attempts to develop individualized dementia care interventions to promote hygiene.

Review of R35's Weekly Skin Checks dated 1/9/22, 1/15/22, 1/22/22, and 2/5/22, included

R 35 received and continues to have nail care, podiatry and hygiene assistance performed as resident allows. R 35 will be re-approached for care and refusals will be documented. R 35's dementia care plan was reviewed, and interventions updated as needed. Existing residents with dementia, their care plan was reviewed, and care interventions updated as needed.
The IDT team was in-serviced on the Dementia-Clinical Protocol policy with emphasis on identifying and creating interventions that will maximize the resident overall quality of life.
The Director of Nursing and/or designee will be responsible for compliance.
Audits on dementia behavioral interventions and effectiveness will begin weekly x 4 weeks then monthly to ensure compliance.
All audits will be reviewed by the Administrator and the Administrator will present the audit results to QAPI for review and recommendation.

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F 744	Continued From page 40 R35's fingernails and toenails needed trimming. On 2/7/22, at 5:36 p.m. R35 was observed lying in bed. R35's fingernails were long with a moderate amount of dried dark brown matter both underneath and on top of his nails. On 2/8/22, at 2:55 p.m. R35 was observed laying in bed. R25's fingernails remained long with a moderate amount of dried dark brown matter underneath and on top of his nails. During an interview on 2/8/22, at 4:08 p.m. R35's family member (FM)-A stated R35 dug in his soiled incontinence product which left his nails very dirty. FM-A stated she knew R35 did not like having his nails cut, but felt the facility could try other ways to address the situation rather than leaving his nails dirty. FM-B was also interviewed at this time and stated she felt the facility could try different intervention to attempt getting R35's nails clean. FM-B was not aware of any behavioral interventions attempted to assist R35 with nail care. During an interview on 2/9/22 at 8:43 a.m. hospice registered nurse, (RN)-D stated she was unaware of any behavioral interventions related to R35's nail care. RN-D observed R35's nails and stated, "Those nails are gross. I think he is scratching himself. These need to be soaked." At 8:47 a.m. RN-D stated R35 "refused" to have his nails cut. RN-D stated she did not attempt any behavioral interventions, but added, "If he was in a bathtub, they could soak." During an interview on 2/9/22, at 10:56 a.m. social worker (SW)-A stated she knew R35 had severely impaired cognition, but was unaware of	F 744		

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F 744	Continued From page 41 any behaviors the resident displayed. SW-A was not aware R35 was resistive to care or assistance from staff. SW-A stated if R35 was resistive, staff could attempt to approach him in a different way. During an interview on 2/9/22, at 11:14 a.m. the director of nursing (DON) stated when a resident resisted care staff should re-approach. Staff should offer care in different ways, use calm words, and try to make the resident feel calm. The DON added it could be helpful to have a different staff member attempt to talk with a resident. If the interventions were not successful, the nurse should document in the medical record the care was refused and what interventions were attempted. If a resident had ongoing refusals of care, it should be reported to nursing supervisors to see how they could help with the situation. The DON was not aware of any ongoing refusals of care from R35, however, was aware R35 could be combative at times. When R35 was in a friendly mood, staff could be successful in completing his cares. Facility policy titled Dementia - Clinical Protocol revised 11/18, included, "For the individual with confirmed dementia, the IDT [interdisciplinary team] with identify a resident-centered care plan to maximize remaining function and quality of life." "The IDT will adjust interventions and the overall plan depending on the individual's response to those interventions, progression of dementia, development of new acute medical conditions, changes in resident or family wishes, and other relevant factors."	F 744		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		3/12/22

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F 758	Continued From page 42 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their	F 758		

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	245544	A. BUILDING ______ B. WING ______	C 02/10/2022

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F 758	Continued From page 43 rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure adequate medical justification was provided or a gradual dose reduction (GDR) was attempted for consumed antidepressant medication for 1 of 5 residents (R57) reviewed for unnecessary medication use. Further, the facility failed to ensure orders for as needed (PRN) antianxiety medication were clarified, or ceased after 14 days, for 1 of 5 residents (R17) reviewed. Findings include: R57's quarterly Minimum Data Set (MDS), dated 2/22/22, identified R57 had moderate cognitive impairment and required extensive assistance to complete most activities of daily living (ADLs). Further, the MDS outlined R57 scored a "03" on the completed PHQ-9 screening and consumed antidepressant medication on a daily basis during the look-behind period. R57's printed Clinical Physician Orders, printed 2/10/22, identified R57's physician-ordered medications being provided by the nursing home. This included duloxetine (an antidepressant medication) 60 milligrams (mg) on a daily basis at bedtime. The report listed a start date of the medication as 12/28/21 (the last	F 758	F 758 R 57 s pharmacist will be contacted to generate a gradual dose reduction recommendation and will implement and/or initiate a gradual dose reduction based on the MD s response. Pharmacist recommendations from survey exit until present for residents who require a gradual dose attempt, the recommendation was sent to the MD and the MD response to attempt a gradual dose reduction was noted and implemented. R 17 s physician was contacted and the PRN order for diazepam and hydoxzine for 3 months were renewed for 3 months . Existing residents PRN anti-anxiety/anti-psychotic orders were reviewed and updated as needed. Future residents will have an automatic 14 day stop date initiated for antipsychotics and antianxiety medications unless otherwise indicated by the MD. The IDT team and nursing staff were in-serviced on the Psychotropic Use Policy and procedure with emphasis on attempts to reduce psychotropic medications should occur in 2 separate quarters unless contraindicated and PRN	

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F 758 Continued From page 44

post-hospitalization readmission). However, R57's Extended Care Nursing Home Visit note, dated 11/17/21, identified R57 reported "his self perceived state of health is terrible," and was "difficult to engage in conversation," per the physician. This note listed R57's medications which included duloxetine, however, the listed start date was 7/2018.

R57's medical record was reviewed and lacked any physician's medical justification within the past calendar year supporting the ongoing use of R57's psychotropic medication consumption or rationale why a gradual dose reduction (GDR) was not attempted and/or considered.

On 2/9/22 at 1:30 p.m., the assistant director of nursing (ADON) stated she had reviewed R57's medical record and was unable to provide any supporting documentation from R57's physician addressing the lack of GDR for R57's consumed duloxetine. R57 started the medication in 2020 and had continued on the same dosing since then with no recorded GDR(s) being attempted. ADON verified the medical record should contain "their [physician] clinical rationale" or justification for the ongoing use of the medication adding, "They just have to have one [justification]."

An undated Gradual Dose Reduction policy directed, "A [GDR] should be attempted after the resident has been in the facility or after a newly initiated psychotropic medication has been in use for one year. The GDR attempts should occur in 2 separate quarters unless there is documentation from the MD [medical doctor] that the GDR is contraindicated."

R17's admission Minimum Data Set (MDS) dated

F 758

medications will have an automatic stop date initiated unless otherwise specified by the physician. For orders beyond the 14 day stop date, the physician rationale along with the updated order will be sent to the pharmacy for processing.
The Director of Nursing and/or designee will be responsible for compliance.
Audits on Gradual Dose Reduction attempts and PRN stop dates will begin weekly x 4 weeks then monthly to ensure compliance.
All audits will be reviewed by the Administrator and the Administrator will present the audit results to QAPI for review and recommendation.

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F 758	Continued From page 45	F 758		

12/3/21, indicated R17 was cognitively intact and had diagnoses of an acute fracture of the lower extremity and acute respiratory failure.

R17's provider orders dated 11/29/21, indicated R17 had an order for diazepam (medication to treat anxiety) 5 milligrams (mg), give one tablet every 12 hours as needed (PRN) for anxiety. Further, a subsequent provider order dated 12/17/21, indicated R17 had an order for hydroxyzine (medication to treat anxiety) 25 mg, give one tablet every 8 hours PRN for anxiety. Neither medication had a stop date, duration identified, or parameters when each medication should be administered.

Review of R17's Medication Administration Record (MAR) dated 1/1/22 through 2/9/22, indicated R17 was administered hydroxyzie 31 times and diazepam 21 times.

A progress note dated 12/23/21, at 9:55 p.m. indicated a medication regimen review (MRR) was completed by the pharmacist and had accompanying recommendations, however, the recommendations were not documented within the progress note. R17's corresponding MRR was requested, however, was not provided by the facility.

Review of R17's medical record lacked indication R17 had been evaluated by the attending physician and a documented rational for use of a PRN of a psychotropic drug beyond 14 days.

During an interview on 2/10/22, at 2:01 p.m. the director of nursing (DON) verified R17's PRN diazepam and hydroxine orders did not have an end date and R17 received both medications for

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F 758	Continued From page 46 anxiety. During an interview on 2/11/22, at 12:05 p.m. the consultant pharmacist stated R17's December MRR requested end dates (for PRN diazepam and hydroxine) and also to review the prescribed hydroxyzine and diazepam for polypharmacy (simultaneous use of multiple drugs to treat a single ailment). A response to the December MRR was not received, hence, the same request for review was repeated on R17's January MRR. The process was important to ensure residents did not have duplicate therapy. Further, having two medications for the same indication could happen, however, there needed to be further directions on what medication should given for mild or severe anxiety. Facility policy titled Medication Therapy revised 4/07, indicated the consultant pharmacist shall review each resident's medication regimen monthly and collaborate to address issues of medication prescribing and monitoring.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		3/12/22

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F 761	Continued From page 47 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to secure 3 of 4 medication carts observed for medication storage. This had the potential to affect all residents who could access unsecured medications. Findings include: On 2/7/22, at 11:49 a.m. a medication cart was observed unlocked and unattended in the East Hallway. The medication cart was located outside of the nurses' station and out of view of staff. Registered nurse (RN)-A returned to the medication cart at 11:52 a.m. and stated it was not common practice to leave a medication cart unlocked, however, he went to provide a resident food. Two unidentified residents passed by the unlocked medication cart prior to RN-A's arrival. On 2/7/22, at 1:57 p.m. a medication cart was observed unlocked and unattended at the far end of the South Hallway. At 1:59 p.m., trained medication aide (TMA)-A returned to the	F 761	F 761 When identified during survey, the resident carts were locked by the nursing staff. No ill effects were experienced by this deficient practice. Future medication pass times, the cart will be locked when the nurse leaves the cart unattended. Nursing staff were in-serviced on the Storage of Medication policy with emphasis on item #7 that the medication cart must be locked when unattended by staff. The Director of Nursing and/or designee will be responsible for compliance. Audits on locked medication carts will begin weekly x 4 weeks then monthly to ensure compliance. All audits will be reviewed by the Administrator and the Administrator will present the audit results to QAPI for review and recommendation.	

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F 761	Continued From page 48 medication cart and stated she stepped away to provide a resident medications. She stated it was important to keep the medication cart locked to prevent residents from accessing medications in the cart. TMA-A stated there were no residents in the hallway when she left. One unidentified resident was observed in the hallway prior to TMA-A's return to the medication cart. On 2/10/22, at 7:18 a.m. a medication cart was observed unlocked and unattended in the middle of the North Hallway. Upon return at 7:20 a.m., licensed practical nurse (LPN)-A stated she stepped away from the medication cart to look for something, but acknowledged she should had locked the medication cart when she left. One unidentified resident was observed ambulating in the hallway. During an interview on 2/10/22, at 12:43 p.m. the director of nursing (DON) stated medication carts must be locked when unattended as residents often pass by and could open the cart and take medications. Facility policy titled Storage of Medication revised 11/20, identified compartments (including, but not limited to, drawers, cabinets, room, refrigerators, cart, and boxes) containing drugs and biological's were locked when not in use. Unlocked medication carts were not to be left unattended.	F 761		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in	F 773		3/12/22

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F 773	Continued From page 49 accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain a urine specimen timely and promptly notify the ordering physician of results for 1 of 1 residents (R12) who was diagnosed with a urinary tract infection. Findings include: R12's Admission Record dated 2/10/22, indicated R12 had a history of being diagnosed with a UTI. R12's annual Minimum Data Set (MDS) dated 8/24/21, indicated R12 had intact cognition and was always incontinent of bladder. R12's care plan dated 2/10/21, directed staff to, "Report pertinent lab results to MD [medical doctor]." A progress note dated 11/24/21, at 3:27 p.m. indicated urinalysis and urine culture (UA/UC) was not collected. Afternoon shift was informed to collect the sample. A subsequent progress note dated 11/25/21, at 12:47 p.m. indicated a UA/UC sample which was collected was contaminated. R12's primary care provider (PCP) was notified as R12 did not have symptoms and requested correspondence as to whether the specimen	F 773	F 773 R 12 MD was notified that the lab report results were not reported timely. The MD response will be recorded in the resident medical record. R 12 was treated with antibiotic therapy as ordered. Existing resident lab orders from survey exit until present were reviewed and orders updated as needed. Future resident lab orders will be initiated and sample collections that are not obtained, the physician will be notified, and orders executed. The nursing staff was in-serviced on the Lab and Diagnostic Test Result policy with focus on obtaining the lab specimen and notifying the MD of the lab results. The Director of Nursing and/or designee will be responsible for compliance. Audits on lab specimen collection and lab result reporting to the MD will begin weekly x 4 weeks then monthly to ensure compliance. All audits will be reviewed by the Administrator and the Administrator will present the audit results to QAPI for review and recommendation.	

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needed to be obtained.

A faxed physicians order dated 11/26/22, indicated nurse practitioner (NP)-B wrote an order for a UA/UC to be collected for R12. The document was initialed by facility staff and indicated "noted" on 11/27/21.

A progress note dated 12/2/21, at 4:21 a.m., six days after NP-B's order was provided, indicated R12 was not cooperative during the shift to produce a UA/UC. The oncoming shift was to be updated.

A subsequent faxed physicians order dated 12/3/21, indicated NP-B wrote an order which included, "THIRD REQUEST." Additionally, "UA/UC ordered 11/18/21 and 11/26/21" and no results were available. The facility was to contact the lab to obtain results or re-order the test if it was not completed. Further, if R12 refused the test a faxed refusal was requested. A hand written note which indicated "to be followed up on Monday [12/4/21]" was documented on the fax.

An additional faxed physicians order dated 12/17/21, indicated NP-B wrote an order which included, "FOURTH REQUEST, URGENT." Additionally, "UA/UC ordered 11/18/21, 11/26/21, and 12/3/21" and no results were available. The facility was to contact the lab to obtain results or re-order the test if it was not completed and R12 was "still having symptoms of a UTI." A hand written note which indicated "Noted, sample collected today." This was 29 days after the initial sample was requested.

R12's December 2021 Medication Administration Record (MAR) indicated R21 was prescribed

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F 773	Continued From page 51 Ciprofloxacin (antibiotic) 250 milligrams (mg) every 12 hours for 3 days for a UTI. Subsequent review of R12's progress notes indicated: - 1/27/22, at 2:42 p.m. R12 was noted to be screaming when attempting to urinate. The nurse practitioner was notified and a UA/UC was ordered. - 1/28/22, 10:32 p.m. R12 was noted to be unable to urinate and experienced pain when attempting to do so. An order was obtained to perform a strait catheterization. A urine sample was obtained at 7:30 p.m. and the lab was called to pick up the sample as soon as possible. No "agent" was able to take the call and two messages were left. - 2/12/22, at 10:53 p.m. R12 was placed on an antibiotic for a UTI for seven days. During an interview on 2/9/22, at 1:05 p.m. NP-A stated a UA/UC was ordered for for R12 on 12/3/21, which was the third request for the lab to be completed, however, there was no response from the facility. The NP was notified the UA was positive on 12/16/21, and an order for Ciprofloxacin was prescribed. NP-A stated a culture sensitivity report (checks to see what kind of antibiotic will work best to treat an infection) was not provided, however, the medication was prescribed as R12 was symptomatic for a UTI and there was already a delay in treatment after multiple requests for testing. Further, on 1/27/22, an additional UA/UC was ordered for R12 due to dysuria (difficulty urinating). The provider was notified R12 was unable to provide a urine sample later that day (1/27/22) and an order for catheterization was provided. On 1/29/22, the provider was notified the UA was positive, but a	F 773		

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F 773	Continued From page 52 sensitivity report was not provided. The facility was informed on 1/31/22, the NP was still waiting for sensitivity results and did not want to treat the UTI without the information. The facility did not follow-up with the provider regarding the request. A NP saw R12 at the facility on 2/9/22, and the sensitivity report was found at that time for the UA/UC which was collected on 1/27/22. An order for Ceftriaxone (antibiotic) 1 gram injection was ordered at that time. NP-A added, there was a communication breakdown from the facility and ensuring a sensitivity report was provided. The sensitivity report was important as it determined if antibiotic treatment was appropriate. During an interview on 2/9/22, at 1:50 p.m. the assistant director of nursing (ADON) stated staff were expected to chart abnormal lab values and fax the information a a residents PCP. The ADON did not know why there was a delay in R12's initial UA/UC which was ordered on 11/18/21. Further, the ADON reviewed R12's medical record and was unable to identify if R12's sensitivity report was shared with the PCP. The ADON stated she also had a concern regarding the collection of R12's UA/UC on 1/27/22 to today (2/9/22) when the NP was informed of the culture sensitivity report. The ADON stated it appeared R12's culture sensitivity report was faxed to R12's PCP, however, "it does not appear it got there." The ADON reviewed R12's medical record and did not see an indication R12's culture sensitivity report was shared with the PCP. The ADON added, "Staff should had followed up to ensure the fax was received or if there was a clinical justification for not providing treatment." It was best practice for medical providers to wait for sensitivities when determining treatment for a UTI.	F 773		

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F 773	Continued From page 53 The facility policy "Lab and Diagnostic Test Results - Clinical Protocol," updated 4/30/21, included, "The facility nurse will review and process all lab results for his/her assigned residents. Once reviewed, the nurse must date, initial and then place in the designated area for the Unit Secretary/Health Information Coordinator for scanning. If the staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility (supervisor, charge nurse, etc.) should follow or coordinate the procedure. Results that are pending must be relayed to the oncoming nurse and written on the 24-hour report." The policy also included, "Facility staff should document information about when, how, and to whom the information was provided and the response. This should be done in the Progress Notes section of the medical record and not on the lab results report, because test results should be correlated with other relevant information such as the individual's overall situation, current symptoms, advance directives, prognosis, etc."	F 773		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet	F 791		3/12/22

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F 791	Continued From page 54 the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure missed dental appointments were rescheduled to promote oral hygiene and reduce the risk of complication for 1 of 3 residents (R57) reviewed for dental care and oral hygiene.	F 791	F 791 R 57 care plan and group sheet was updated to include dental cares. R 57 will have an appointment made be seen by the dentist. Existing residents who need dental services their dental care plan was	

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F 791	Continued From page 55	F 791		

Findings include:

R57's quarterly Minimum Data Set (MDS), dated 2/2/22, identified R57 had moderate cognitive impairment, demonstrated no rejection of care(s) behavior, and required extensive assistance to complete his personal hygiene needs. Further, R57's Census listing in the electronic medical record (EMR), printed 2/10/22, identified R57's current payer source as Medicaid.

R57's care plan, dated 2/9/21, identified R57 had an alteration in his activities of daily living (ADL) self care and directed, "PERSONAL HYGIENE ROUTINE: Set-up, Cares in pairs (two staff at all times for witness)." However, the plan lacked any developed problems, goals, or specific interventions for R57's dentition and/or oral hygiene.

On 2/7/22 at 1:10 p.m., R57 was observed laying in bed in his room. R57 was interviewed and expressed he had sustained several falls over the previous months and "chipped my teeth" as a result in several spots. R57 showed the suveyor his teeth and had several missing or broken teeth present on his upper palate. R57 stated he had seen a dentist for them awhile back who voiced they needed to be fixed, however, no further action had been taken since then to repair or remove them. R57 stated he would like to see a dentist to get them fixed and expressed the nursing home "laziness" was to blame for them not being addressed so far.

R57's progress note(s) were reviewed and identified:

reviewed, and appointments were scheduled as needed. Resident refusals will be documented. Future residents with dental concerns that develop during the facility stay, the resident will be seen by the dentist as needed.
Social Service and Nursing staff was in-serviced on the Dental Services policy with emphasis on scheduling dental services for emergent and follow up care and quarterly review of dental services needed or received by the resident
Social services and/or designee will be responsible for compliance.
Audits on resident dental appointments and quarterly and as needed care plan review will begin weekly x 4 weeks then monthly to ensure compliance.
All audits will be reviewed by the Administrator and the Administrator will present the audit results to QAPI for review and recommendation.

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F 791		F 791		

Continued From page 56

On 8/30/21, a previous director or nursing (DON) recorded R57 had declined to go for his dental appointment so the risks and benefits of the refusal were explained to him. The note recorded, "[R57] verbally agreed to go to next visit if it is rescheduled."

On 10/21/21, R57 was recorded as having a scheduled dental appointment for the following day, on 10/22/21, which R57 was aware of having.

However, R57's Hennepin County Medical Center - Nursing Home Visit Progress Note, dated 10/26/21, identified R57 was hospitalized and unable to make the scheduled dental appointment. The note included an assessment and plan for R57 from the medical provider which included, "11. Broken teeth ... Oral surgery appointment was missed on 10/22 as the patient was in hospital. NH [nursing home] staff asked to follow up to ensure appointment is rescheduled."

R57's medical record was reviewed and lacked evidence R57's missed dental appointment had been rescheduled, or offered and declined, despite the medical provider's recorded entry and R57 missing the previous appointment.

When interviewed on 2/9/22 at 9:44 a.m., nursing assistant (NA)-C stated she routinely cared for R57 and explained he "sometime" did refuse help with cares, including oral cares with a toothbrush, so she used only mouthwash to clean his teeth. NA-C verified R57 had missing teeth on his top palate and described them like "an open space." Further NA-C stated she was "not aware" if R57 had been to dentist to have his missing teeth addressed.

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F 791	Continued From page 57 On 2/9/22 at 9:53 a.m., the health unit secretary (HUC)-A was interviewed and explained she was the person responsible to help coordinate and arrange appointments with in-house and outside dental providers. HUC-A stated R57 had not been to, or had any recent dental appointments scheduled or completed, despite the medical provider orders asking them to be arranged. HUC-A stated she was unaware of the note(s) in R57's medical record. HUC-A reviewed the 2021 and 2022 appointment calendars and verified R57 had not been rescheduled for the missed dental appointment from 10/21/21. Further, HUC-A stated she would get one scheduled "right away" and added it was important to ensure dental appointments were made and completed timely as it was "important to your overall health." When interviewed on 2/9/22 at 10:53 a.m., the acting director of nursing (DON) reviewed R57's medical record and verified the missed dental appointment was not rescheduled, despite being directed and requested by R57's medical provider. The DON voiced he would expect such appointments to be made or, at minimum, offered and recorded in the progress notes if refused. This was important to do as untreated dental issues could cause infection. An undated Dental Examination/Assessment policy was provided which directed each resident would be offered dental services as needed. However, the policy lacked any direction or guidance on how to ensure missed appointments would be reviewed and/or tracked to ensure they're rescheduled.	F 791		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		3/12/22

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F 812	Continued From page 58 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure water pitchers were clean for 3 of 4 residents (R13, R35, R28) observed to consume water from facility provided pitchers. Findings include: R13's admission Minimum Data Set (MDS) dated 11/29/21, indicated R13 had intact cognition and was independent with eating. R13's diagnoses included malnutrition and adult failure to thrive. R35's quarterly MDS dated 1/3/22, indicated R25 had severely impaired cognition and needed extensive assistance with eating. R25's	F 812	F 812 R 13, R 35 and R 28 water pitchers and straws were removed, washed, sanitized and filled with fresh water and redistributed. All other resident water pitchers were immediately removed from resident rooms, washed, sanitized and filled with fresh water and redistributed. There was no ill effects to R 13, R 35 and R 28 for this deficient practice. Nursing, dietary and the IDT team was in-serviced on the Bedside Water Container policy with emphasis on night shift collecting and replacing resident water pitchers and soiled containers will be delivered to dietary department for	

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F 812	Continued From page 59 diagnoses included type II diabetes. R28's significant change MDS dated 12/21/21, indicated R28 had moderately impaired cognition and was independent with eating. R28's diagnoses include acute respiratory failure. On 2/8/22, at 2:20 p.m. R13 had a facility supplied water pitcher at their bedside. The re-usable plastic straw was observed to have a moderate amount of dried, flaky, beige colored crust on both the inside and outside portion of the straw. On 2/8/22, at 2:21 p.m. R35 had a facility supplied water pitcher at bedside. The re-usable plastic straw was observed to have a moderate amount of dried beige colored crust on both the inside and outside portion of the straw. On 2/9/22, at 8:27 a.m. R13's water pitcher and straw was observed and was unchanged from the previous observation on 2/8/22. During an interview on 2/8/22, at 2:23 p.m. licensed practical nurse (LPN)-A stated nursing assistants pass water after breakfast daily. The kitchen was in charge of washing water pitchers, however, LPN-A was unsure how often water pitchers and straws were changed/cleaned. On 2/9/22, at 3:46 p.m. R28's facility provided water pitcher was observed at bedside. The re-usable plastic straw was observed to have a dried orange film and some small black spots on the inside of the straw. R28 stated, "They never replace it," adding, "I clean it myself." During an interview on 2/9/22, at 8:27 a.m.	F 812	cleaning. The Director of Nursing and/or designee will be responsible for compliance. Audits on water delivery and water pitcher cleanliness will begin weekly x 4 weeks then monthly to ensure compliance. All audits will be reviewed by the Administrator and the Administrator will present the audit results to QAPI for review and recommendation.	

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F 812	Continued From page 60 nursing assistant (NA)-D stated she completed a water pass for R13 and R35 earlier that morning. NA-D stated when a residents water pitcher was observed to be dirty, the nursing assistant whom completed the water pass would obtain a clean pitcher from the kitchen prior to providing water. NA-D added water pitchers were changed out almost every day, however, the straw usually got dirty first, especially after residents ate. NA-D then observed R13's water pitcher, which was was in the same condition as when observed on 2/8/22, and described the straw as "dirty" and identified it needed to be cleaned despite already completing the water pass for the resident. During an interview on 2/9/22, at 9:27 a.m. the director of nursing (DON) stated nursing assistants should provide residents with a clean water pitcher and straw daily. It was important to provide a clean water pitcher and straw to prevent infection. A dirty pitcher or straw would lead to a resident taking in bacteria. Facility policy titled Serving Drinking Water dated 10/2010, indicated, Offer the resident a fresh cup of water. Place the water pitcher and cup within easy reach of the resident. Place flexible straws next to the water pitcher."	F 812		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed	F 888		3/12/22

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a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for

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F 888	Continued From page 62 whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all	F 888		

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applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure COVID-19 vaccination

F 888
Facility contracted agencies were sent the

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F 888	Continued From page 64 policies and procedures included a process that all staff including contractrated staff had received the COVID-19 vaccination or were granted an religious and/or medical exemption. This resulted in less than 100% staff vaccination rate which increases the potential of spreading COVID to residents who resided at the facility. Findings include: Facility policy titled Victory Health and Rehab Center Mandatory Vaccine Policy (undated) indicated the policy applied to all employees of Victory. Employees were required to be fully vaccinated to have a medical or religious exemption. The policy did not identify that contracted staff whom provided care were included in this process. During an interview on 2/8/22, at 7:55 a.m. staffing coordinator (SC)-A indicated the facility was not aware if their contracted staff were or were not vaccinated. SC-A stated, "Sometimes we ask, but we don't get proof." Also, there was no indication the facility had received any attestations of vaccination from the contracted staff which included hospice staff whom cared for the faciltiy residents. During an interview on 2/8/22, at 2:10 p.m. the administrator stated contracted staff were screened upon entrance. Further, he had "no idea which nurse would be coming in." The administrator stated, to the best of his knowledge the facility only contracted with hospice and no other services. During an interview on 2/9/22, at 1:04 p.m. the infection preventionist stated the facility had not	F 888	facility attestation indicating that no contracted employee's will be sent to the facility that have not obtained a vaccine, medical or religious exemption. The facility mandatory vaccine policy was reviewed and updated to include this verbiage. The Staffing Coordinator was in-serviced on the updated policy and that contracted employee's that do not provide the necessary documentation will not be allowed to enter the facility. The Director of Nursing and/or designee will be responsible for compliance. Audits on completed attestation, tracking and reporting of contracted staff will begin weekly x 4 weeks then monthly to ensure compliance. All audits will be reviewed by the Administrator and the Administrator will present the audit results to QAPI for review and recommendation.	

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F 888	Continued From page 65 started tracking the vaccination status of contracted staff who provide care to residents. Further, "We know we haven't started tracking yet, but need to." During an interview on 2/10/22, at 4:05 p.m. the administrator stated the facility policy needed to be expanded to include all facility and contracted staff providing care to residents.	F 888		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure radiators were clean and free from debris for 2 of 2 residents (R11, R53) reviewed for environment. Findings include: R11's quarterly Minimum Data Set (MDS) dated 11/21/21, indicated R11 was cognitively intact. R53's quarterly MDS dated 1/26/22, indicated R53 was cognitively intact. During an observation on 2/7/22, at 1:27 p.m. R11's radiator grates were covered with a black matter which was sticky. R11 was unsure what the substance was and stated, "I've told [maintenance] about it." R11 was unsure when the radiator grates were cleaned.	F 921	F 921 R 11 and R 53 radiators were cleaned. R 53 was assessed for allergy symptoms. The MD was notified and the MD response will be recorded in the resident medical record. All other resident room radiators were checked and cleaned as needed. Resident rooms will be placed on the maintenance log for monthly room radiator cleaning. Housekeeping and Maintenance staff was in-serviced on the QOL Homelike Environment item #2 that the facility will maximize the resident environment with a clean, sanitary and orderly environment. Maintenance Director and/or designee will be responsible for compliance. Audits on radiator cleaning will begin weekly x 4 weeks then monthly to ensure compliance.	3/12/22

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F 921	Continued From page 66 During an observation on 2/7/22, at 4:57 p.m. R53's radiator vent located below the window in their room had a sticky black residue which was removable when touched. The resident was all along the heater. During an interview on 2/7/22, at 4:55 p.m. R53 stated there was thick black mold, or something, on the radiators. R53 stated it was disgusting and did not help her allergies. During an interview on 2/10/22, at 9:26 a.m. housekeeper (HSK)-A stated resident radiators were wiped down about twice a month and a log was maintained by the supervisor. HSK-A confirmed there was a black sticky residue on R53's radiator, but was unsure what the substance was. During an interview on 2/10/22, at 2:05 p.m. the housekeeping supervisor stated there was a cleaning log, but housekeeping only cleaned the tops of radiators and any deep cleaning was done by maintenance. The housekeeping supervisor verified there was black sticky residue on R53's radiator and stated, "Yeah, this needs to be cleaned." R53 stated, "It's so bad. It hurts my allergies." During a follow-up interview on 2/10/22, at 2:30 p.m. the housekeeping supervisor stated maintenance was not available for an interview. Maintenance normally scrubbed radiator vents with air brushes monthly, however, verified it appeared the vents were not cleaned for awhile. Facility policy titled Safe Environment (undated) indicated the "facility will provide a safe, functional, sanitary and comfortable environment	F 921	All audits will be reviewed by the Administrator and the Administrator will present the audit results to QAPI for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING ______ B. WING ______	C 02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 921	Continued From page 67 for residents."	F 921		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 28, 2022

Administrator
Victory Health & Rehabilitation Center
512 49th Avenue North
Minneapolis, MN 55430

Re: State Nursing Home Licensing Orders
Event ID: 8YIY11

Dear Administrator:

The above facility was surveyed on February 7, 2022 through February 10, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**02/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY HEALTH & REHABILITATION CENTER	**512 49TH AVENUE NORTH** **MINNEAPOLIS, MN 55430**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual life safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/08/2022. At the time of this survey, Victory Health & Rehabilitation Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed — 03/03/2022

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	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Victory Health & Rehab Center is a 2-story building with a partial basement that was built in 1990 and was determined to be of Type II(222) construction. This facility is divided into three separate smoke compartments. This facility is fully protected throughout by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is centrally monitored for automatic fire department notification.

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K 000	Continued From page 2 The facility has a capacity of 87 beds and had a census of 51 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a), is NOT MET as evidenced by:	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 321		3/12/22

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K 321	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1 and 19.3.2.1.3. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 02/08/2022 at 10:00 AM, it was revealed by observation that the beauty shop was being used as a combustible storage room over 50 square feet in size and did not have a self-closing door. 2. On 02/08/2022 at 10:15 AM, it was revealed by observation that Room 171 had a fire-rated door that did not latch closed when tested. An interview with the Facility Director verified these deficienct findings at the time of discovery.	K 321	K 321 Items in this storage area were removed on 2/9/2022. All other storage areas doors were tested and are fully operational Room 171 door was repaired on 3/3/2022 All other resident doors were tested and all doors are fully operational. Monthly resident room and storage room doors will be tested for full function and repairs as needed. Maintenance director and/or designee is responsible for compliance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and	K 345	K 345 The facility fire alarm system was tested	3/12/22

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K 345	Continued From page 4 inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/08/2022 at 9:30 AM, it was revealed by a review of available documentation that the facility did not have documentation of a semi-annual inspection of the fire alarm system. An interview with the Facility Director verified this deficient finding at the time of discovery.	K 345	on 9/9 as per plan of correction submitted for survey completed on 8/10/2021 Results of this test was recorded in the facility life safety binder presented at survey. The fire alarm will be tested semi-annually by ECSI. Maintenance director and/or designee is responsible for compliance.	
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services 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 shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to establish a fire alarm out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 346	K346 The fire safety out of service policy was provided as per email request on 1/9. Policy has been amended to state" Fire watch status will be implemented immediatly upon identifying an outage to the facilities fire alarm system. NFPA requires notification to MDOH (the	3/12/22

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K 346	Continued From page 5 On 02/08/2022 at 9:30 AM, it was revealed by a review of available documentation that the facility did not have a current fire alarm out of service policy which stated four hours within a 24-hour period. An interview with the Facility Maintenance Director verified this deficient finding at the time of discovery.	K 346	authority having Jurisdiction) if outage continues for more than 4 hours in a 24 hour period. Facility staff will be in serviced on this policy with focus on performing fire watch activities should the system falter. Maintenance director and or designee is responsible for compliance	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _______________ b) Who provided system test ____________________ c) Water system supply source ___________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the automatic fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5 and 9.7.7 and	K 353	K353 The ceiling tile was replaced on 3/3/2022 All other facility tiles were inspected and replaced as needed.	3/12/22

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K 353	Continued From page 6 NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 4.1.5.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/08/2022 at 10:30 AM, it was revealed by observation that there was a missing ceiling tile in the hallway outside the kitchen area. An interview with the Facility Maintenance Director verified this deficient finding at the time of discovery.	K 353	Weekly facility environmental rounds will be initiated, and areas of concern will be documented and repaired per priority. Maintenance director and/or designee is responsible for compliance.	
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to establish a fire sprinkler system out of service policy per	K 354	K 354 The Fire safety out of service policy was as per email request on1/9	3/12/22

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K 354	Continued From page 7 NFPA 101 (2012 edition), Life Safety Code, section 9.7.6, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Chapter 15. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/08/2022 at 9:30 AM, it was revealed by available documentation that the facility does not have a current fire sprinkler out of service policy for the automatic fire sprinkler system. An interview with the Facility Maintenance Director verified this deficient finding at the time of discovery.	K 354	Facility staff will be in-serviced on this policy with focus on performing fire watch activities should the system falter. The fire watch policy was amended to include "Fire watch will be implemented immediatly on identification of outage in the facilities fire alarm and sprinkler system failure. If outage continues for greater then 4 hours facilty will report outage to MDOH as the Authority Having Jurisdiction. Maintenance director and/or designee is responsible for compliance.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a	K 920		3/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 920	Continued From page 8 substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to utilize relocatable power taps per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2.3.6 and 10.2.4, NFPA 70 (2011 edition), National Electrical Code, sections 400.8 and 590.3, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 02/08/2022 at 11:15 AM, it was revealed by observation that a relocatable power tap was plugged into another relocatable power tap in the phone room located on the main floor level. 2. On 02/08/2022 at 11:30 AM, it was revealed by observation that a relocatable power tap behind the pop machine showed signs of burnt arcing. An interview with the Facility Maintenance Director verified these deficient findings at the time of discovery.	K 920	K920 Power tap cords were removed from phone room and from behind the vending machine Maintenance director inspected all areas for any other power tap cords. None other were identified. Staff will be educated on use of power tap cords. Maintenance director and/or designee is responsible for completion.	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: ______ B. WING ______	C **02/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY HEALTH & REHABILITATION CENTEI	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/7/22, 2/8/22, 2/9/22, and 2/10/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure.	2 000		

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	00166	A. BUILDING: ______ B. WING ______	C 02/10/2022

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED, however, NO deficiencies were cited due to actions implemented by the facility prior to survey: H5544291C (MN80457) H5544293C (MN80295) H5544298C (MN78969) H5544301C (MN78078) The following complaints were found to be UNSUBSTANTIATED: H5544292C (MN80389), H5544294C (MN79726), H5544295C (MN79545), H5544296C (MN79288), H5544297C (MN79201), H5544299C (MN78490), H5544300C (MN78337), H5544302C (MN78064), H5544303C (MN77969), H5544304C (MN75790), and H5544305C (MN78024). Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health	2 000		

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2 000	Continued From page 2 Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which	2 265		3/12/22

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2 265	Continued From page 3 results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to notify the medical provider and/or resident representative of a new wound or need to alter treatment due to the unavailability of a prescribed antibiotic for 2 of 3 residents (R55, R28) reviewed for change of condition. Findings include: Stage II pressure ulcer: partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissue is not visible. Granulation tissue, slough and eschar, are not present.	2 265	corrected	

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2 265	Continued From page 4	2 265		

R55's quarterly Minimum Data Set (MDS) dated 1/29/22, indicated R55 was severely cognitively impaired and lacked indication of any skin issues.

R55's care plan dated 5/24/21, indicated R55 had the potential to develop a pressure ulcer due to immobility and diagnoses. R55 goal was for their skin to be intact, free from redness, blisters, or discoloration. The care plan listed several interventions to help R55 meet their goal which including monitoring/documenting/reporting changes in skin status.

A progress note dated 1/26/22, at 11:36 p.m. indicated R56 had, "a blister of size smaller than a dime was noted on the left buttock."

R55's medical record was reviewed and lacked any evidence the newly developed area had been communicated to the physician despite the area being identified on 1/26/22.

During interview on 2/10/22, at 10:06 a.m. licensed practical nurse (LPN)-E explained a clear, fluid-filled blister was noted on R55's coccyx area (1/26/22) and verified R55's representative, nor the doctor was notified of the skin alteration.

On 2/10/22, at 10:10 a.m. R55's personal care was observed with nursing assistant (NA)-A and LPN-B. At this time, a Stage II pressure ulcer on R55's left buttocks was observed. The wound bed was pink and moist with a small amount of drainage. The Stage II pressure ulcer measured 0.5 centimeters (cm) x 1 cm. LPN-B verified the wound was a Stage II pressure ulcer.

During interview on 2/10/22, at 10:25 a.m. the director of nursing (DON) stated the R55's

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2 265	Continued From page 5	2 265		

representative and the physician should had been notified of the skin alteration to obtain a treatment order.

R28's Admission Record printed 2/10/22, indicated he had diagnoses including cancer, cirrhosis (liver damage), dementia, and respiratory failure.

R28's significant change Minimum Data Set (MDS) dated 12/21/21, indicated R28 was moderately cognitively impaired.

R28's physician orders printed 2/10/22, indicated R28 had a toe infection to his right side and was prescribed cefuroxime axetil (antibiotic) 500 milligrams by mouth twice daily for 10 days starting on 1/18/22, at 8:00 p.m.

Review of R28's Orders - Administration Notes revealed the following:
- 1/18/22, at 8:10 p.m. the pharmacy could not deliver today (cefuroxime axetil) today due to billing reasons. The medication was to be delivered the following day.
- 1/19/22, at 8:32 a.m. cefuroxime axetil was not available.
- 1/19/22, at 7:50 p.m. cefuroxime axetil was not available.
- 1/20/22, at 11:18 a.m. R28 was transferred to the hospital.

Review of R28's medical record lacked evidence the facility notified the physician R28 did not receive and/or administer antibiotics as ordered 1/18/22, through 1/20/22.

A progress note dated 1/20/22, at 1:34 p.m. indicated the facility received a call from the hospital informing them R28 was admitted due to

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2 265	Continued From page 6 cellulitis of the right leg. During interview on 2/10/22, at 12:43 p.m. the director of nursing (DON) confirmed the facility did not administer R28's prescribed antibiotic. During interview on 2/10/22, at 3:23 p.m. nurse practitioner (NP)-C stated she was not informed R28's antibiotics were not administered. She expected facility staff to update her and it was unacceptable not do do so. The Change in a Resident's Condition or Status policy dated 2/2021, indicated, "The nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee, could develop/revise and implement policies and procedures to assure the resident's physician is notified of hospitalization, significant change in a resident's condition, and/or the need to alter treatment; then, educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 265		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's	2 550		3/12/22

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2 550	Continued From page 7 comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded for 1 of 1 resident (R17) whom received oxygen and 1 of 3 residents (R55) reviewed for pressure ulcers. Findings include: R17's admission Minimum Data Set (MDS) dated 12/3/21, indicated R17 was cognitively intact and had a diagnoses of acute respiratory failure. The MDS lacked indication R17 received oxygen therapy during the seven-day lookback period which ended on 12/3/21. R17's hospital discharge orders dated 11/26/21, indicated R17 had oxygen at 2 liters (L) nasal cannula ordered at bedtime. During an interview on 2/10/22, at 9:23 a.m. registered nurse RN-C verified coding oxygen was missed on R17's admission MDS and a correction was needed. R55's quarterly Minimum Data Set (MDS) dated 1/29/22, lacked indication of any current skin issues, including pressure or non-pressure related injuries with an observation period which ended on 1/29/22. A progress note dated 1/26/22, at 11:36 p.m. indicated, "a blister of size smaller than a dime was noted on the left buttock."	2 550	corrected	

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2 550	Continued From page 8 On 2/10/22, at 10:10 a.m. R55's personal care was observed with nursing assistant (NA)-A and licensed practical nurse (LPN)-B. A wound bed which was pink and moist with a small amount of drainage was noted. The wound measured 0.5 centimeters (cm) x 1 cm. LPN-B verified the open area was a Stage II pressure ulcer. During an interview on 2/10/22, at 8:33 a.m. registered nurse (RN)-C stated R55's quarterly MDS dated 1/29/22, was submitted incorrectly and a modification was needed to reflect a Stage II pressure injury. Facility policy titled MDS Error Correction dated 9/10, indicated "The assessment coordinator and/or interdisciplinary assessment team will follow the established processes for making corrections to the MDS. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could educate the nursing staff on completion of the Minimum Data Set (MDS) in accordance with the Resident Assessment Instrument (RAI) manual. They could then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 550		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		3/12/22

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2 565	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a comprehensive care plan was developed to reflect assessed and identified needs to promote continuity of care for 2 of 4 residents (R57, R17) reviewed for dental oxygen use. Findings include: R57's quarterly Minimum Data Set (MDS), dated 2/2/22, identified R57 had moderate cognitive impairment, demonstrated no rejection of care behavior(s), and required extensive assistance to complete his personal hygiene needs. On 2/7/22 at 1:10 p.m., R57 was observed laying in bed in his room. R57 was interviewed and expressed he had sustained several falls which led to several chipped teeth. R57 stated he had discussed fixing them with the staff, however, no further action had been taken so far to get his teeth and hygiene care addressed. R57's Hennepin County Medical Center Nursing Home Visit - Progress Note, dated 10/26/21, identified R57 was seen at the nursing home after being hospitalized. The note included a section labeled, "Physical Exam," which outlined, "Poor dentition." Further, a section labeled, "Assessment and Plan," identified R57's various medical complications which included, "11. Broken teeth ... Oral surgery appointment was missed ... NH [nursing home] staff was asked to follow up to ensure appointment is rescheduled." When interviewed on 2/9/22 at 9:44 a.m., nursing	2 565	corrected	

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2 565	Continued From page 10 assistant (NA)-C stated she routinely cared for R57 and provided morning cares to him, if he allowed them. NA-C explained R57 had several missing teeth and would often refuse oral cares with a toothbrush. So, as a result, NA-C stated she would just provide him some mouth wash adding, "I always make sure we use the mouthwash." NA-C stated she believed all staff were doing R57's oral care and hygiene in this manner adding, "they should [be]." However, R57's care plan, dated 2/9/21, lacked any identified problem statements, goal(s), or specific interventions for R57's oral hygiene or care despite having been identified as missing several teeth and often refusing oral care with a tooth brush resulting in the use of strictly mouth wash for hygiene. On 2/9/22 at 10:53 a.m., the acting director of nursing (DON) was interviewed and reviewed R57's care plan and medical record. The DON verified the care plan lacked any guidance or interventions for R57's oral hygiene or dentition and stated it "should be" added. The DON expressed he was unaware the staff were only using mouthwash to provide oral hygiene to R57. Further, the DON reviewed the pre-printed NA "assignment sheets" (used as a pocket reference for care guide) and verified it lacked information or interventions on R57's oral hygiene or dentition needs. The DON stated the care plan and assignment sheets should be updated with R57's dentition and oral hygiene interventions to help reduce the risk of bacteria growth in R57's mouth. R17's admission Minimum Data Set (MDS) dated 12/3/21, indicated R17 was cognitively intact and had diagnoses of an acute fracture of the lower extremity and acute respiratory failure. R17	2 565		

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2 565	Continued From page 11	2 565		

required assistance to support and balancing when walking. The MDS lacked indication of oxygen use.

R17's hospital discharge orders dated 11/26/21, indicated R17 had oxygen at 2 liters (L) nasal cannula ordered at bedtime.

R17's Order Summary Report dated 12/1/21, indicated R17 was non weight bearing on their right lower extremity.

However, R17's care plan dated 12/2/21, and corresponding nursing assistant care sheet dated 1/14/22, lacked evidence of goal(s), or specific interventions related to R17's mobility and oxygen needs.

During an interview on 2/9/22, at 10:23 a.m. nursing assistant (NA)-B stated she did not usually work with R17 and was unaware of any specific mobility needs R17 had.

During an interview on 2/9/21, at 10:51 a.m. licensed practical nurse (LPN)-B stated R17's mobility was limited and R17 worked with therapy. LPN-B confirmed R17 was received oxygen when he was in bed, however, this was not addressed on R17's care plan.

During an interview on 2/10/21, at 12:27 p.m. the director of nursing (DON) verified R17's care plan lacked indication of R17's oxygen needs and mobility. The DON stated the information needed to be included on R17's care plan to ensure R17's needs were met.

Facility policy titled Care Plan, Comprehensive Person-Centered revised 2016, indicated a comprehensive care plan that meets the

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2 565	Continued From page 12 resident's physical, psychosocial, and functional needs was developed for each resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and/or revise applicable policies and procedures to ensure resident care plans are developed and individualized; then, educate staff. The DON, or designee, could then perform audits to ensure each residents care plan is developed and individualized. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to perform a comprehensive root cause analysis which identified individualized risk factors to reduce the likelihood of subsequent	2 830	corrected	3/12/22

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2 830	Continued From page 13 falls for 1 of 1 resident (R56) reviewed for accidents. Findings include: R56's Admission Record indicated he had diagnoses of cirrhosis (liver damage) and diabetes. R56's admission Minimum Data Set (MDS) dated 12/27/21, indicated R56 required supervision with transfers, ambulation, toilet use, and personal hygiene. R56 was not steady when turning around or when facing the opposite direction while walking. R56's Falls Care Area Assessment (CAA) dated 1/5/22, indicated R56 was unsteady when walking and turning the opposite direction, but able to stabilize. A subsequent Falls CAA dated 2/2/22, identified R56 received narcotic, anti-anxiety, and insulin which could lead to weakness and unsteadiness. The CAA directed to review the care plan for corresponding interventions. Review of R56's progress notes revealed: - On 1/14/22, at 12:00 a.m. staff met R56 sitting by the west unit medication cart. It was noted R56's left knee and the right side of his lower leg was bleeding. R56 indicated he slipped on the slippery ground in the smoking area and fell on his stomach. R56 sustained a bruise and minor skin break to the right side of his lower leg. - 1/29/22, at 10:33 p.m. R56 was feeling weak, tripped, and fell backwards as he was walking. He leaned on the wall near the social workers office. Bleeding was noted to R56's right knee. - 2/9/22, at 4:22 p.m. R56 stated he fell outside at 7:00 a.m. when he went outside to smoke. The fall was unwitnessed and no injury was noted.	2 830		

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Review of R56's care plan dated 12/20/21, indicated R56 was at low risk for falls with a documented goal of, "Resident will be free of falls through the review date." Despite R56's falls on 1/14/22 and 1/29/22, R56's care plan was not reviewed and/or updated until 2/10/22.

During an interview on 2/7/22, at 12:08 p.m. R56 stated a few weeks ago, he went outside to have a cigarette and fell in the smoking area. R56 stated staff did not put salt down and his feet came out from under him.

During interview on 2/9/22, at 1:28 p.m. R56 stated he did not take pain medications at the time of his first fall (1/14/22) and did not feel medications impacted his balance. R56 stated he did not feel the staff salted the sidewalks or patios at the facility. R56 stated he, "fell outside today" because he was unable to see ice on the sidewalk in front of the building.

During interview on 2/10/22, at 11:24 a.m. registered nurse (RN)-A stated staff opened a risk management form, called the nurse practitioner (NP), informed the supervisor, and updated family when a resident fell. A root cause analysis was conducted for every fall to determine why it happened and to populate appropriate interventions to prevent the fall from happening again. RN-A reviewed R56's electronic health record (EHR) and confirmed there were no additional interventions identified after R56's falls on 1/14/22 and 1/29/22. A fall demanded a risk assessment every time and no risk assessments completed after each of R56's falls.

During interview on 2/10/22, at 12:43 p.m. the director of nursing (DON) stated when a resident

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2 830	Continued From page 15	2 830		

fell, staff conducted an assessment, updated the provider, completed a risk management form, and updated the care plan to prevent re-occurrence. The DON stated R56 went outside to smoke wearing slippers and fell on icy concrete. After the fall, staff put salt out on the concrete on the patio area. The DON reaffirmed there should had been an updated care plan for every fall R56 had and verified there were no new interventions added to R56's care plan after falls on 1/14/22 and 1/29/22.

During interview on 2/10/22, at 4:09 p.m. the administrator stated all falls were reviewed during the morning clinical standup meeting. A root cause analysis was completed and interventions were added to the care plan. The administrator stated R56 did not have an unsteady gait and the cause of R56's falls was related to too much medication.

Review of R56's EHR lacked Fall Incident Reports / Root Cause Analysis for falls on 1/14/22 and 1/29/22.

Facility policy titled Falls and Fall Risk, Managing dated 3/18, identified staff, with input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. Further, the policy identified if falling occurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could develop, review, and/or revise policies and procedures related to performing fall risk

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2 830	Continued From page 16 assessments and comprehensive root cause analysis. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and implement timely interventions to promote healing and reduce the risk of complications for a newly developed State II pressure ulcer for 1 of 3 residents (R55) reviewed for pressure ulcers.	2 900	corrected	3/12/22

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2 900	Continued From page 17 Findings include: Stage II pressure ulcer: partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissue is not visible. Granulation tissue, slough and eschar, are not present. R55's quarterly Minimum Data Set (MDS) dated 1/29/22, indicated R55 was severely cognitively impaired and required extensive assistance of one staff for bed mobility and toileting. The MDS lacked indication of any skin issues. R55's care plan dated 5/24/21, indicated R55 had the potential to develop a pressure ulcer due to immobility and diagnoses. R55 had a goal of maintaining intact skin, being free from redness, blisters, and discoloration. The care plan identified several interventions to help R55 meet the goal which included monitoring/documenting/reporting changes in skin status. The care plan lacked indication of any active skin conditions. R55's progress notes dated 1/26/22, at 11:36 p.m. indicated, "a blister of size smaller than a dime was noted on the left buttock." Despite documentation of the skin condition, R55's most recent Weekly Skin Check dated 2/5/22, indicated R55's skin was intact. R55's medical record was reviewed and lacked evidence treatment orders had been sought or a comprehensive wound assessment/reassessment was completed for the wound identified on 1/26/22.	2 900		

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2 900	Continued From page 18 During interview on 2/10/22, at 10:06 a.m. licensed practical nurse (LPN)-E explained a clear, fluid-filled blister was noted on R55's left coccyx area. LPN-E verified R55's treatment was not sought for the newly identified skin condition. On 2/10/22, at 10:10 a.m. R55's personal care was observed with nursing assistant (NA)-A and LPN-B. At this time, a Stage II pressure ulcer was seen on R55's left buttock. The wound bed was pink and moist with a small amount of sanguineous drainage. The wound measured 0.5 centimeters x 1 cm. LPN-B verified the open area was a State II pressure ulcer. During interview on 2/10/22, at 10:25 a.m. the director of nursing (DON) stated the LPN should document the size and characteristics of a wound on the wound assessment form in the electronic medical record (EMR). The DON verified facility protocol was not implemented for R55's skin condition. A provided Pressure Ulcers/Skin Breakdown Clinical Protocol dated April 2018, indicated,"The nurse shall describe and document/report the following: 1. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue 2. Pain assessment 3. Resident's mobility status 4. Current treatments, including support surfaces 5. All active diagnoses SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review/revise policies/procedures for pressure ulcer prevention and care, educate staff, and then	2 900		

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2 900	Continued From page 19 perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21134	MN RULE 4658.0670 Supb. 2. Dishwashing; Sanitation, storage Sanitization; storage. All utensils and equipment must be thoroughly cleaned, and food-contact surfaces of utensils and equipment must be given sanitization treatment and must be stored in such a manner as to be protected from contamination. Cleaned and sanitized equipment and utensils must be handled in a way that protects them from contamination. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure water pitchers were clean for 3 of 4 residents (R13, R35, R28) observed to consume water from facility provided pitchers. Findings include: R13's admission Minimum Data Set (MDS) dated 11/29/21, indicated R13 had intact cognition and was independent with eating. R13's diagnoses included malnutrition and adult failure to thrive. R35's quarterly MDS dated 1/3/22, indicated R25 had severely impaired cognition and needed extensive assistance with eating. R25's diagnoses included type II diabetes.	21134	corrected	3/12/22

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21134	Continued From page 20 R28's significant change MDS dated 12/21/21, indicated R28 had moderately impaired cognition and was independent with eating. R28's diagnoses include acute respiratory failure. On 2/8/22, at 2:20 p.m. R13 had a facility supplied water pitcher at their bedside. The re-usable plastic straw was observed to have a moderate amount of dried, flaky, beige colored crust on both the inside and outside portion of the straw. On 2/8/22, at 2:21 p.m. R35 had a facility supplied water pitcher at bedside. The re-usable plastic straw was observed to have a moderate amount of dried beige colored crust on both the inside and outside portion of the straw. On 2/9/22, at 8:27 a.m. R13's water pitcher and straw was observed and was unchanged from the previous observation on 2/8/22. During an interview on 2/8/22, at 2:23 p.m. licensed practical nurse (LPN)-A stated nursing assistants pass water after breakfast daily. The kitchen was in charge of washing water pitchers, however, LPN-A was unsure how often water pitchers and straws were changed/cleaned. On 2/9/22, at 3:46 p.m. R28's facility provided water pitcher was observed at bedside. The re-usable plastic straw was observed to have a dried orange film and some small black spots on the inside of the straw. R28 stated, "They never replace it," adding, "I clean it myself." During an interview on 2/9/22, at 8:27 a.m. nursing assistant (NA)-D stated she completed a water pass for R13 and R35 earlier that morning. NA-D stated when a residents water pitcher was	21134		

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observed to be dirty, the nursing assistant whom completed the water pass would obtain a clean pitcher from the kitchen prior to providing water. NA-D added water pitchers were changed out almost every day, however, the straw usually got dirty first, especially after residents ate. NA-D then observed R13's water pitcher, which was was in the same condition as when observed on 2/8/22, and described the straw as "dirty" and identified it needed to be cleaned despite already completing the water pass for the resident.

During an interview on 2/9/22, at 9:27 a.m. the director of nursing (DON) stated nursing assistants should provide residents with a clean water pitcher and straw daily. It was important to provide a clean water pitcher and straw to prevent infection. A dirty pitcher or straw would lead to a resident taking in bacteria.

Facility policy titled Serving Drink Water dated 10/2010, indicated, Offer the resident a fresh cup of water. Place the water pitcher and cup within easy reach of the resident. Place flexible straws next to the water pitcher."

SUGGESTED METHOD OF CORRECTION: The dietary manager, or designee, could update/create policies and procedures related to ensuring residents have clean water pitchers; then educate staff regarding any revisions. The dietary manager, or designee, could perform audits periodically, to ensure implementation of protocols.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21325	Continued From page 22	21325		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure missed dental appointments were rescheduled to promote oral hygiene and reduce the risk of complication for 1 of 3 residents (R57) reviewed for dental care and oral hygiene. Findings include: R57's quarterly Minimum Data Set (MDS), dated 2/2/22, identified R57 had moderate cognitive impairment, demonstrated no rejection of care(s) behavior, and required extensive assistance to complete his personal hygiene needs. Further, R57's Census listing in the electronic medical record (EMR), printed 2/10/22, identified R57's current payer source as Medicaid. R57's care plan, dated 2/9/21, identified R57 had an alteration in his activities of daily living (ADL) self care and directed, "PERSONAL HYGIENE ROUTINE: Set-up, Cares in pairs (two staff at all times for witness)." However, the plan lacked any	21325	corrected	3/12/22

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developed problems, goals, or specific interventions for R57's dentition and/or oral hygiene.

On 2/7/22 at 1:10 p.m., R57 was observed laying in bed in his room. R57 was interviewed and expressed he had sustained several falls over the previous months and "chipped my teeth" as a result in several spots. R57 showed the suveyor his teeth and had several missing or broken teeth present on his upper palate. R57 stated he had seen a dentist for them awhile back who voiced they needed to be fixed, however, no further action had been taken since then to repair or remove them. R57 stated he would like to see a dentist to get them fixed and expressed the nursing home "laziness" was to blame for them not being addressed so far.

R57's progress note(s) were reviewed and identified:

On 8/30/21, a previous director or nursing (DON) recorded R57 had declined to go for his dental appointment so the risks and benefits of the refusal were explained to him. The note recorded, "[R57] verbally agreed to go to next visit if it is rescheduled."

On 10/21/21, R57 was recorded as having a scheduled dental appointment for the following day, on 10/22/21, which R57 was aware of having.

However, R57's Hennepin County Medical Center - Nursing Home Visit Progress Note, dated 10/26/21, identified R57 was hospitalized and unable to make the scheduled dental appointment. The note included an assessment and plan for R57 from the medical provider which

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21325	Continued From page 24 included, "11. Broken teeth ... Oral surgery appointment was missed on 10/22 as the patient was in hospital. NH [nursing home] staff asked to follow up to ensure appointment is rescheduled." R57's medical record was reviewed and lacked evidence R57's missed dental appointment had been rescheduled, or offered and declined, despite the medical provider's recorded entry and R57 missing the previous appointment. When interviewed on 2/9/22 at 9:44 a.m., nursing assistant (NA)-C stated she routinely cared for R57 and explained he "sometime" did refuse help with cares, including oral cares with a toothbrush, so she used only mouthwash to clean his teeth. NA-C verified R57 had missing teeth on his top palate and described them like "an open space." Further NA-C stated she was "not aware" if R57 had been to dentist to have his missing teeth addressed. On 2/9/22 at 9:53 a.m., the health unit secretary (HUC)-A was interviewed and explained she was the person responsible to help coordinate and arrange appointments with in-house and outside dental providers. HUC-A stated R57 had not been to, or had any recent dental appointments scheduled or completed, despite the medical provider orders asking them to be arranged. HUC-A stated she was unaware of the note(s) in R57's medical record. HUC-A reviewed the 2021 and 2022 appointment calendars and verified R57 had not been rescheduled for the missed dental appointment from 10/21/21. Further, HUC-A stated she would get one scheduled "right away" and added it was important to ensure dental appointments were made and completed timely as it was "important to your overall health."	21325		

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21325	Continued From page 25 When interviewed on 2/9/22 at 10:53 a.m., the acting director of nursing (DON) reviewed R57's medical record and verified the missed dental appointment was not rescheduled, despite being directed and requested by R57's medical provider. The DON voiced he would expect such appointments to be made or, at minimum, offered and recorded in the progress notes if refused. This was important to do as untreated dental issues could cause infection. An undated Dental Examination/Assessment policy was provided which directed each resident would be offered dental services as needed. However, the policy lacked any direction or guidance on how to ensure missed appointments would be reviewed and/or tracked to ensure they're rescheduled. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could develop, review, and/or revise policies and procedures to ensure dental services are provided. The DON, or designee, could educate all appropriate staff on the policies and procedures. The DON, or designee, could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in	21390		3/12/22

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21390	Continued From page 26 residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure COVID-19 vaccination policies and procedures included a process that all staff including contract staff had received the COVID-19 vaccination or were granted an religious and/or medical exemption. This resulted in less than 100% staff vaccination rate which increases the potential of spreading COVID to residents who resided at the facility. Findings include: Facility policy titled Victory Health and Rehab	21390	corrected	

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Center Mandatory Vaccine Policy (undated) indicated the policy applied to all employees of Victory. Employees were required to be fully vaccinated to have a medical or religious exemption. The policy did not identify that contracted staff whom provided care were included in this process.

During an interview on 2/8/22, at 7:55 a.m. staffing coordinator (SC)-A indicated the facility was not aware if their contracted staff were or were not vaccinated. SC-A stated, "Sometimes we ask, but we don't get proof." Also, there was no indication the facility had received any attestations of vaccination from the contracted staff which included hospice staff whom cared for the facility residents.

During an interview on 2/8/22, at 2:10 p.m. the administrator stated contracted staff were screened upon entrance. Further, he had "no idea which nurse would be coming in." The administrator stated, to the best of his knowledge the facility only contracted with hospice and no other services.

During an interview on 2/9/22, at 1:04 p.m. the infection preventionist stated the facility had not started tracking the vaccination status of contracted staff who provide care to residents. Further, "We know we haven't started tracking yet, but need to."

During an interview on 2/10/22, at 4:05 p.m. the administrator stated the facility policy needed to be expanded to include all facility and contracted staff providing care to residents.

SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review

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21390	Continued From page 28 their infection control program to ensure policies and procedures are established to include a process for ensuring contracted staff have been vaccinated for COVID-19 or have a valid exemption; then, inservice staff regarding policy and procedure, and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to secure 3 of 4 medication carts observed for medication storage. This had the potential to affect all residents who could access unsecured medications. Findings include: On 2/7/22, at 11:49 a.m. a medication cart was observed unlocked and unattended in the East Hallway. The medication cart was located outside of the nurses' station and out of view of staff. Registered nurse (RN)-A returned to the medication cart at 11:52 a.m. and stated it was not common practice to leave a medication cart unlocked, however, he went to provide a resident food. Two unidentified residents passed by the	21610	corrected	3/12/22

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unlocked medication cart prior to RN-A's arrival.

On 2/7/22, at 1:57 p.m. a medication cart was observed unlocked and unattended at the far end of the South Hallway. At 1:59 p.m., trained medication aide (TMA)-A returned to the medication cart and stated she stepped away to provide a resident medications. She stated it was important to keep the medication cart locked to prevent residents from accessing medications in the cart. TMA-A stated there were no residents in the hallway when she left. One unidentified resident was observed in the hallway prior to TMA-A's return to the medication cart.

On 2/10/22, at 7:18 a.m. a medication cart was observed unlocked and unattended in the middle of the North Hallway. Upon return at 7:20 a.m., licensed practical nurse (LPN)-A stated she stepped away from the medication cart to look for something, but acknowledged she should had locked the medication cart when she left. One unidentified resident was observed ambulating in the hallway.

During an interview on 2/10/22, at 12:43 p.m. the director of nursing (DON) stated medication carts must be locked when unattended as residents often pass by and could open the cart and take medications.

Facility policy titled Storage of Medication revised 11/20, identified compartments (including, but not limited to, drawers, cabinets, room, refrigerators, cart, and boxes) containing drugs and biological's were locked when not in use. Unlocked medication carts were not to be left unattended.

SUGGESTED METHOD OF CORRECTION: The Administrator, director of nursing (DON), or

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21610	Continued From page 30 designee, could develop, review, and/or revise policies and procedures for proper storage of medications; educate all appropriate staff on the policies and procedures; and, conduct audits on a regular basis to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure radiators were clean and free from debris for 2 of 2 residents (R11, R53) reviewed for environment. Findings include: R11's quarterly Minimum Data Set (MDS) dated 11/21/21, indicated R11 was cognitively intact. R53's quarterly MDS dated 1/26/22, indicated R53 was cognitively intact. During an observation on 2/7/22, at 1:27 p.m. R11's radiator grates were covered with a black matter which was sticky. R11 was unsure what the substance was and stated, "I've told [maintenance] about it." R11 was unsure when the radiator grates were cleaned.	21665	corrected	3/12/22

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During an observation on 2/7/22, at 4:57 p.m. R53's radiator vent located below the window in their room had a sticky black residue which was removable when touched. The resident was all along the heater.

During an interview on 2/7/22, at 4:55 p.m. R53 stated there was thick black mold, or something, on the radiators. R53 stated it was disgusting and did not help her allergies.

During an interview on 2/10/22, at 9:26 a.m. housekeeper (HSK)-A stated resident radiators were wiped down about twice a month and a log was maintained by the supervisor. HSK-A confirmed there was a black sticky residue on R53's radiator, but was unsure what the substance was.

During an interview on 2/10/22, at 2:05 p.m. the housekeeping supervisor stated there was a cleaning log, but housekeeping only cleaned the tops of radiators and any deep cleaning was done by maintenance. The housekeeping supervisor verified there was black sticky residue on R53's radiator and stated, "Yeah, this needs to be cleaned." R53 stated, "It's so bad. It hurts my allergies."

During a follow-up interview on 2/10/22, at 2:30 p.m. the housekeeping supervisor stated maintenance was not available for an interview. Maintenance normally scrubbed radiator vents with air brushes monthly, however, verified it appeared the vents were not cleaned for awhile.

Facility policy titled Safe Environment (undated) indicated the "facility will provide a safe, functional, sanitary and comfortable environment for residents."

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21665	Continued From page 32 SUGGESTED METHOD OF CORRECTION: The director of maintenance, or designee, could develop and implement policies and procedures to ensure that the nursing home was maintained in a safe, clean, functional, comfortable and homelike manner. The director of maintenance, or designee, could then monitor staff for adherence to these policies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21665		
21825	MN St. Statute 144.651 Subd. 9 Patients & Residents of HC Fac.Bill of Rights Subd. 9. Information about treatment. Residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the residents can reasonably be expected to understand. Residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a resident's medical record, the information shall be given to the resident's guardian or other person designated by the resident as a representative. Individuals have the right to refuse this information. Every resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of	21825		3/12/22

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	which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods.			
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to allow a resident to participate in treatment decisions for 1 of 1 resident (R27) reviewed for hospice.		corrected	
	Findings include:			
	R27's Admission Record dated 2/10/22, lacked indication R27 had a legal guardian or durable Power of Attorney (DPOA). R27's diagnoses included unspecified dementia without behavioral disturbance.			
	R27's significant change Minimum Data Set (MDS) dated 12/21/21, indicated R27 was moderately cognitively impaired and received hospice services.			
	R27's care plan dated 12/15/21, indicated R27 received hospice care with a listed intervention to respect resident's rights to make decisions.			
	R27's Provider Orders for Life-Sustaining Treatment (POLST) dated 12/14/21, indicated R27 had a do-not-resuscitate (DNR) order, however, the document was not signed by R27. The document was signed by family member (FM)-A.			

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A document titled Hospice Transaction Form was signed by FM-A on 12/14/21. A corresponding document titled Admission Consent (hospice) had a box marked with an "x" to the immediate left of wording "Patient unable to sign due do to" with a hand written note which indicated "increased confusion." The document was also signed by FM-A.

R27's medical record was reviewed and lacked evidence had a legal guardian or DPOA paperwork. Additionally, R27's medical record lacked evidence a licensed physician or court had determined R27 lacked the capacity to make her own decisions.

Upon interview on 2/7/22, at 6:04 p.m. R27 stated, "I don't want to be on hospice, nor did I sign any paperwork to be on hospice." Additionally, "I don't want to be a DNR"

Upon interview on 2/8/22, at 10:25 a.m. the administrator stated R27 was sent to the hospital on a previous date for an emergent situation. Further, the administrator stated he initiated a DNR request for R27.

Upon a second interview on 2/10/22, at 8:48 a.m. R27 again confirmed she did not want hospice care and stated, "I want the staff to do everything possible to keep me alive and make me better."

Upon interview on 2/8/22, at 2:34 p.m. the assistant director of nursing (ADON) stated R27 had threw a hospice worker out of her room when approached about hospice services. Due to the incident, the hospice worker was asked to come back at a later time to conduct an evaluation and complete admission paperwork. R27 was again

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21825	Continued From page 35 approached by facility staff and a hospice work and R27 was "fairly agreeable" for hospice care. The ADON verified R27 was her own decision maker. The ADON was unable to explain why FM-A had signed R27's POLST and hospice admission paperwork. Upon interview on 2/9/22, at 1:15 p.m. a hospice manager stated R27 initially refused hospice services. Further, hospice normally verified an individual had a DPOA prior to a representative signing. During an interview on 2/9/22, at 3:25 p.m. hospice registered nurse, (RN)-E stated they assessed R27 on 12/14/21 and noted R27 was "alert and oriented." Further, when RN-E explained they were from hospice, R27 repeatedly stated "nope" so RN-E had left R27's room. RN-E stated FM-A had already signed R27's hospice admission paperwork and verified R27 did not sign documentation (consent), however, had later verbally agreed. Upon interview on 2/9/22, at 3:55 p.m. FM-A stated she signed a POLST and hospice admission paperwork on behalf of R27. FM-A verified she was not a guardian or DPOA for R27. FM-A stated hospice affiliates explained a POLST and paperwork needed to be signed for R27 to be eligible for hospice services. Further, the facility explained R27 would get extra help when signed on for hospice services. Upon interview on 2/10/22, at 9:36 a.m. the social services director (SSD) stated if a resident was able to make their own decisions, a family member should not sign any of their paperwork. Upon a second interview on 2/10/22, at 10:50	21825		

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21825	Continued From page 36 a.m. the hospice manager stated, hospice RN-F initially went to the facility on 11/19/21 to conduct an assessment on R27. R27 had verbalized she did not want hospice services at that time. The hospice manager stated he also went to the facility and spoke with R27 at an unknown time and date and R27 said "okay" to services, however, stated R27 was confused at the time of the visit. Subsequently, the ADON again called and asked for hospice to return review hospice services again with R27 [on 12/14/21]. The hospice manager verified R27's POLST and hospice admission paperwork was sent to FM-A to sign due to his previous assessment of R27 being too confused to sign paperwork. A policy regarding guardianship and DPOA was requested, however, not provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, or designee, could review and/or revise policies and procedures regarding consent for services. Staff could then be educated on policy and procedures and develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21825		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend	21880		3/12/22

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21880	Continued From page 37 changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21880	corrected	

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21880	Continued From page 38 facility failed to make prompt efforts to resolve grievances for 6 of 6 residents (R158, R52, R59, R101, R102, and R3) reviewed for grievances. Findings include: Review of the facility Grievance Log revealed: - R158 voiced concerns related to infection control practices, pain management, and call light response times on 10/22/21. Follow-up was requested, however, not documented. - R52 voiced a concern related to call light response times on 10/25/21, and bathing preferences on 11/2/21. Follow-up was requested, but not documented. - R59 voiced a concern related to call light response times on 11/5/21. A corresponding Grievance Form dated 11/5/21, contained a summary of the concern, but did not include documentation of a complaint resolution. - R101 voiced a concern related to call light response times on 11/17/21. Follow-up was requested, but not documented. - R102 voiced a concern related to her roommate's disruptive behavior on 12/1/21. A corresponding Grievance Form dated 12/1/21, contained a summary of the concern, but did not include documentation of a complaint resolution. - R3 voiced a concern related to podiatry services and pain management on 12/12/21. A corresponding Grievance Form dated 12/13/21, contained a summary of the concern, but did not include documentation of a complaint resolution. During an interview on 2/9/22, at 12:44 p.m. the administrator stated all grievances should be reviewed during the daily interdisciplinary team (IDT) meeting. The assigned department head should address the concern and bring a completed Grievance Form with a documented	21880		

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resolution to the daily IDT meeting. The facility social worker was responsible for maintaining the completed Grievance Forms. The administrator added all grievances should have a resolution within 5-days of the verbalized concern. The administrator stated Grievance Forms for R158, R52, and R101 were "missing." Further, he did not know if the concerns in which R59, R102, and R3 were addressed/resolved.

During an interview on 2/9/22, at 3:40 p.m. social worker (SW)-A stated all concerns voiced by residents should have investigative steps and a resolution documented on a Grievance Form.

R158, R59, R101, and R102 had discharged and were unable to be interviewed.

R52 was unavailable for interview and R3 refused to be interviewed.

Facility policy titled Grievance/Complaints, Filing dated 2/14/21, directed, "The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative." "Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) workings days of receiving the grievance and/or complaint." "The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems." "The results of all grievances files [sic] investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: ______ B. WING ______	C 02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY HEALTH & REHABILITATION CENTEI	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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) COMPLETE DATE
21880	Continued From page 40 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding making sure identified concerns, both voiced and in writing, are addressed with satisfaction in a timely manner; then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		