

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

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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,

Kumala Fiske Downing

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: <u>Kamala.Fiske-Downing@state.mn.us</u>

	-	& MEDICAID SERVICES			0		APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	тірі			E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
			AL BOILD				С
		245544	B. WING				
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
V/OTOD)				5′	12 49TH AVENUE NORTH		
VICTORY	HEALTH & REHABIL			Μ	IINNEAPOLIS, MN 55430		
(X4) ID PREFIX	(EACH DEFICIENCY		ID PREFIZ	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETION DATE
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			n 				
E 000	Initial Comments		E 0	00			
	On 2/7/22. 2/8/22.	2/9/22, and 2/10/22, a survey					
		Appendix Z, Emergency					
		uirements, §483.73(b)(6) was					
		standard recertification					
	survey. The facility	was IN compliance.					
	The facility is enroll	ed in ePOC and therefore a					
		uired at the bottom of the first					
		567 form. Although no plan of					
		ed, it is required that the facility					
	•	ot of the electronic documents.					
F 000	INITIAL COMMENT	ſS	F 0	00			
		2/9/22, and 2/10/22, a					
		tion survey was conducted at					
		plaint investigation was also cility was found to be NOT in					
		e requirements of 42 CFR 483,					
		ments for Long Term Care					
	Facilities.						
	The fellowing comm	lainta una a fauna dita la a					
		laints were found to be however, NO deficiencies					
		ctions implemented by the					
	facility prior to surve						
	H5544291C (MN80						
	H5544293C (MN80						
	H5544298C (MN78	969)					
	The following comm	laint was found to be					
	SUBSTANTIATED:	laint was found to be					
		078) with a related deficiency					
	cited at F744.	,					
		laints were found to be					
	UNSUBSTANTIATE	=D: 389), H5544294C (MN79726),					
	,						
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						03/03/2022

Electronically Signed

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.

		AND HUMAN SERVICES				FORM	03/21/2022 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245544	B. WING				_ 10/2022	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•		
VICTORY	Y HEALTH & REHABII	LITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 000	H5544295C (MN79 H5544297C (MN79 H5544300C (MN78 H5544303C (MN77 and H5544305C (M The survey resulted (IJ) to resident heal began on 2/8/22, w Life-Sustaining Trea had an active do-not the electronic healt R41's was to be ad administrator was r on 2/8/22. The IJ w 10:56 a.m. The above findings Quality of Care and conducted from 2/9 The facility's plan o as your allegation of Departments accep enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat	2010), H5544296C (MN79288), 2010), H5544299C (MN78490), 2037), H5544302C (MN78064), 2037), H5544304C (MN78064), 2069), H5544304C (MN75790), 1N78024). d in an Immediate Jeopardy Ith and safety. An IJ at F678 hen R1's Provider Orders for atment (POLST) identified R41 ot-resuscitate order, however, h record (EHR) indicated ministered CPR. The notified of the IJ at 3:30 p.m. as removed on 2/9/22, at constituted Substandard I an extended survey was 2/22 to 2/10/22. f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will	FO	00				
F 552 SS=D	regulations has bee Right to be Informe CFR(s): 483.10(c)(§483.10(c) Planning	en attained. d/Make Treatment Decisions 1)(4)(5) g and Implementing Care.	F 5	52			3/12/22	
	The resident has th	e right to be informed of, and						

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		AND HUMAN SERVICES				FORM	03/21/2022 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION ((X3) DATE SURV COMPLETE		
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NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
VICTORY	HEALTH & REHABI	LITATION CENTER			512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430			
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F 552	§483.10(c)(1) The in language that he or her total health statt his or her medical of §483.10(c)(4) The in advance, of the car of care giver or pro- §483.10(c)(5) The in advance, by the ph professional, of the care, of treatment at treatment options at option he or she pro- This REQUIREMEN by: Based on interview facility failed to allow treatment decisions reviewed for hospic Findings include: R27's Admission Re-	r her treatment, including: right to be fully informed in r she can understand of his or us, including but not limited to, condition. right to be informed, in re to be furnished and the type fessional that will furnish care. right to be informed in ysician or other practitioner or risks and benefits of proposed and treatment alternatives or und to choose the alternative or efers. NT is not met as evidenced w and document review, the w a resident to participate in s for 1 of 1 resident (R27) ce.	F	552	F 552 R 27 met with hospice liaison and fa social worker regarding hospice serv R 27 Agreed to continue Hospice se and remain a DNR. A new POLST a Hospice agreement were signed by resident. The MD all other residents receiving hospice services their hosp	vices. ervices and the s pice		
	Power of Attorney (included unspecifie disturbance. R27's significant ch (MDS) dated 12/21 moderately cognitiv hospice services.	a legal guardian or durable DPOA). R27's diagnoses d dementia without behavioral nange Minimum Data Set /21, indicated R27 was rely impaired and received			consent for services was reviewed a have the appropriate signature from resident or resident representative. Future residents who desire hospice services after admission to the facilit meet with resident and/or resident representative and hospice liaison a appropriate signatures will be presen The Interdisciplinary Team was in-serviced on Appointing Resident	e ty will nd the nt.		
		ted 12/15/21, indicated R27 are with a listed intervention to			Representative policy with emphasis resident can appoint as resident	s that		

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	ΓIPLI	E CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _			PLETED
		245544	B. WING				C 10/2022
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VICTOR	HEALTH & REHABI	LITATION CENTER		51	12 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
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F 552	Continued From pa	-	F 5	52			
	respect resident's r	ights to make decisions.			representative and the resident wi given opportunities to participate in		
	Treatment (POLST R27 had a do-not-r however, the docur	lers for Life-Sustaining) dated 12/14/21, indicated esuscitate (DNR) order, ment was not signed by R27. s signed by family member			plan of care. The Social Service and/or designed be responsible for compliance. Audits on resident/representative participating in plan of care for host services will begin weekly x 4 wee monthly to ensure compliance.	e will	
	A document titled H signed by FM-A on document titled Adu a box marked with wording "Patient ur hand written note w confusion." The do FM-A.			All audits will be reviewed by the Administrator and the Administrato present the audit results to QAPI f review and recommendation.			
	evidence had a leg paperwork. Addition lacked evidence a	ord was reviewed and lacked al guardian or DPOA nally, R27's medical record licensed physician or court had cked the capacity to make her					
	stated, "I don't wan sign any paperwork	2/7/22, at 6:04 p.m. R27 t to be on hospice, nor did I < to be on hospice." t want to be a DNR"					
	administrator state on a previous date	2/8/22, at 10:25 a.m. the d R27 was sent to the hospital for an emergent situation. strator stated he initiated a 27.					
	R27 again confirme	erview on 2/10/22, at 8:48 a.m. ed she did not want hospice want the staff to do everything					

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	03/21/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	0	(X3) DATE	E SURVEY
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING				PLETED C
		245544	B. WING					_ 10/2022
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATI	E, ZIP CODE		
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F 552		e alive and make me better."	Ft	552				
	assistant director of had threw a hospice approached about h incident, the hospic back at a later time complete admission approached by facil and R27 was "fairly The ADON verified maker. The ADON FM-A had signed R admission paperwo Upon interview on 2 manager stated R2 services. Further, h individual had a DP signing.	2/9/22, at 1:15 p.m. a hospice 7 initially refused hospice ospice normally verified an OA prior to a representative						
	hospice registered assessed R27 on 1 "alert and oriented.' explained they were repeatedly stated "r room. RN-E stated R27's hospice adm R27 did not sign do however, had later Upon interview on 2 stated she signed a admission paperwo verified she was no FM-A stated hospic	on 2/9/22, at 3:25 p.m. nurse, (RN)-E stated they 2/14/21 and noted R27 was ' Further, when RN-E e from hospice, R27 hope" so RN-E had left R27's FM-A had already signed ission paperwork and verified cumentation (consent), verbally agreed. 2/9/22, at 3:55 p.m. FM-A t POLST and hospice ork on behalf of R27. FM-A t a guardian or DPOA for R27. e affiliates explained a POLST ded to be signed for R27 to be						

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TATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO (X3) DAT	E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		G		IPLETED
		245544	B. WING			С
NAME OF F	PROVIDER OR SUPPLIER	240044		STREET ADDRESS, CITY, STATE, ZIP CODE	02	/10/2022
	HEALTH & REHABI	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
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F 552	Continued From pa	age 5	F 55	2		
		services. Further, the facility Ild get extra help when signed rices.				
	services director (S able to make their	2/10/22, at 9:36 a.m. the social SSD) stated if a resident was own decisions, a family t sign any of their paperwork.				
	a.m. the hospice m initially went to the an assessment on did not want hospic hospice manager s facility and spoke w and date and R27 however, stated R2 the visit. Subseque and asked for hosp services again with hospice manager w hospice admission to sign due to his p	erview on 2/10/22, at 10:50 hanager stated, hospice RN-F facility on 11/19/21 to conduct R27. R27 had verbalized she be services at that time. The stated he also went to the with R27 at an unknown time said "okay" to services, 27 was confused at the time of ently, the ADON again called bice to return review hospice R27 [on 12/14/21]. The verified R27's POLST and paperwork was sent to FM-A revious assessment of R27 I to sign paperwork.				
F 569 SS=B	requested, howeve Notice and Convey	ance of Personal Funds	F 56	9		3/12/22
	The facility must no Medicaid benefits- (A) When the amor reaches \$200 less	Notice of certain balances. otify each resident that receives unt in the resident's account than the SSI resource limit for ied in section 1611(a)(3)(B) of				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/21/2022 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION (E SURVEY PLETED	
		245544	B. WING				, 10/2022	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
VICTORY	HEALTH & REHABIL	ITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 569	to the value of the r resources, reaches person, the residen Medicaid or SSI. §483.10(f)(10)(v) C eviction, or death. Upon the discharger resident with a pers facility, the facility m resident's funds, an funds, to the reside individual or probater resident's estate, in This REQUIREMEN by: Based on interview facility failed to ensu- account balances w a timely manner for R64, R60) reviewed and/or expired. Findings include: A provided Victory H Center Funds Balar identified a list of al personal fund acco The listing included discharged resident following: R62 had a balance present reading, "0 Facility."	ge 6 unt in the account, in addition esident's other nonexempt the SSI resource limit for one t may lose eligibility for onveyance upon discharge, e, eviction, or death of a sonal fund deposited with the nust convey within 30 days the of a final accounting of those nt, or in the case of death, the e jurisdiction administering the accordance with State law. NT is not met as evidenced v and document review, the ure remaining personal fund vere distributed to the estate in 4 of 4 residents (R62, R63, d who had been discharged Health and Rehabilitation nce Report, printed 2/10/22, I residents with open, active unts with the nursing home. both currently admitted and ts, and the list identified the of \$817.01 with dictation 1/05/2022 Admitted to Another	F	569	F 569 R 62, R 63, R 64 and R 60 have all to discharged from the facility. Individu checks were issued to each of the receiving party and/or estate. From sexit until present, resident funds were disbursed per facility policy. All discharged/deceased resident accound were reviewed and reconciled. There currently a zero balance. Future residents who expire or transfer to another facility, the resident funds with disbursed in 30 days per facility policy The Business Office Manager was in-serviced on the Refunds Policy ar Procedure with focus on item #2 that discharge and/or resident death, res 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	ual survey e unts e is ill be cy. nd t upon ident er		

Facility ID: 00166

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		E & MEDICAID SERVICES	r			. 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION) (CON	E SURVEY IPLETED		
		245544	B. WING		02/			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
VICTOR	(HEALTH & REHAB	LITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE		
F 569	Home." R64 had a balance present reading, "1 Facility." R60 had a balance present reading, "1 On 2/10/22 at 12:4 manager (BOM) w the nursing home of help manage the re- verified the accour expired residents h were still under the funds and control; provide more detai third-party compar During subsequen p.m., BOM explain notification from th verified the funds h back to the resider BOM stated she ju have been re-paid days and voiced th work with the third- timely distribution g A corresponding el e-mail) was provid company which ou with remaining fun closed, a check wi	 2/09/2020 Discharge to a of \$419.00 with dictation 10/22/2021 Admitted to Another a of \$769.03 with dictation 12/17/2021 Expired." a o p.m., the business office as interviewed and explained used a third-party company to esident fund accounts. BOM nts outlined for discharged or nad positive balances which e nursing home' third-party however, was unable to il until she consulted with the ny. t interview on 2/10/22 at 2:47 ed she had received e third-party company and nad not been returned to paid not their estates' thus far. st learned the funds should or distributed back within 30 nursing home would have to party company to ensure going forward. 	F 569	weeks then monthly to ensure compliance. All audits will be reviewed by th Administrator and the Administ present the audit results to QAI review and recommendation.	rator will			

If continuation sheet Page 8 of 68

		AND HUMAN SERVICES			FORM	03/21/202 APPROVEI 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY IPLETED
		245544	B. WING			C 10/2022
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VICTOR	(HEALTH & REHABIL	LITATION CENTER	-	12 49TH AVENUE NORTH /INNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 569	Continued From pa	ge 8	F 569			
F 580 SS=D	fund distribution up requested, howeve	personal fund accounts and on death or discharge was r, none was received. Injury/Decline/Room, etc.) 14)(i)-(iv)(15)	F 580			3/12/22
	 (i) A facility must im consult with the resconsistent with his or representative(s) w (A) An accident inverse consistent with his or results in injury and physician interventii (B) A significant charmental, or psychosored deterioration in heat status in either life-factorial complication (C) A need to alter the a need to discontinue treatment due to accommence a new ff (D) A decision to transition (14)(i) of this section all pertinent informatis available and prophysician. (iii) The facility must resident and the rescandant of the facility must resident and the rescandant of the facility must resident in formatis available and prophysician. (iii) The facility must resident and the rescandant of the facility must resident in formatis available and prophysician. (iii) The facility must resident and the rescandant of the facility must resident in formatis available and prophysician. (iii) The facility must resident and the rescandant of the facility must resident in formatis available and prophysician. (iii) The facility must resident and the rescandant of the facility must resident in formatis available and prophysician. (iii) The facility must resident and the rescandant of the facility must resident and the rescandant of the facility must rescand the rescandant of the facility must rescand the rescandant of the facility must rescandant of the facility must rescandant of the facility must rescand the rescandant of the facility must rescandant of the fac	olving the resident which I has the potential for requiring on; ange in the resident's physical, ocial status (that is, a Ith, mental, or psychosocial threatening conditions or ns); treatment significantly (that is, ue an existing form of dverse consequences, or to orm of treatment); or ansfer or discharge the neility as specified in otification under paragraph (g) n, the facility must ensure that ation specified in §483.15(c)(2) wided upon request to the t also promptly notify the sident representative, if any, m or roommate assignment				

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		AND HUMAN SERVICES	-			FORM	03/21/2022 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION ()		E SURVEY PLETED	
		245544	B. WING	i			10/2022	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
VICTORY	YHEALTH & REHABII	LITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 580	 (e)(10) of this section (iv) The facility mustion update the address phone number of the representative (s). §483.10(g)(15) Admission to a composite §483.5) must disclositis physical configure locations that composite g483.5) must disclositis physical configure locations that composite g483.5) must disclositis physical configure locations that composite g483.15(c)(9) This REQUIREMENT by: Based on observation review, the facility for provider and/or resistive wound or need to a unavailability of a presidents (R55, R22 condition. Findings include: Stage II pressure uskin with exposed of viable, pink or red, as an intact or ruptor Adipose (fat) is not not visible. Granula are not present. R55's quarterly Min 1/29/22, indicated F 	tions as specified in paragraph on. at record and periodically (mailing and email) and he resident hose in its admission agreement ration, including the various orise the composite distinct cify the policies that apply to veen its different locations	F	580	F 580 R 55 and R 28 both had risk manage incidents created, the MD and family representative notified of new pressu- injury, their response documented in resident electronic medical record. F risk management was completed for delay in antibiotic therapy, the MD ar family representative were notified. care plans and treatments were revia and updated as needed for R27 and All other residents were reviewed an there was no resident change in con that warranted resident and/or family response. Future residents who experience pressure injuries, the MD family representative will be notified, their response will be recorded. Nursing staff will be in-serviced on A Change in Condition policy with emp on notifying the MD and resident	/ ure the R28 r nd The ewed 28. id dition / D and and and		

Facility ID: 00166

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		& MEDICAID SERVICES	1			OMB NO.		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTIO		СОМ	E SURVEY PLETED	
		245544	B. WING _	G			C 10/2022	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS	S, CITY, STATE, ZIP CODE			
VICTOR	HEALTH & REHABI	LITATION CENTER		512 49TH AVENU MINNEAPOLIS,				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	IDER'S PLAN OF CORREC ORRECTIVE ACTION SHO FERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 580	Continued From pa	age 10	F 58	0				
	the potential to dev immobility and diag skin to be intact, fre discoloration. The of interventions to hel including monitoring changes in skin sta A progress note da indicated R56 had, a dime was noted of R55's medical reco any evidence the n communicated to th being identified on During interview on licensed practical n clear, fluid-filled blis coccyx area (1/26/2	ted 1/26/22, at 11:36 p.m. "a blister of size smaller than on the left buttock." ord was reviewed and lacked ewly developed area had been ne physician despite the area		and recordir electronic m The Directo will be respond Audits on ac notification w then monthl All audits wi Administrato present the	responsible parties of the resident chang and recording the response in the reside 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.			
	was observed with LPN-B. At this time R55's left buttocks was pink and moist drainage. The Stag 0.5 centimeters (cn wound was a Stage	0 a.m. R55's personal care nursing assistant (NA)-A and a a Stage II pressure ulcer on was observed. The wound bed t with a small amount of le II pressure ulcer measured n) x 1 cm. LPN-B verified the e II pressure ulcer. a $2/10/22$, at 10:25 a.m. the						
	director of nursing representative and	(DON) stated the R55's the physician should had been alteration to obtain a treatment						

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		AND HUMAN SERVICES					FORM	03/21/2022 APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT	IPLI	E CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _				PLETED
		245544	B. WING _					C 10/2022
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	.	-	
VICTORY	(HEALTH & REHABIL	ITATION CENTER			12 49TH AVENUE NORTH IINNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD I	BE	(X5) COMPLETION DATE
F 580	Continued From pa order.	-	F 58	30				
	indicated he had dia	ecord printed 2/10/22, agnoses including cancer, age), dementia, and						
		ange Minimum Data Set /21, indicated R28 was ely impaired.						
	R28 had a toe infect prescribed cefuroxi	lers printed 2/10/22, indicated ation to his right side and was me axetil (antibiotic) 500 in twice daily for 10 days at 8:00 p.m.						
	revealed the followi - 1/18/22, at 8:10 p. deliver today (cefur billing reasons. The delivered the follow - 1/19/22, at 8:32 a. available. - 1/19/22, at 7:50 p. available.	m. the pharmacy could not oxime axetil) today due to e medication was to be						
	the facility notified t	edical record lacked evidence he physician R28 did not inister antibiotics as ordered 20/22.						
	indicated the facility	ted 1/20/22, at 1:34 p.m. / received a call from the hem R28 was admitted due to leg.						

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	-	AND HUMAN SERVICES			APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245544	B. WING _			C 10/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY	YHEALTH & REHABIL	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Continued From pa	ge 12	F 58	o		
	director of nursing (2/10/22, at 12:43 p.m. the (DON) confirmed the facility R28's prescribed antibiotic.				
	practitioner (NP)-C R28's antibiotics we	2/10/22, at 3:23 p.m. nurse stated she was not informed ere not administered. She aff to update her and it was o do so.				
F 585 SS=E	policy dated 2/2021 notify the resident's physician on call wh significant change i physical/emotional/	mental condition."	F 58	5		3/12/22
	grievances to the fa that hears grievance reprisal and without reprisal. Such griev respect to care and furnished as well as furnished, the beha	ces. esident has the right to voice acility or other agency or entity es without discrimination or t fear of discrimination or vances include those with t treatment which has been s that which has not been vior of staff and of other r concerns regarding their LTC				
	facility must make p	esident has the right to and the prompt efforts by the facility to the resident may have, in s paragraph.				
	§483.10(j)(3) The fa	acility must make information				

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OTATE						. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY
						С
		245544	B. WING _			/10/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
VICTOR	(HEALTH & REHABIL	ITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 585	on how to file a grie to the resident. §483.10(j)(4) The fa grievance policy to of all grievances reaction contained in this pa provider must give a to the resident. The include: (i) Notifying residen postings in promine facility of the right to (meaning spoken) of grievances anonym of the grievance off can be filed, that is, address (mailing an number; a reasonal completing the revious to obtain a written of grievance; and the independent entities be filed, that is, the Quality Improvement	ge 13 vance or complaint available acility must establish a ensure the prompt resolution garding the residents' rights ragraph. Upon request, the a copy of the grievance policy grievance policy must t individually or through on locations throughout the o file grievances orally or in writing; the right to file ously; the contact information icial with whom a grievance his or her name, business ad email) and business phone ble expected time frame for ew of the grievance; the right lecision regarding his or her contact information of s with whom grievances may pertinent State agency, nt Organization, State Survey ong-Term Care Ombudsman	F 58	85		
	program or protectii (ii) Identifying a Grie responsible for over receiving and trackii conclusions; leading by the facility; main information associa example, the identifi grievances submitte written grievance de coordinating with st	on and advocacy system; evance Official who is rseeing the grievance process, ing grievances through to their g any necessary investigations taining the confidentiality of all ted with grievances, for ty of the resident for those ed anonymously, issuing ecisions to the resident; and ate and federal agencies as f specific allegations;				

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TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY /PLETED	
IND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		C	
		245544	B. WING			/10/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH	Ξ		
VICTOR				MINNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 585	Continued From pa	ige 14	F 5	85			
	prevent further poter right while the allege investigated; (iv) Consistent with reporting all alleged abuse, including inj and/or misappropria anyone furnishing s provider, to the adm as required by State (v) Ensuring that all include the date the summary statement the steps taken to i summary of the per regarding the reside as to whether the g confirmed, any corr taken by the facility and the date the wr (vi) Taking appropri accordance with St of the residents' rig or if an outside entit the State Survey Ag Organization, or loc confirms a violation rights within its area	aking immediate action to ential violations of any resident ed violation is being §483.12(c)(1), immediately d violations involving neglect, uries of unknown source, ation of resident property, by services on behalf of the ninistrator of the provider; and e law; I written grievance decisions e grievance was received, a t of the resident's grievance, nvestigate the grievance, a rtinent findings or conclusions ent's concerns(s), a statement rievance was confirmed or not rective action taken or to be as a result of the grievance, itten decision was issued; ate corrective action in ate law if the alleged violation hts is confirmed by the facility ty having jurisdiction, such as gency, Quality Improvement cal law enforcement agency for any of these residents' a of responsibility; and idence demonstrating the					
	3 years from the iss decision. This REQUIREMEN by:	ces for a period of no less than suance of the grievance NT is not met as evidenced					
	facility failed to mak grievances for 6 of	v and document review, the ke prompt efforts to resolve 6 residents (R158, R52, R59, 3) reviewed for grievances.		F 585 R 158 was discharged from the R 52 grievance was responded R 59 was discharged from the	to 3/4		

Facility ID: 00166

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		AND HUMAN SERVICES			F	FORM	03/21/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3	(X3) DATE COMP C	
		245544	B. WING				<i>,</i> 0/2022
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	02/1	UILULL
VICTORY	(HEALTH & REHABI	LITATION CENTER			2 49TH AVENUE NORTH INNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	Continued From pa	age 15	F 5	85			
	- R158 voiced cond control practices, p response times on requested, howeve - R52 voiced a con response times on preferences on 11// requested, but not - R59 voiced a con response times on Grievance Form da summary of the con documentation of a - R101 voiced a co response times on requested, but not - R102 voiced a co roommate's disrupt corresponding Grie contained a summa include documenta - R3 voiced a conc and pain managem corresponding Grie contained a summa include documenta - R3 voiced a conc and pain managem corresponding Grie contained a summa include documenta - R3 voiced a conc and pain managem corresponding Grie contained a summa include documenta	cern related to call light 10/25/21, and bathing 2/21. Follow-up was documented. cern related to call light 11/5/21. A corresponding ated 11/5/21, contained a ncern, but did not include a complaint resolution. ncern related to call light 11/17/21. Follow-up was documented. ncern related to her tive behavior on 12/1/21. A evance Form dated 12/1/21, ary of the concern, but did not tion of a complaint resolution. ern related to podiatry services nent on 12/12/21. A evance Form dated 12/13/21, ary of the concern, but did not tion of a complaint resolution. ern related to podiatry services nent on 12/12/21. A evance Form dated 12/13/21, ary of the concern, but did not tion of a complaint resolution.			R 101 grievance was responded to 3/ R 102 grievance was responded to or R 3 grievance was responded to on 3 All other grievances from survey exit to present have been reviewed and resolved. Future grievance will be recorded, and resolution will be record per facility policy The IDT team will be in-serviced on the Grievance Policy with emphasis on providing resident resolution within 5 of of receipt of concern. Resident and/or family resolution will be recorded on the grievance form. Pending grievances to require more than the policy timefram the resident/representative will be not and their response will be recorded on grievance form. The Social Services Director and/or designee will be responsible for compliance. Audits on timely grievance response to begin weekly x 4 weeks then monthly ensure compliance. All audits will be reviewed by the Administrator and the Administrator wo present the audit results to QAPI for review and recommendation.	n 3/4 B/4 to rded he days or the that ne, tified, on the will / to	
	corresponding Grie contained a summa include documenta During an interview administrator stated reviewed during the (IDT) meeting. The should address the completed Grievan resolution to the da	evance Form dated 12/13/21, ary of the concern, but did not tion of a complaint resolution. of on 2/9/22, at 12:44 p.m. the d all grievances should be e daily interdisciplinary team assigned department head			review and recommendation.		

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		AND HUMAN SERVICES			FORM	03/21/2022 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245544	B. WING			C 10/2022
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VICTOR	Y HEALTH & REHABIL			512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 585	completed Grievand added all grievance within 5-days of the administrator stated R52, and R101 wer not know if the cond R3 were addressed During an interview worker (SW)-A state residents should ha resolution documer R158, R59, R101, a were unable to be in R52 was unavailabl to be interviewed. Facility policy titled dated 2/14/21, direc staff will make pron grievances to the sa and/or representativ grievance and/or co will review and inve submit a written rep Administrator within receiving the grievan resident, or person complaint on behalf informed (verbally a the investigation an to correct any ident all grievances files will be maintained of	ce Forms. The administrator es should have a resolution e verbalized concern. The d Grievance Forms for R158, re "missing." Further, he did cerns in which R59, R102, and d/resolved. To on 2/9/22, at 3:40 p.m. social ed all concerns voiced by ave investigative steps and a need on a Grievance Form.				

Facility ID: 00166

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIDI	E CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,			IPLETED
						С
		245544	B. WING		02	/10/2022
NAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
VICTOR	HEALTH & REHABIL	ITATION CENTER	-	12 49TH AVENUE NORTH IINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 656	Continued From pa	ge 17	F 656			
F 656 SS=D	Develop/Implement CFR(s): 483.21(b)(2	Comprehensive Care Plan 1)	F 656			3/12/22
	§483.21(b)(1) The f implement a compr care plan for each r resident rights set fo §483.10(c)(3), that i objectives and time medical, nursing, ar needs that are ident assessment. The co describe the followin (i) The services that or maintain the resid physical, mental, ar required under §483. (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclu- treatment under §48 (iii) Any specialized rehabilitative service provide as a result of recommendations. findings of the PAS/ rationale in the resid (iv)In consultation w resident's represent (A) The resident's p future discharge. Fa whether the resident	t are to be furnished to attain dent's highest practicable id psychosocial well-being as 3.24, §483.25 or §483.40; and t would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 33.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. <i>v</i> ith the resident and the tative(s)- oals for admission and reference and potential for acilities must document it's desire to return to the sessed and any referrals to				

Facility ID: 00166

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		AND HUMAN SERVICES				FORM	03/21/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED C
		245544	B. WING				_ 10/2022
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
VICTOR	Y HEALTH & REHABII	LITATION CENTER			I2 49TH AVENUE NORTH INNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	plan, as appropriate requirements set for section. This REQUIREMEN by: Based on observat review, the facility for comprehensive car reflect assessed an continuity of care for reviewed for dental Findings include: R57's quarterly Min 2/2/22, identified R8 impairment, demon behavior(s), and reac complete his perso On 2/7/22 at 1:10 p in bed in his room. expressed he had se led to several chipp discussed fixing the further action had be teeth and hygiene of R57's Hennepin Co Home Visit - Progressi identified R57 was being hospitalized. Iabeled, "Physical Ed dentition." Further, "Assessment and F medical complication	pose. s in the comprehensive care e, in accordance with the orth in paragraph (c) of this NT is not met as evidenced tion, interview, and document ailed to ensure a e plan was developed to id identified needs to promote or 2 of 4 residents (R57, R17) and oxygen use. imum Data Set (MDS), dated 57 had moderate cognitive istrated no rejection of care quired extensive assistance to nal hygiene needs. , R57 was observed laying R57 was interviewed and sustained several falls which bed teeth. R57 stated he had em with the staff, however, no been taken so far to get his care addressed. punty Medical Center Nursing pass Note, dated 10/26/21, seen at the nursing home after The note included a section Exam," which outlined, "Poor	F 6	556	F 656 R 57 care plan and group sheet was updated to include dental cares. R be placed on the list to be seen by t dentist. R 17 care plan for oxygen of was created and the group sheets w reviewed and updated as needed. F MDS was modified to include oxyge Existing residents who utilize oxyge care plans were reviewed and upda needed. Existing residents who nee dental services their care plan was reviewed, and appointments were scheduled as needed. Upon admis resident comprehensive care plans created per facility policy. Nursing staff was in-serviced on the Plan, Comprehensive policy with for that the care plan is developed to ad treatment concerns and appropriate interventions are initiated to enhance optimal resident functioning. The Director of Nursing and/or desig will be responsible for compliance. Audits on resident comprehensive of plan addressing areas of concern w begin weekly x 4 weeks then month ensure compliance. All audits will be reviewed by the Administrator and the Administrator present the audit results to QAPI for review and recommendation.	57 will he use vas a 17's en use. n their ted as d sion will be cus ddress e care cus ddress e se gnee care care cus ddress e will by to will	

Facility ID: 00166

		I AND HUMAN SERVICES E & MEDICAID SERVICES					FORM	03/21/2022 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	T	(X3) DATE COM	E SURVEY PLETED
		245544	B. WING					C 10/2022
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
VICTORY	Y HEALTH & REHABIL				12 49TH AVENUE NORTH /INNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD I	BE	(X5) COMPLETION DATE
F 656	missed NH [nurs follow up to ensure When interviewed of assistant (NA)-C sta R57 and provided m allowed them. NA-C missing teeth and w with a toothbrush. S she would just prov adding, "I always m mouthwash." NA-C were doing R57's of manner adding, "the However, R57's car any identified proble specific intervention care despite having several teeth and of tooth brush resulting wash for hygiene. On 2/9/22 at 10:53 nursing (DON) was R57's care plan and verified the care pla interventions for R5 and stated it "should expressed he was to Further, the DON re "assignment sheets for care guide) and or interventions on needs. The DON st assignment sheets dentition and oral hy	sing home] staff was asked to appointment is rescheduled." on 2/9/22 at 9:44 a.m., nursing tated she routinely cared for morning cares to him, if he C explained R57 had several would often refuse oral cares So, as a result, NA-C stated vide him some mouth wash nake sure we use the s stated she believed all staff oral care and hygiene in this	F 6	56				

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	03/21/2022 APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	0		0938-0391 E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING .				PLETED
		245544	B. WING					C 10/2022
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COD)E	•=:	
VICTORY	(HEALTH & REHABIL	LITATION CENTER			12 49TH AVENUE NORTH /INNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 656	Continued From pa	ge 20	F 6	56				
	12/3/21, indicated F had diagnoses of a extremity and acute required assistance	inimum Data Set (MDS) dated R17 was cognitively intact and n acute fracture of the lower e respiratory failure. R17 to support and balancing MDS lacked indication of						
		narge orders dated 11/26/21, oxygen at 2 liters (L) nasal bedtime.						
		ary Report dated 12/1/21, non weight bearing on their y.						
	corresponding nurs 1/14/22, lacked evid	re plan dated 12/2/21, and ing assistant care sheet dated dence of goal(s), or specific d to R17's mobility and oxygen						
	nursing assistant (N	on 2/9/22, at 10:23 a.m. IA)-B stated she did not 17 and was unaware of any eds R17 had.						
	licensed practical n mobility was limited LPN-B confirmed R	on 2/9/21, at 10:51 a.m. urse (LPN)-B stated R17's and R17 worked with therapy. 17 was received oxygen when ever, this was not addressed						
	director of nursing (lacked indication of	on 2/10/21, at 12:27 p.m. the DON) verified R17's care plan R17's oxygen needs and stated the information needed						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY
		0.655.4			С
		245544	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	02/10/2022
	PROVIDER OR SUPPLIER	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 656	Continued From pa to be included on R needs were met.	ge 21 17's care plan to ensure R17's	F 656	3	
F 678 SS=J	Person-Centered re comprehensive car resident's physical, needs was develop Cardio-Pulmonary I	Care Plan, Comprehensive evised 2016, indicated a e plan that meets the psychosocial, and functional ed for each resident. Resuscitation (CPR) 3)	F 678	3	3/12/22
	support, including C such emergency ca emergency medica related physician or advance directives.	onnel provide basic life CPR, to a resident requiring are prior to the arrival of I personnel and subject to rders and the resident's NT is not met as evidenced			
	Based on observat review, the facility fa do-no-resuscitate (I reflected throughou residents (R41) rev This resulted in an R41 who would had	DNR) order was accurately it the medical record for 1 of 2 iewed for advanced directives. immediate jeopardy (IJ) for d received cardiopulmonary), contrary to their wishes, in		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 advance directives were reviewed and updated a needed. Future residents will have their code status order and POLST will be reviewed upon admission, readmission significant change, quarterly and as	ed is r
	Provider Orders for (POLST) identified do-not-resuscitate of health record (EHR administered CPR. of the IJ at 3:30 p.m removed on 2/9/22,	order, however, the electronic) indicated R41's was to be The administrator was notified n. on 2/8/22. The IJ was		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, quarte and as needed and that this informatior	rly

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	03/21/2022 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			X3) DATE COM	E SURVEY PLETED	
		245544	B. WING			C 02/10/2022		
	PROVIDER OR SUPPLIER	LITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 678	severity level of D, but potential to cau Findings include: R41's Admission R indicated R41 had acute respiratory fa issues in the tissue cardiomyopathy (di and obstructive sle R41's significant ch (MDS) dated 1/8/22 cognitively intact. R41's physician ord 4:10 p.m. included dated 6/16/21. R41's care plan da Full Code, with a gu Directives will be he review R41's code as needed. R41's POLST signe provider on 11/5/21 R41's Care Confert 12/1/21 and 1/25/2 was Full Code. R41's Social Service p.m. identified R41 During interview on registered nurse (F	isolated with no actual harm ise more than minimal harm. ecord printed 2/11/22, diagnoses of heart failure, ailure with hypoxia (low oxygen es), morbid obesity, isease of the heart muscle), ep apnea. hange Minimum Data Set 2, indicated R41 was ders reviewed on 2/7/22, at R41 was Full Code (CPR) ted 7/13/21, indicated R41 was oal of "Resident's Advanced onored." Staff were directed to status on a quarterly basis and ed by and R41 and the medical	F 6	578	matched to the medical record. The Social Services Director and/or designee will be responsible for compliance. Audits on resident code status, POL and advanced directive care plan accuracy will begin 2x week for 2 we weekly x 4 weeks then monthly to er compliance. All audits will be reviewed by the Administrator and the Administrator of present the audit results to QAPI for review and recommendation.	eeks, nsure will		

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 03/21/2022 APPROVED : 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	CON	E SURVEY IPLETED	
		245544	B. WING			C 02/10/2022		
	PROVIDER OR SUPPLIER	LITATION CENTER		5	TREET ADDRESS, CITY, STATE, ZIP CODE 12 49TH AVENUE NORTH MINNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 678	the information did initiated. During interview or practical nurse (LP cardiac arrest, both would be reviewed would be initiated. During interview or stated in the event EHR and paper cha discrepancy exister R41's EHR banner p.m. indicated R41 POLST identiifed D During interview or confirmed his code signed the appropr During interview or stated he reviewed signed POLST in the whether to provide discrepancy, he wo confirmed R41's EI and R41's POLST the electronic docu changed when R47 completed, or staff when he did not wa During interview or of nursing (DON) v was identified as F	ve a pulse or respirations). If not match CPR would be a 2/7/22, at 2:17 p.m. licensed N)-A stated in the event of the EHR and paper chart . If a discrepancy existed CPR a 2/7/22, at 2:18 p.m. LPN-B of cardiac arrest, both the art would be reviewed. If a d CPR would be initiated. observed on 2/7/22, at 4:10 was Full Code; athough R41's DNR. a 2/7/22 at 4:13 p.m. R41 e status was DNR and he had iate forms. a 2/7/22, at 4:14 p.m. RN-B the both EHR banner and the he paper chart to determine CPR. If there was a buld initiate CPR. RN-B HR banner indicated Full Code indicated DNR. RN-B stated mentation should have been I's new POLST was would perform CPR on him	F 6	578				

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		AND HUMAN SERVICES					FORM	03/21/2022 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245544	B. WING _					C 10/2022
NAME OF I	PROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
VICTORY HEALTH & REHABILITATION CENTER					2 49TH AVENUE NORTH INNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD B		(X5) COMPLETION DATE
F 678	DNR. The DON sta for approximately the have treated R41 a if there was any dou During interview on of social services (If wanted to change a the provider, a nurse resident representate have the resident (of completed she gave placed the docume communicated any verbally at a daily te social worker change change the banner EHR but thought nur right away. If she no check with the nurse would proceed with During interview on worker (SW)-A state involved in the POLS signed it, she gave the code status in the didn't match she am performed CPR beau it would have been During interview on administrator stated completed the orde in the EHR and the did not know why R updated in the EHR	ted the discrepancy existed ree months and he would s a Full Code. He re-affirmed ubt he would "save the life." 2/8/22, at 8:51 a.m. director DSS) stated if a resident a POLST she would meet with e, and the resident (or tive), fill out the POLST, and or representative) sign it. Once e a copy to the resident and nt in the paper chart. She changes in code status eam meeting, and a nurse or a ged the care plan. She did not or the physician order in the ursing staff would change it oticed a conflict, she would e manager, but expected staff	F 67					

Facility ID: 00166

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		AND HUMAN SERVICES					FORM	APPROVED	
	RS FOR MEDICARE	& MEDICAID SERVICES				0		0938-0391	
STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		`́сом	E SURVEY PLETED	
		245544	B. WING _			C 02/10/2022			
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODI	Ξ			
VICTORY	HEALTH & REHABIL			5	12 49TH AVENUE NORTH				
VICTOR				N	IINNEAPOLIS, MN 55430				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRE	IOITO	N	(X5)	
PRÉFIX				PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE				COMPLETION DATE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	ROP		57.112	
			l.						
F 678	Continued From pa	ge 25	F 67	78					
	Dunin a interview en	0/0/00 at 14:40 a res							
		2/8/22, at 11:49 a.m. tated code status must be							
		resident admission and							
		ne expected any change in							
		tely communicated with staff.							
	He stated the POLS	ST must reflect the resident's							
		ust respect the resident's							
		once a POLST was signed by							
		e physician he gave it to the							
		nto the chart, and he							
		ST a physician order. His							
	expected staff to follow the orders on the paper								
	copy of the POLST to ensure resident's wishes were respected.								
	nore respected.								
	During interview on	2/8/22, at 1:38 p.m. R41							
		his code status a few months							
		n the provider, and the social							
		nad him sign a form. He							
		anding of DNR versus Full							
		IR meant "if your heart stops,							
		npt to get it going again, and							
		ey do what they can to get you tated he changed his code							
		"didn't want to have any							
	chance of being bra								
	chance of being bre								
	The facility Advance	e Directives policy updated							
		sident's code status would be							
		cally from the resident, hospital							
		esident advanced directive							
		formation would be entered							
		Medical Record for physician							
		e. Social Services reviews							
		vance Directives upon							
		needed but at least quarterly the plan of care. POLST							
		be added to all resident charts							

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/21/2022 APPROVED 0938-0391	
		(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED C				
	245544		B. WING _			02/10/2022		
NAME OF F	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	•		
VICTORY	HEALTH & REHABI	LITATION CENTER			49TH AVENUE NORTH NEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 678	Continued From pa	ge 26	F 67	'8				
	upon admission.							
	identified if the resid unclear, CPR would determined that the order not to adminis The IJ was remove when the facility de systemic removal p interview and docur - All residents recor the electronic bann advance directive c current POLST and - Seven LPNs and t POLST completion on 2/8/22, as evide Sheet. - A process was im nurses completed r	esuscitation revised 2/2018, dent's DNR status was d be initiated until it was ere was a DNR or a physician's ster CPR. d on 2/9/22, at 10:56 a.m. veloped and implemented a lan which was verified by ment review. rds were reviewed to ensure er, physician orders, and are plans reflected the most						
	included notification education via signa phone/text. - On 2/9/22, LPN-A	n of required mandatory ge at the time clock and via , LPN-B, DON, and DSS were						
	regarding POLST c policy. - The policy for adv and updated to inclu- reviewed upon adm in condition by the I	ified they received education ompletion, order entry, and anced directives was reviewed ude the POLST will be hit, quarterly, and with change DT (interdisciplinary team) st the medical record for						
F 684 SS=G	accuracy. Quality of Care		F 68	34			3/12/22	

		AND HUMAN SERVICES	T		F OME	FORM / B NO.	03/21/2022 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED		
		245544	B. WING			02/10/2022		
NAME OF I	PROVIDER OR SUPPLIER	·			REET ADDRESS, CITY, STATE, ZIP CODE			
VICTOR	(HEALTH & REHABII	LITATION CENTER			2 49TH AVENUE NORTH INNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	CFR(s): 483.25	-	F 6	84				
	Quality of care is a applies to all treatm facility residents. Ba assessment of a re that residents recei accordance with pro- practice, the compri- care plan, and the re This REQUIREMEN by: Based on observat review, the facility fr assess/reassess a implement antibiotic physician for 1 of 1 hospitalizations. Th R28 who was hosp and required intrave Findings include: R28's Admission Re indicated R28 had of cancer, cirrhosis (line R28's significant ch (MDS) dated 12/21, moderately cognitive transfers, and required one staff with dress	 \$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 hat residents receive treatment and care in accordance with professional standards of poractice, 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 mplement antibiotic therapy as ordered by the obysician for 1 of 1 resident (R28) reviewed for nospitalizations. 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, ndicated 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 noderately cognitively impaired, independent with ransfers, and required extensive assistance of one staff with dressing and personal hygiene. The MDS indicated R28 did not have a history of 			F 684 R 28 had a risk management incidem created and thoroughly investigated f root cause along with a new wound assessment, skin care plan review, re of wound treatment orders and the M reviewed for pressure injury accuracy 28 s MD was notified that the oral antibiotic medication was not administered as ordered and the wou was not relayed to the MD. The MD response will be recorded in the resident s electronic medical record. Existing resident who have wounds, t wound assessments, orders and care plans were reviewed and updated as needed. Existing resident orders who verbal/telephone/prescriber written fro survey exit until present will be review and updated as needed. Future resid who require treatment, orders will be obtained from the MD and implement per facility policy. Nursing staff were in-serviced on Medication Treatment Order policy wi emphasis of recording orders into the	for eview IDS y. R und s their e ether om ved lents ted		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED		
AND PLAN C			A. BUILDING	;		C 02/10/2022		
			B. WING					
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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
F 684	••••••••••••••••••••••••	-	F 684					
	indication of open a Subsequently, the of lacked documentat Check which was s Review of R28's Pr following: - 1/13/22, at 1:01 a hospital" at 8:00 p.1 medication. - 1/13/22, at 2:43 a (LPN)-F documento hospital with an ant Hospital Discharge 11:02 p.m. directed (Ceftin; an antibioti 1 tablet by mouth 2 toe infection on his seek medical care infection did not im R28's Weekly Skin identified R28 had no new skin concet diagnosed with a to R28's physician or 3:00 p.m. (five days facility initiated call had a toe infection instructed to clean cleanser, apply an change the dressin indicated R28 was	ack dated 12/29/21, lacked any areas on R28's skin. electronic health record (EHR) ion of R28's Weekly Skin scheduled for 1/6/22. rogress Notes included the .m. R28, "sent himself to the m. on 1/12/22 to request pain .m. licensed practical nurse ed R28 returned from the tibiotic order. Corresponding Instructions dated 1/12/22, at I R28 to take cefuroxime axetil c) 500 milligrams (mg) tablet, times daily for 10 days for a right foot. Further, R28 was to if his pain or swelling for the prove within 2 days. Check dated 1/13/22, intact skin, no open areas, and rns despite previously being be infection on 1/13/22. ders received on 1/18/22, at s after the initial order after a to the provider) indicated R28 of the right leg. Staff were the wound with wound absorbent dressing, and g twice daily. The orders also prescribed Ceftin 500 mg by or 10 days starting on 1/18/22,		resident medical record when r and on the Pressure Injury Skii Breakdown Policy with emphas notifying the physician for new skin breakdown and completion skin assessments. The Director of Nursing and/or will be responsible for complian Audits on timely notification to a treatment delays and new press injuries and resident order impl will begin 2x week x 2 weeks, w weeks then monthly to ensure compliance. All audits will be reviewed by th Administrator and the Administ present the audit results to QA review and recommendation.	e Injury Skin vith emphasis of an for new areas of I completion of weekly sing and/or designee or compliance. ification to the MD on d new pressure t order implementation 2 weeks, weekly x 4 t to ensure iewed by the ne Administrator will sults to QAPI for			

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		AND HUMAN SERVICES					FORM	APPROVED		
CENTERS FOR MEDICARE & MEDICAID SERVICES								MB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION			E SURVEY PLETED		
		245544	B. WING				С			
	PROVIDER OR SUPPLIER	245544	B. WING		TREET ADDRESS, CITY, STATE, Z		02/10/2022			
NAME OF F	ROVIDER OR SUPPLIER				12 49TH AVENUE NORTH	IP CODE				
VICTORY	(HEALTH & REHABIL	LITATION CENTER			AINNEAPOLIS, MN 55430					
(X4) ID					PROVIDER'S PLAN OF		(X5)			
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1			COMPLETION DATE		
1/10		,			DEFICIENC					
=										
F 684	- 1	-	F 6	84						
		2, through 1/31/22, lacked								
	discharge on 1/13/2	s administered after hospital 22.								
	Subsequent review	of R28's Progress Notes								
	revealed:	of fize 3 Frogress holes								
		. the pharmacy could not								
		n) for billing reasons.								
	would be reschedul	ming tomorrow and the doses								
		.m. and 7:50 p.m. indicated								
	Ceftin was not avail	lable.								
		a.m. R28 was transferred to								
	the hospital.	.m. the facility received a call								
		nd was informed R28 was								
	admitted for celluliti	is of the right leg.								
		.m. R28 remained in the								
	hospital and receive	ed IV antibiotics. .m. R28 was readmitted to the								
	facility.									
	D29's modical race	rd lacked indication R28's								
	physician was notifi									
	administered as ord									
	A Hospital Interage	ncy Transfer Form dated								
		R28 was prescribed Ceftin for								
		therapy to treat an ulcer on								
		e during a previous visit on								
		ecently failed outpatient During admission on 1/20/22,								
		have an ulcer over his right								
		charging puss, swelling, and								
	redness which exte	ended up his right ankle.								
	R28's electronic he	alth record (EHR) lacked								
	documentation of R	R28's wound from 1/13/21								
	(when R28 initially r	returned from the hospital)								

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		AND HUMAN SERVICES			FORM	03/21/2022 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245544	B. WING			C 10/2022
NAME OF	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VICTOR	Y HEALTH & REHABIL			12 49TH AVENUE NORTH /INNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	until 1/30/22 when a identified R28 had a second toe. The We measurements and Subsequently, a We 2/5/22, identified R2 slightly red and swo measured 0.5 centi however, additional not documented. During interview on stated he was in the ago for a sore on hi He stated he had a toe which kept getti increased to four in stated he was place hospital and was of walking boot on his During an observat R28's right second multiple shallow sca surface. During interview on registered nurse (R completed weekly w issues were docum have documented F orders for it to be cl concerns were docum the wound, and rep practitioner (NP). T wound or referred t	a Weekly Skin Check an open area to his right eekly Skin Check lacked d wound characteristics. eekly Skin Check dated 28's right toe continued to be ollen with an open area which imeters (cm) by 0.7 cm, I wound characteristics were 2/7/22, at 1:04 p.m. R28 e hospital two to three weeks is foot due to an ill-fitting shoe. "little nick" on his right second ing bigger. The swelling iches above his ankle. R28 ed on IV antibiotics at the oserved to be wearing a	F 684			

Facility ID: 00166

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					0. 0938-039		
	IDENTIFICATION NUMBER:				MPLETED		
		AL BOILDING			С		
	245544	B. WING		02	/10/2022		
OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	•			
& REHABI	LITATION CENTER						
H DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETIO DATE		
drainage an be document to document to document ress of eact tions were tions were tions were of nursing of on 1/12/22 ly in the model as a "breake the and the no c order to the ication. The administer a R28's hosp ated the and he progress nurses sho bing dressin ind assess nurses sho bing dressin an interview ractitioner (ed the facil to request	nd wound characteristics need. He stated it was neent skin assessments to show ch wound and whether successful or if additional required. 2/10/22, at 12:43 p.m. the (DON) stated R28 went to the for a toe issue and returned orning on 1/13/22. He stated down" upon R28's return urse should had faxed R28's ne pharmacy and the had arrived to the facility within "lapse" R28 did not receive e DON confirmed the facility any antibiotics from 1/13/22, pital admission on 1/20/22. The tibiotic would had been helpful sion of the infectious process. puld had evaluated the wound ng changes and he expected to ment documentation to follow sion. The DON verified R28's ked wound documentation. on 2/10/22, at 3:23 p.m. NP)-C reviewed R28's EHR ity called the nurse line on an order for an antibiotic to		1				
real at the sent of the sent o	SUMMARY STA CH DEFICIENCY ULATORY OR L drainage and be documer int to documer int to documer interview on of nursing f interview on of nursing f interview on of nursing f and the nursing f interview on of nursing f and the nursing f ic order to the dication. The administer a nurses sho ong dressir und assess ind progress ind pro	IDENTIFICATION NUMBER: 245544 OR SUPPLIER A REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION) Hed From page 31 drainage and wound characteristics be documented. He stated it was int to document skin assessments to show gress of each wound and whether itions were successful or if additional itions were required. interview on 2/10/22, at 12:43 p.m. the of nursing (DON) stated R28 went to the I on 1/12/22, for a toe issue and returned rly in the morning on 1/13/22. He stated as a "breakdown" upon R28's return 2) and the nurse should had faxed R28's ic order to the pharmacy and the tion would had arrived to the facility within . Due to the "lapse" R28 did not receive dication. The DON confirmed the facility administer any antibiotics from 1/13/22, restated as session of the infectious process. n urses should had evaluated the wound oing dressing changes and he expected to und assessment documentation to follow an interview on 2/10/22,	TION IDENTIFICATION NUMBER: A. BUILDING QR SUPPLIER 245544 B. WING	TION IDENTIFICATION NUMBER: A. BUILDING 245544 B. WING OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COL 12 49TH AVENUE NORTH STREET ADDRESS, CITY, STATE, ZIP COL SUMMARY STATEMENT OF DEFICIENCIES ID PROFUNERY WOLS BE PRECEDED BY FULL PREFIX ULATORY OR LSC IDENTIFYING INFORMATION) PREFIX ted From page 31 F 684 drainage and wound characteristics Deficiency be documented. He stated it was not to document skin assessments to show gress of each wound and whether F 684 tions were successful or if additional tions were required. interview on 2/10/22, at 12:43 p.m. the of nursing (DON) stated R28 went to the lon 1/12/22, for a toe issue and returned rhy in the morning on 1/13/22. He stated as a "breakdown" upon R28's return 2) and the nurse should had faxed R28's ic order to the pharmacy and the tion would had arrived to the facility within . Due to the "lapse" R28 did not receive lication. The DON confirmed the facility administer any antibiotics from 1/13/22. If R28's hospital admission on 1/20/22. The ated the antibiotic would had been helpful the progression of the infectious process. , nurses should had evaluated the wound oing dressing changes and he expected to und assessment documentation to follow und progression. The DON verified R28's I record lacked wound documentation. an interview on 2/10/22, at 3:23 p.m. ractitioner (NP)-C reviewed R28's EHR ted the facility calle	TTOM IDENTIFICATION NUMBER: A BUILDING 02 OR SUPPLIER 3. BUILDING 5. WING 02 A S REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH SUMMARY STATEMENT OF DEFICIENCIES DPROVIDER'S PLAN OF CORRECTION SHOULD BE DPROVIDER'S PLAN OF CORRECTION SHOULD BE CH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG CACS ACCRRECTIVE ACTION SHOULD BE CH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CACS ACCRRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG CACS ACCRRECTIVE ACTION SHOULD BE Ind ocumented. He stated it was not to documented. He stated it was not to document skin assessments to show gress of each wound and whether titons were successful or if additional titons were required. F 684 interview on 2/10/22, at 12:43 p.m. the of nursing (DON) stated R28 went to the lon 1/13/22. For a toe issue and returned rly in the morning on 1/13/22. The stated as a "breakdown" upon R28's return 2) and the nurse should had faxed R28's ic order to the pharmacy and the tion would had arrived to the facility within .Due to the "lapse" R28 did not receive lication. The DON confirmed the facility administer any antibiotics from 1/13/22. The ataet the antibiotic would had been helpful the progression. The DON verified R28's EHR ted the facility called the nurse line on interview on 2/10/22, at 3:23 p.m. ractitioner (NP)-C reviewed R28's EHR ted the facility called the nurse line on interview an order for an antibiotic to		

Facility ID: 00166

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						0.0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	TE SURVEY MPLETED
			A. DOILDI			С
		245544	B. WING _		02	/10/2022
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
/ICTORY	YHEALTH & REHAB	ILITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 684	Continued From p	age 32	F 68	34		
	•	ssess a wound and update the		-		
	provider and it was	s unacceptable not to do so.				
	-	she was not informed R28's started on 1/18/22 (second				
		id the hospitalization could had				
	been avoided had	R28 not gone eight days				
	without being adm	inistered the antibiotic.				
	During an interviev	<i>w</i> on 2/10/22, at 4:21 p.m. the				
		e had R28 received the				
		tic, as ordered, on 1/12/22, he				
	likely would had av	voided hospitalization.				
		2 a.m. and 12:29 p.m. a				
		w with LPN-F, who documented				
		iotic order on 1/13/22, was ssage left. No return call was				
	received.					
	Facility policy titled	Pressure Ulcers/Skin				
	Breakdown - Clinic	cal Protocol dated 4/18,				
		e shall described and full assessment of pressure				
		cation, stage, length, width, and				
	depth, presence of	f exudates (drainage), or				
F 686	necrotic tissue.	Prevent/Heal Pressure Ulcer	F 68			3/12/22
	CFR(s): 483.25(b)		го			5/12/22
	§483.25(b) Skin In	tearity				
	§483.25(b)(1) Pres					
	Based on the com	prehensive assessment of a				
		y must ensure that- ves care, consistent with				
		ards of practice, to prevent				
	pressure ulcers ar	nd does not develop pressure				
	ulcers unless the i	ndividual's clinical condition				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/21/202 APPROVEI 0938-039	
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		245544	B. WING			C 10/2022	
NAME OF	PROVIDER OR SUPPLIER		L	STREET ADDRESS, CITY, STATE, ZIP COD			
VICTOR	Y HEALTH & REHABIL	ITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE	
F 686	 (ii) A resident with p necessary treatmer with professional st promote healing, pr new ulcers from det This REQUIREMEN by: Based on observat review, the facility fa assess and implem promote healing an complications for a pressure ulcer for 1 for pressure ulcers. Findings include: Stage II pressure ul skin with exposed of viable, pink or red, p as an intact or ruptu Adipose (fat) is not not visible. Granula are not present. R55's quarterly Min 1/29/22, indicated F impaired and requir one staff for bed mo lacked indication of R55's care plan dat the potential to devo immobility and diag maintaining intact s blisters, and discolor identified several in the goal which inclu 	ressure ulcers receives at and services, consistent andards of practice, to event infection and prevent veloping. NT is not met as evidenced ion, interview, and document ailed to comprehensively ent timely interventions to d reduce the risk of newly developed State II of 3 residents (R55) reviewed cer: partial-thickness loss of lermis. The wound bed is moist, and may also present ured serum-filled blister. visible and deeper tissue is tion tissue, slough and eschar, imum Data Set (MDS) dated R55 was severely cognitively ed extensive assistance of obility and toileting. The MDS any skin issues. ed 5/24/21, indicated R55 had elop a pressure ulcer due to noses. R55 had a goal of kin, being free from redness, oration. The care plan terventions to help R55 meet	F 6	 F 686 R 55 had a new weekly skin measurement completed, a ris management incident initiated investigated, the care plan upot treatment orders reviewed and as needed. Existing residents wounds orders, weekly assess care plan was reviewed and up needed. Future residents, the notified of new skin concern at treatment orders received and implemented per order. Nursing staff were in-serviced Pressure Injury Skin Breakdow with emphasis of notifying the for new areas of skin breakdow accurately documenting the siz presence of exudate or necrot and completion of the wound a weekly. The Director of Nursing and/or will be responsible for complia Audits on notification to the MI pressure injuries and completi weekly wound assessments w week x 2 weeks, weekly x 4 w monthly to ensure compliance All audits will be reviewed by th Administrator and the Administ present the audit results to QA review and recommendation. 	and lated and l updated who have sments and odated as MD will be nd the vn Policy physician wn and ze, location, ic tissue assessment designee nce. D of new on of ill begin 2x eeks then ne trator will		

Facility ID: 00166

If continuation sheet Page 34 of 68

		AND HUMAN SERVICES					FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION	0	(X3) DATE	E SURVEY
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING				pleted C
		245544	B. WING					_ 10/2022
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	ODE		
VICTORY	Y HEALTH & REHABIL	LITATION CENTER			512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 686	Continued From pa skin status. The car active skin condition R55's progress note p.m. indicated, "a b dime was noted on documentation of th recent Weekly Skin indicated R55's skin R55's medical reco evidence treatment comprehensive wou assessment/reasse wound identified on During interview on licensed practical n clear, fluid-filled blis coccyx area. LPN-E not sought for the n On 2/10/22, at 10:1 was observed with LPN-B. At this time, seen on R55's left to pink and moist with sanguineous draina	nge 34 re plan lacked indication of any ns. es dated 1/26/22, at 11:36 lister of size smaller than a the left buttock." Despite ne skin condition, R55's most a Check dated 2/5/22, n was intact. rd was reviewed and lacked corders had been sought or a und essment was completed for the a 1/26/22. 2/10/22, at 10:06 a.m. urse (LPN)-E explained a ster was noted on R55's left E verified R55's treatment was newly identified skin condition. 0 a.m. R55's personal care nursing assistant (NA)-A and , a Stage II pressure ulcer was puttock. The wound bed was a small amount of age. The wound measured 0.5 . LPN-B verified the open area	F 6		DEFICIENCY)			
	director of nursing (document the size a on the wound asses medical record (EM	2/10/22, at 10:25 a.m. the (DON) stated the LPN should and characteristics of a wound ssment form in the electronic IR). The DON verified facility aplemented for R55's skin						

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		AND HUMAN SERVICES & MEDICAID SERVICES		FOR	D: 03/21/2022 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3) DA	TE SURVEY
		245544	B. WING	0	C 2/10/2022
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
VICTORY	' HEALTH & REHABIL	ITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Clinical Protocol da nurse shall describe following:	ge 35 e Ulcers/Skin Breakdown ted April 2018, indicated,"The e and document/report the of pressure sore including	F 68	6	
F 689 SS=D	location, stage, leng of exudates or neur 2. Pain assessmen 3. Resident's mobili 4. Current treatmen 5. All active diagnos	oth, width and depth, presence otic tissue t ty status ts, including support surfaces ses azards/Supervision/Devices	F 68	9	3/12/22
	supervision and ass accidents. This REQUIREMEN by:	resident receives adequate sistance devices to prevent NT is not met as evidenced			
	facility failed to perf cause analysis whic factors to reduce th	and document review, the orm a comprehensive root ch identified individualized risk e likelihood of subsequent ent (R56) reviewed for		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	
		ecord indicated he had sis (liver damage) and		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.	,
	R56's admission M	nimum Data Set (MDS) dated		IDT and the nursing staff will be	

Facility ID: 00166

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED
		245544	B. WING			C 10/2022
NAME OF	PROVIDER OR SUPPLIER	2.00.1		STREET ADDRESS, CITY, STATE, Z	•	10/2022
	(HEALTH & REHABI	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 689	transfers, ambulati hygiene. R56 was in around or when fact while walking. R56's Falls Care At 1/5/22, indicated R and turning the opp stabilize. A subseq identified R56 rece insulin which could unsteadiness. The care plan for correst Review of R56's pr - On 1/14/22, at 12 by the west unit me R56's left knee and was bleeding. R56 slippery ground in t his stomach. R56 s skin break to the rig - 1/29/22, at 10:33 tripped, and fell bac He leaned on the w office. Bleeding wa - 2/9/22, at 4:22 p.r 7:00 a.m. when he fall was unwitnessed Review of R56's ca indicated R56 was documented goal of through the review 1/14/22 and 1/29/2	age 36 I R56 required supervision with on, toilet use, and personal not steady when turning cing the opposite direction rea Assessment (CAA) dated 56 was unsteady when walking posite direction, but able to uent Falls CAA dated 2/2/22, ived narcotic, anti-anxiety, and lead to weakness and CAA directed to review the sponding interventions. ogress notes revealed: :00 a.m. staff met R56 sitting edication cart. It was noted the right side of his lower leg indicated he slipped on the the smoking area and fell on sustained a bruise and minor ght side of his lower leg. p.m. R56 was feeling weak, ckwards as he was walking. vall near the social workers s noted to R56's right knee. m. R56 stated he fell outside at went outside to smoke. The ed and no injury was noted. are plan dated 12/20/21, at low risk for falls with a of, "Resident will be free of falls date." Despite R56's falls on 2, R56's care plan was not odated until 2/10/22.	F 68	89 in-serviced on Assessing Causes policy with empli identifying root cause an with effective intervention The Director of Nursing will be responsible for co Audits on root cause and interventions will begin 2 weeks, then 1x a week x monthly to ensure comp All audits will be reviewe Administrator and the Ac present the audit results review and recommenda	hasis on d patterns along ns. and/or designee ompliance. alysis and fall tx a week for 2 d weeks then liance. d by the dministrator will to QAPI for	

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE CONSTRUCTION). 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	• •			MPLETED
						С
		245544	B. WING			/10/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
VICTOR	HEALTH & REHABI	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 689	Continued From pa	ge 37	F 6	589		
	a cigarette and fell	ago, he went outside to have in the smoking area. R56 put salt down and his feet er him.				
	stated he did not ta time of his first fall medications impac did not feel the staf at the facility. R56 s	2/9/22, at 1:28 p.m. R56 ke pain medications at the (1/14/22) and did not feel ted his balance. R56 stated he f salted the sidewalks or patios stated he, "fell outside today" hable to see ice on the the building.				
	registered nurse (R management form, (NP), informed the when a resident fel conducted for every happened and to p interventions to pre again. RN-A review record (EHR) and c additional intervent on 1/14/22 and 1/2	vent the fall from happening red R56's electronic health confirmed there were no ions identified after R56's falls 9/22. A fall demanded a risk time and no risk assessments				
	director of nursing of fell, staff conducted provider, completed and updated the ca re-occurrence. The to smoke wearing s concrete. After the concrete on the pat	2/10/22, at 12:43 p.m. the (DON) stated when a resident an assessment, updated the d a risk management form, ire plan to prevent DON stated R56 went outside slippers and fell on icy fall, staff put salt out on the tio area. The DON reaffirmed een an updated care plan for				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/21/2022 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	COM	E SURVEY IPLETED C
		245544	B. WING				10/2022
NAME OF F	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY	HEALTH & REHABIL	ITATION CENTER			49TH AVENUE NORTH INEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689 F 744 SS=D	interventions added on 1/14/22 and 1/29 During interview on administrator stated the morning clinical cause analysis was were added to the of stated R56 did not I cause of R56's falls medication. Review of R56's EF Reports / Root Cau and 1/29/22. Facility policy titled dated 3/18, identified attending physician resident-centered fa the specific risk fac at risk or with a hist identified if falling o interventions, staff different interventio approach remains r Treatment/Service CFR(s): 483.40(b)(3) A ress diagnosed with den appropriate treatme maintain his or her mental, and psycho	And verified there were no new to R56's care plan after falls 2/22. 2/10/22, at 4:09 p.m. the d all falls were reviewed during standup meeting. A root completed and interventions care plan. The administrator have an unsteady gait and the swas related to too much dR lacked Fall Incident se Analysis for falls on 1/14/22 Falls and Fall Risk, Managing ed staff, with input of the , will implement a all prevention plan to reduce tor(s) of falls for each resident ory of falls. Further, the policy ccurs despite initial will implement additional or ns, or indicate why the current relevant. for Dementia 3) ident who displays or is nentia, receives the ent and services to attain or highest practicable physical,	F 6				3/12/22
		ion, interview, and document			F 744		

Facility ID: 00166

If continuation sheet Page 39 of 68

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DAT	E SURVEY
					С
	240044			02/	10/2022
	LITATION CENTER				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETIO DATE
review, the facility freassess and deverent or address exhibited of 1 resident (R35) refused hygiene as Findings include: R35's quarterly Min 1/3/22, indicated R impairment, had no and no refusal of caindicated R35 requipersonal hygiene a included Alzheimer dementia with behat R35's care plan up had behaviors of criself-transferring an bedroom/public plasmear stool on the was noted to refuse limited to, personal repositioning, groot to monitor behavior of the location, time or situations. Despite the facility ongoing refusals of lacked indication demonted to reassessment and individualized demonted to refuse of the location of reassessment and individualized demonted to refuse of lacked indication of reassessment and individualized demonted to refuse of lacked indication of reassessment and individualized demonted to refuse of lacked indication of reassessment and individualized demonted to refuse of lacked indication of reassessment and individualized demonted to refuse of lacked indication of reassessment and individualized demonted to refuse of lacked indication of reassessment and individualized demonted to refuse of lacked indication of reassessment and individualized demonted to refuse of lacked indication of reassessment and individualized demonted to refuse of lacked indication of reassessment and individualized demonted to refuse of lacked indication of reassessment and individualized demonted to refuse of lacked indication of reassessment and individualized demonted to refuse of lacked indication of reassessment and individualized demonted to refuse of lacked indication of reassessment and individualized demonted to refuse of lacked indication of reassessment and individualized demonted to refuse of lacked indication of reassessment and individualized demonted to refuse of lacked indication of reassessment and individualized demonted to refuse of lacked indication of lacked ind	ailed to comprehensively lop individualized interventions d behaviors of dementia for 1 who had soiled nails and sistance. mum Data Set (MDS) dated 35 had a severe cognitive o physical or verbal behaviors, ares. The MDS further ired extensive assistance with nd bathing. R35's diagnoses 's disease with early onset and avioral disturbance. dated 1/19/22 indicated, R35 rawling/laying on the floor, d disrobing in the ces. Also, R35 was noted to walls and his clothing. R35 e cares, including, but not hygiene, nail care, ming, and bathing. Staff were ral episodes and attempt to ng causes when considering f day, persons involved, and having recognized R35 had care, R35's medical record f a comprehensive attempts to develop entia care interventions to	F 744	R 35 received and continues to care, podiatry and hygiene assis performed as resident allows. R re-approached for care and refu- be documented. R 35's dement plan was reviewed, and interver updated as needed. Existing res- with dementia, their care plan w reviewed, and care interventions as needed. The IDT team was in-serviced of Dementia-Clinical Protocol polic emphasis on identifying and cre- interventions that will maximize resident overall quality of life. The Director of Nursing and/or of will be responsible for compliand Audits on dementia behavioral interventions and effectiveness weekly x 4 weeks then monthly compliance. All audits will be reviewed by the Administrator and the Administra	stance 35 will be isals will a care stions sidents as updated on the ty with ating the designee ce. will begin to ensure e ator will	
	PROVIDER OR SUPPLIER Y HEALTH & REHABIN SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pareview, the facility f reassess and deverto to address exhibited of 1 resident (R35) refused hygiene as Findings include: R35's quarterly Min 1/3/22, indicated R impairment, had no and no refusal of ca indicated R35 requipersonal hygiene a included Alzheimerto dementia with beha R35's care plan up had behaviors of cr self-transferring an bedroom/public platory smear stool on the was noted to refused limited to, personal repositioning, groot to monitor behavior determine underlying the location, time of situations. Despite the facility ongoing refusals of lacked indication of reassessment and individualized demon promote hygiene.	DF CORRECTION IDENTIFICATION NUMBER: 245544 PROVIDER OR SUPPLIER Y HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 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	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING 245544 B. WING PROVIDER OR SUPPLIER 245544 Y HEALTH & REHABILITATION CENTER JD PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) JD PREFIX TAG Continued From page 39 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. F 744 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.	CP DEFICIENCIES (X1) PROVIDERSUPPLIENCIAL (X2) MULTIPLE CONSTRUCTION DEP CORRECTION 245544 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE Y HEALTH & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECIDENCES (EACH DEFICIENCY MUST BE PRECIDENCES (EACH DEFICIENCY MUST BE PRECIDENCES) D PROVIDERS PLAN OF CORRECT (EACH DEFICIENCY MUST BE PRECIDENCES) Continued From page 39 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. F 744 Findings include: R 35'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. F 1eD T team was in-serviced o Dementia-Clinical Protocol polic emphasis on identifying and cre will be responsible for compliann Audits on dementia behavioral distuations. 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. All audits will be reviewed by the Administrator and the Administry present the auddit results to QAF review and recommendation.	COP DEFICIENCIES (11) PROVIDERSUPPLIERCULA (22) MULTIFLE CONSTRUCTION (23) MULTIFLE CONSTRUCTION (23) MULTIFLE CONSTRUCTION (23) MULTIFLE CONSTRUCTION (23) MULTIFLE CONSTRUCTION (24) MULTIFLE CONSTRUCTION (23) MULTIFLE CONSTRUCTION (23) MULTIFLE CONSTRUCTION (24) MULTI

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		AND HUMAN SERVICES					FORM	APPROVED
		& MEDICAID SERVICES				0		0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION		COM	E SURVEY PLETED
		245544	B. WING					C 10/2022
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
VICTOR	(HEALTH & REHABIL	LITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430					
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF			(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG	x	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPE		COMPLETION DATE
F 744	Continued From pa	ge 40	F 7	44				
		nd toenails needed trimming.						
	in bed. R35's finger	o.m. R35 was observed lying nails were long with a of dried dark brown matter both top of his nails.						
	in bed. R25's finger	o.m. R35 was observed laying mails remained long with a of dried dark brown matter top of his nails.						
	family member (FM soiled incontinence very dirty. FM-A sta having his nails cut other ways to addre leaving his nails dirt at this time and stat different interventio nails clean. FM-B w	on 2/8/22, at 4:08 p.m. R35's I)-A stated R35 dug in his product which left his nails ted she knew R35 did not like , but felt the facility could try ess the situation rather than ty. FM-B was also interviewed ted she felt the facility could try n to attempt getting R35's vas not aware of any tions attempted to assist R35						
	hospice registered unaware of any beh R35's nail care. RN stated, "Those nails scratching himself. 8:47 a.m. RN-D stat nails cut. RN-D stat	on 2/9/22 at 8:43 a.m. nurse, (RN)-D stated she was navioral interventions related to -D observed R35's nails and s are gross. I think he is These need to be soaked." At ted R35 "refused" to have his ted she did not attempt any tions, but added, "If he was in Id soak."						
	social worker (SW)	on 2/9/22, at 10:56 a.m. -A stated she knew R35 had cognition, but was unaware of						

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		AND HUMAN SERVICES					FORM	03/21/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		(X3) DATI COM	E SURVEY PLETED
		245544	B. WING					_ 10/2022
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CO	DDE		
VICTORY	YHEALTH & REHABIL	LITATION CENTER			12 49TH AVENUE NORTH IINNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 758 SS=D	not aware R35 was from staff. SW-A sta could attempt to ap During an interview director of nursing (resisted care staff s should offer care in words, and try to ma The DON added it of different staff memb resident. If the inter the nurse should do the care was refuse attempted. If a resid care, it should be re- to see how they cou DON was not aware care from R35, how be combative at tim friendly mood, staff completing his care Facility policy titled revised 11/18, inclu confirmed dementia team] with identify a to maximize remain life." "The IDT will a overall plan depend response to those in dementia, developm conditions, changes and other relevant f	esident displayed. SW-A was resistive to care or assistance ated if R35 was resistive, staff proach him in a different way. on 2/9/22, at 11:14 a.m. the (DON) stated when a resident should re-approach. Staff different ways, use calm ake the resident feel calm. could be helpful to have a ber attempt to talk with a ventions were not successful, ocument in the medical record ed and what interventions were dent had ongoing refusals of eported to nursing supervisors ald help with the situation. The e of any ongoing refusals of vever, was aware R35 could hes. When R35 was in a could be successful in es. Dementia - Clinical Protocol ded, "For the individual with a, the IDT [interdisciplinary a resident-centered care plan hing function and quality of adjust interventions and the ling on the individual's nterventions, progression of nent of new acute medical s in resident or family wishes, factors." sychotropic Meds/PRN Use	F 7					3/12/22

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DEPARTMENT OF HEALTH ANI CENTERS FOR MEDICARE & N				FORM	: 03/21/2022 APPROVED . 0938-0391
) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
	245544	B. WING			C 10/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY HEALTH & REHABILITA			512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
PREFIX (EACH DEFICIENCY MUS	IENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR(DEFICIENCY)	LD BE	(X5) COMPLETION DATE
affects brain activities a processes and behavio but are not limited to, di categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehen resident, the facility mu §483.45(e)(1) Resident psychotropic drugs are unless the medication is specific condition as dia in the clinical record; §483.45(e)(2) Resident drugs receive gradual of behavioral interventions contraindicated, in an e drugs; §483.45(e)(3) Resident psychotropic drugs purs unless that medication diagnosed specific cond in the clinical record; ar §483.45(e)(4) PRN order are limited to 14 days. §483.45(e)(5), if the atth prescribing practitioner appropriate for the PRN	bic Drugs. otropic drug is any drug that associated with mental or. These drugs include, drugs in the following nsive assessment of a ust ensure that ats who have not used the not given these drugs is necessary to treat a iagnosed and documented ats who use psychotropic dose reductions, and us, unless clinically effort to discontinue these ats do not receive rsuant to a PRN order is necessary to treat a indition that is documented and ders for psychotropic drugs Except as provided in tending physician or r believes that it is	F 758			

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				APPROVE . 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
						С
		245544	B. WING			10/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
VICTOR	(HEALTH & REHABIL	ITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 758	Continued From pa	ae 43	F 7	758		
		dent's medical record and				
		n for the PRN order.				
	§483.45(e)(5) PRN	orders for anti-psychotic				
	drugs are limited to	14 days and cannot be				
		attending physician or				
		oner evaluates the resident for				
		s of that medication. NT is not met as evidenced				
	by:	VI IS NOT MELAS EVIDENCED				
		and document review, the		F 758		
		ure adequate medical		R 57 s pharmacist will be	e contacted to	
		ovided or a gradual dose		generate a gradual dose r		
		as attempted for consumed		recommendation and will		
		dication for 1 of 5 residents		and/or initiate a gradual de		
		unnecessary medication use. failed to ensure orders for as		based on the MD s response Pharmacist recommendat		
		anxiety medication were		survey exit until present fo		
		after 14 days, for 1 of 5		require a gradual dose att		
	residents (R17) rev			recommendation was sen		
	Findings include:			the MD response to attem dose reduction was noted		
				implemented.		
		imum Data Set (MDS), dated		R 17 s physician was cor		
	-	R57 had moderate cognitive juired extensive assistance to		PRN order for diazepam a for 3 months were renewe		
		vities of daily living (ADLs).		Existing residents PRN		
		utlined R57 scored a "03" on		anti-anxiety/anti-psychotic	orders were	
		-9 screening and consumed		reviewed and updated as		
	antidepressant med	dication on a daily basis during		residents will have an auto	omatic 14 day	
	the look-behind per	iod.		stop date initiated for anti antianxiety medications u		
	R57's printed Clinic	al Physician Orders, printed		indicated by the MD.	11633 011161 11136	
		R57's physician-ordered		The IDT team and nursing	g staff were	
		provided by the nursing home.		in-serviced on the Psycho		
		etine (an antidepressant		Policy and procedure with	emphasis on	
		grams (mg) on a daily basis at		attempts to reduce psycho		
	bedtime. The repor medication as 12/2	t listed a start date of the		medications should occur		
	medication as 12/2	N/21 (The last	1	quarters unless contraind	cated and PRN	1

Facility ID: 00166

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE			0938-039 SURVEY
ND PLAN C	F CORRECTION	DENTIFICATION NUMBER:					PLETED
		245544	B. WING _	3. WING			C 10/2022
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	02,	
VICTORY	'HEALTH & REHABI	LITATION CENTER			2 49TH AVENUE NORTH INNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 758	R57's Extended Ca dated 11/17/21, ide perceived state of h "difficult to engage physician. This note which included duld start date was 7/20 R57's medical reco any physician's me past calendar year R57's psychotropic rationale why a gra was not attempted On 2/9/22 at 1:30 p nursing (ADON) sta medical record and supporting docume addressing the lack duloxetine. R57 sta and had continued with no recorded G verified the medica [physician] clinical n ongoing use of the have to have one [j An undated Gradua directed, "A [GDR] resident has been i initiated psychotrop for one year. The G 2 separate quarters documentation from the GDR is contrain	a readmission). However, are Nursing Home Visit note, entified R57 reported "his self health is terrible," and was in conversation," per the e listed R57's medications boxetine, however, the listed 18. ord was reviewed and lacked dical justification within the supporting the ongoing use of medication consumption or dual dose reduction (GDR) and/or considered. o.m., the assistant director of ated she had reviewed R57's was unable to provide any entation from R57's physician c of GDR for R57's consumed arted the medication in 2020 on the same dosing since then DR(s) being attempted. ADON I record should contain "their rationale" or justification for the medication adding, "They just ustification]." al Dose Reduction policy should be attempted after the in the facility or after a newly bic medication has been in use GDR attempts should occur in s unless there is n the MD [medical doctor] that hdicated."	F 75	58	medications will have an automatic date initiated unless otherwise spec by the physician. For orders beyon 14 day stop date, the physician ratio along with the updated order will be to the pharmacy for processing. The Director of Nursing and/or desi will be responsible for compliance. Audits on Gradual Dose Reduction attempts and PRN stop dates will b weekly x 4 weeks then monthly to e compliance. All audits will be reviewed by the Administrator and the Administrator present the audit results to QAPI for review and recommendation.	cified d the onale e sent gnee egin ensure	
	R17's admission M	inimum Data Set (MDS) dated					

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		AND HUMAN SERVICES					FORM	APPROVED
		& MEDICAID SERVICES				0		
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						
		245544	B. WING					
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>		STREET ADDRESS. CITY, STATE	ZIP CODE	UZI	10/2022
					512 49TH AVENUE NORTH			
VICTOR	Y HEALTH & REHABIL	LITATION CENTER		N	MINNEAPOLIS, MN 55430			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID					(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	×	CROSS-REFERENCED T	ADDRESS, CITY, STATE, ZIP CODE H AVENUE NORTH APOLIS, MN 55430		
			<u> </u>					
F 758	Continued From pa	nge 45	F 7	58				
		R17 was cognitively intact and		00				
		in acute fracture of the lower						
		e respiratory failure.						
	P17's provider orde	ers dated 11/29/21, indicated						
		or diazepam (medication to						
	treat anxiety) 5 milli	igrams (mg), give one tablet						
	every 12 hours as r	needed (PRN) for anxiety.						
		ent provider order dated R17 had an order for						
		ation to treat anxiety) 25 mg,						
		ry 8 hours PRN for anxiety.						
	Neither medication	had a stop date, duration						
	identified, or param should be administe	eters when each medication ered.						
		edication Administration						
		ed 1/1/22 through 2/9/22, administered hydroxyzie 31						
	times and diazepan							
		ted 12/23/21, at 9:55 p.m. tion regimen review (MRR)						
		the pharmacist and had						
		ommendations, however, the						
	recommendations v	were not documented within						
		R17's corresponding MRR						
	facility.	wever, was not provided by the						
	laomy.							
		edical record lacked indication						
		uated by the attending						
		cumented rational for use of a ppic drug beyond 14 days.						
	i i i i i i i poyonoli e							
		on 2/10/22, at 2:01 p.m. the						
		(DON) verified R17's PRN						
		oxine orders did not have an received both medications for						

Facility ID: 00166

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	-	AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245544	B. WING		C 02/10/2022	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY	Y HEALTH & REHABIL	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	anxiety.	-	F 75	8		
	consultant pharmad MRR requested end and hydroxine) and hydroxyzine and dia (simultaneous use of single ailment). A re MRR was not receir for review was reper The process was in did not have duplicat two medications for happen, however, t	on 2/11/22, at 12:05 p.m. the cist stated R17's December d dates (for PRN diazepam also to review the prescribed azepam for polypharmacy of multiple drugs to treat a esponse to the December ved, hence, the same request eated on R17's January MRR. nportant to ensure residents ate therapy. Further, having the same indication could here needed to be further medication should given for ety.				
F 761 SS=E	4/07, indicated the review each resider monthly and collabo medication prescrib Label/Store Drugs a	and Biologicals	F 76	1		3/12/22
	Drugs and biological labeled in accordan professional princip appropriate access	g of Drugs and Biologicals als used in the facility must be ace with currently accepted ales, and include the ory and cautionary e expiration date when				
	§483.45(h)(1) In ac	of Drugs and Biologicals cordance with State and acility must store all drugs and				

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		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION ()	COM	E SURVEY PLETED
		245544	B. WING			(02/*	C 10/2022
NAME OF I	PROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•=	
VICTOR	Y HEALTH & REHABII	LITATION CENTER			12 49TH AVENUE NORTH /INNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 761	Continued From pa	ge 47	F 7	'61			
		d compartments under proper ls, and permit only authorized access to the keys.					
	locked, permanentl storage of controlle the Comprehensive Control Act of 1976 abuse, except when package drug distri quantity stored is m be readily detected This REQUIREMEN by:	NT is not met as evidenced			E 704		
	review, the facility f medication carts of storage. This had th residents who could medications.	tion, interview, and document ailed to secure 3 of 4 oserved for medication ne potential to affect all d access unsecured			F 761 When identified during survey, the resident carts were locked by the nur staff. No ill effects were experienced this deficient practice. Future medica pass times, the cart will be locked wh the nurse leaves the cart unattended	d by ation hen I.	
	observed unlocked	a.m. a medication cart was and unattended in the East cation cart was located outside			Nursing staff were in-serviced on the Storage of Medication policy with emphasis on item #7 that the medica cart must be locked when unattended staff.	ation	
	Registered nurse (F medication cart at 1 not common praction unlocked, however, food. Two unidentifi	on and out of view of staff. RN)-A returned to the 11:52 a.m. and stated it was ce to leave a medication cart , he went to provide a resident ied residents passed by the on cart prior to RN-A's arrival.			The Director of Nursing and/or desig will be responsible for compliance. Audits on locked medication carts wi begin weekly x 4 weeks then monthly ensure compliance. All audits will be reviewed by the Administrator and the Administrator w	ll y to	
	On 2/7/22, at 1:57 p observed unlocked of the South Hallwa	p.m. a medication cart was and unattended at the far end ay. At 1:59 p.m., trained MA)-A returned to the			present the audit results to QAPI for review and recommendation.		

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		AND HUMAN SERVICES				FORM	03/21/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245544	B. WING				C 10/2022
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VICTOR	Y HEALTH & REHABIL	LITATION CENTER			12 49TH AVENUE NORTH /INNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 761	medication cart and provide a resident r important to keep th prevent residents fr the cart. TMA-A sta the hallway when sl resident was observed TMA-A's return to th On 2/10/22, at 7:18 observed unlocked of the North Hallwa licensed practical n stepped away from something, but ack locked the medicati unidentified resident the hallway. During an interview director of nursing (must be locked whe often pass by and c medications. Facility policy titled 11/20, identified cor limited to, drawers, cart, and boxes) co were locked when r medication carts we Lab Srvcs Physicial CFR(s): 483.50(a)(2) The f (i) Provide or obtain ordered by a physic	d stated she stepped away to medications. She stated it was ne medication cart locked to om accessing medications in ted there were no residents in he left. One unidentified ved in the hallway prior to he medication cart. a.m. a medication cart was and unattended in the middle y. Upon return at 7:20 a.m., urse (LPN)-A stated she the medication cart to look for nowledged she should had ion cart when she left. One at was observed ambulating in c on 2/10/22, at 12:43 p.m. the (DON) stated medication carts could open the cart and take Storage of Medication revised mpartments (including, but not cabinets, room, refrigerators, ntaining drugs and biological's not in use. Unlocked ere not to be left unattended. n Order/Notify of Results 2)(i)(ii)	F 7	761			3/12/22

Facility ID: 00166

If continuation sheet Page 49 of 68

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/21/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION (E SURVEY PLETED
		245544	B. WING				, 0/2022
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY	YHEALTH & REHABIL	ITATION CENTER			12 49TH AVENUE NORTH /INNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 773	Continued From pa accordance with Sta practice laws.	ge 49 ate law, including scope of	F	773			
	 (ii) Promptly notify t physician assistant, nurse specialist of I outside of clinical re with facility policies notification of a pra- physician's orders. This REQUIREMEN by: Based on interview facility failed to obta and promptly notify results for 1 of 1 res diagnosed with a ur Findings include: R12's Admission Re R12 had a history of R12's annual Minim 8/24/21, indicated F was always incontin R12's care plan dat "Report pertinent la doctor]." A progress note dat indicated urinalysis was not collected. A collect the sample. 	AT is not met as evidenced and document review, the ain a urine specimen timely the ordering physician of sidents (R12) who was inary tract infection. ecord dated 2/10/22, indicated f being diagnosed with a UTI. hum Data Set (MDS) dated R12 had intact cognition and hent of bladder. ed 2/10/21, directed staff to, b results to MD [medical ted 11/24/21, at 3:27 p.m. and urine culture (UA/UC) Afternoon shift was informed to A subsequent progress note			F 773 R 12 MD was notified that the lab re results were not reported timely. The response will be recorded in the resi medical record. R 12 was treated wi antibiotic therapy as ordered. Existin resident lab orders from survey exit present were reviewed and orders updated as needed. Future resident 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 Lab and Diagnostic Test Result polic focus on obtaining the lab specimen notifying the MD of the lab results. The Director of Nursing and/or desig will be responsible for compliance. Audits on lab specimen collection ar result reporting to the MD will begin weekly x 4 weeks then monthly to er	e MD ident th ng until t lab t lab t lab a the cy with a and gnee nd lab	
	sample which was of R12's primary care as R12 did not have	2:47 p.m. indicated a UA/UC collected was contaminated. provider (PCP) was notified e symptoms and requested to whether the specimen			compliance. All audits will be reviewed by the Administrator and the Administrator present the audit results to QAPI for review and recommendation.		

Facility ID: 00166

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		AND HUMAN SERVICES					FORM	APPROVED
						0		0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION			E SURVEY PLETED
			A. BUILDI	ING				C
		245544	B. WING					
NAME OF F	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE,	ZIP CODE		
VICTORY	(HEALTH & REHABIL			5	512 49TH AVENUE NORTH			
VICTORI		LITATION CENTER		N	MINNEAPOLIS, MN 55430			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN O	F CORRECTION	١	(X5)
PRÉFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	X	(EACH CORRECTIVE AC CROSS-REFERENCED TO			COMPLETION DATE
TAG	REGULATORTOR		TAG		DEFICIEN			
			l.					
F 773	Continued From pa	ae 50	F 7	72				
	needed to be obtair	•	1 /	15				
		leu.						
	A faxed physicians	order dated 11/26/22,						
		ctitioner (NP)-B wrote an order						
		collected for R12. The						
		aled by facility staff and						
	indicated "noted" or	n 11/27/21.						
	A museusse moto del	had 10/0/01 at 4:01 a main						
		ted 12/2/21, at 4:21 a.m., six rder was provided, indicated						
		rative during the shift to						
		The oncoming shift was to be						
	updated.							
	•							
		d physicians order dated						
		NP-B wrote an order which						
		REQUEST." Additionally,						
		/18/21 and 11/26/21" and no						
		ble. The facility was to contact sults or re-order the test if it						
		Further, if R12 refused the						
		was requested. A hand						
		ndicated "to be followed up on						
	Monday [12/4/21]" \	was documented on the fax.						
		physicians order dated						
		NP-B wrote an order which						
		I REQUEST, URGENT." C ordered 11/18/21, 11/26/21,						
		o results were available. The						
		ict the lab to obtain results or						
		t was not completed and R12						
	was "still having syr	mptoms of a UTI." A hand						
	written note which i	ndicated "Noted, sample						
		nis was 29 days after the initial						
	sample was reques	sted.						
	D10's December 00	21 Madiantian Administration						
		021 Medication Administration cated R21 was prescribed						

Facility ID: 00166

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· /	TE SURVEY MPLETED
		245544	B. WING		02	C 2/10/2022
	PROVIDER OR SUPPLIEF		5	STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 773	every 12 hours for Subsequent review indicated: - 1/27/22, at 2:42 p screaming when a practitioner was ne ordered. - 1/28/22, 10:32 p. to urinate and exp to do so. An order strait catheterizatio obtained at 7:30 p pick up the sample "agent" was able t messages were le - 2/12/22, at 10:53 antibiotic for a UT During an interview stated a UA/UC w 12/3/21, which wa be completed, how from the facility. T positive on 12/16/2 Ciprofloxacin was culture sensitivity of antibiotic will wo was not provided,	biotic) 250 milligrams (mg) 3 days for a UTI. w of R12's progress notes p.m. R12 was noted to be attempting to urinate. The nurse otified and a UA/UC was m. R12 was noted to be unable erienced pain when attempting was obtained to perform a on. A urine sample was m. and the lab was called to e as soon as possible. No o take the call and two oft. b p.m. R12 was placed on an l for seven days. w on 2/9/22, at 1:05 p.m. NP-A as ordered for for R12 on s the third request for the lab to wever, there was no response he NP was notified the UA was 21, and an order for prescribed. NP-A stated a report (checks to see what kind ork best to treat an infection) however, the medication was	F 773			
	stated a UA/UC w 12/3/21, which wa be completed, how from the facility. T positive on 12/16/2 Ciprofloxacin was culture sensitivity of antibiotic will we was not provided, prescribed as R12 and there was alre multiple requests an additional UA/L dysuria (difficulty u notified R12 was u	as ordered for for R12 on s the third request for the lab to wever, there was no response he NP was notified the UA was 21, and an order for prescribed. NP-A stated a report (checks to see what kind ork best to treat an infection)				

If continuation sheet Page 52 of 68

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED NAME OF PROVIDER OR SUPPLIER 245544 STREET ADDRESS, CITY, STATE, ZIP CODE VICTORY HEALTH & REHABILITATION CENTER 512 49TH AVENUE NORTH			AND HUMAN SERVICES				FORM	03/21/2022 APPROVED 0938-0391
245544 B. WING 02/10/202 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE VICTORY HEALTH & REHABILITATION CENTER 512 49TH AVENUE NORTH	STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		LE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
VICTORY HEALTH & REHABILITATION CENTER 512 49TH AVENUE NORTH			245544	B. WING	i			
I VICTORY HEALTH & REHABILITATION CENTER	NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEAPOLIS, MN 55430	VICTOR	Y HEALTH & REHABII	LITATION CENTER			512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
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 UAUC 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 UAUC which was ordered on 11/18/21. Further, the ADON reviewed R12's smedical record and was unable to identify if R12's sensitivity report was shared with the PCP. The ADON stated she also had a concerne regarding the collection of R12's UAUC on Stated if tappeared 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. The ADON stated the appeared 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	sensitivity report wa was informed on 1// for sensitivity result UTI without the info follow-up with the p A NP saw R12 at the sensitivity report wa UA/UC which was of for Ceftriaxone (ant ordered at that time communication bre ensuring a sensitivit sensitivity report wa antibiotic treatment During an interview assistant director of were expected to cl fax the information did not know why th UA/UC which was of the ADON reviewed was unable to ident was shared with the also had a concern R12's UA/UC on 1// the NP was informed report. The ADON so culture sensitivity re however, "it does ne ADON reviewed R1 see an indication R was shared with the "Staff should had for was received or if th for not providing tre for medical provide	as not provided. The facility 31/22, the NP was still waiting is and did not want to treat the ormation. The facility did not provider regarding the request. he facility on 2/9/22, and the as found at that time for the collected on 1/27/22. An order tibiotic) 1 gram injection was a NP-A added, there was a akdown from the facility and ty report was provided. The as important as it determined if a was appropriate. on 2/9/22, at 1:50 p.m. the f nursing (ADON) stated staff hart abnormal lab values and a a residents PCP. The ADON here was a delay in R12's initial ordered on 11/18/21. Further, d R12's medical record and tify if R12's sensitivity report e PCP. The ADON stated she regarding the collection of 27/22 to today (2/9/22) when ed of the culture sensitivity stated it appeared R12's eport was faxed to R12's PCP, ot appear it got there." The 12's medical record and did not 12's culture sensitivity report e PCP. The ADON added, ollowed up to ensure the fax here was a clinical justification eatment." It was best practice rs to wait for sensitivities when	F 7	773			

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DA1	. 0938-039 E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			APLETED
		245544	B. WING			C / 10/2022
NAME OF	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
VICTOR	Y HEALTH & REHABI	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 773 F 791 SS=D	Results - Clinical F included, "The faci process all lab resu- residents. Once re- initial and then place the Unit Secretary/ for scanning. If the review lab and diag follow the remainder reporting and docu- implications, anoth (supervisor, charge coordinate the pro- pending must be re- and written on the also included, "Fac- information about v information about v information was pr should be done in the medical record report, because test with other relevant individual's overall advance directives Routine/Emergenc CFR(s): 483.55(b) §483.55(b) Nursing The facility- §483.55(b)(1) Mus outside resource, i	Lab and Diagnostic Test protocol," updated 4/30/21, lity nurse will review and ults for his/her assigned viewed, the nurse must date, ce in the designated area for Health Information Coordinator staff who first receive or gnostic test results cannot er of this procedure for menting the results and their er nurse, etc.) should follow or cedure. Results that are elayed to the oncoming nurse 24-hour report." The policy cility staff should document when, how, and to whom the ovided and the response. This the Progress Notes section of and not on the lab results st results should be correlated information such as the situation, current symptoms, , prognosis, etc." y Dental Srvcs in NFs (1)-(5) rvices sist residents in obtaining ir emergency dental care.	F 773			3/12/22

Facility ID: 00166

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		OMB NO. 0938-0391
		(X3) DATE SURVEY COMPLETED C
B. WIN	B	02/10/2022
	STREET ADDRESS, CITY, STATE, ZI	IP CODE
ULL PRE		ION SHOULD BE COMPLETION THE APPROPRIATE DATE
covered uested, from the /s, refer for ur within tation of d still eat al ces that ing those of l may not of facility d are r ncurred enced cument d dental of or l and of facility d	F 791 F 791 R 57 care plan and group updated to include denta have an appointment ma the dentist. Existing resid	o sheet was I cares. R 57 will ide be seen by dents who need
	BER: A. BUILI B. WINC ULL PREF TON)	VCLIA BER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING

Facility ID: 00166

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
						(C
		245544	B. WING _			02/*	10/2022
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY	HEALTH & REHABIL	ITATION CENTER			INNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From pa Findings include: R57's quarterly Min 2/2/22, identified R4 impairment, demon behavior, and requi complete his person R57's Census listing record (EMR), print current payer source R57's care plan, da an alteration in his a self care and direct ROUTINE: Set-up, times for witness)." developed problema interventions for R5 hygiene. On 2/7/22 at 1:10 p in bed in his room. expressed he had so previous months ar result in several spot his teeth and had so present on his upper seen a dentist for th they needed to be f action had been tak remove them. R57 dentist to get them	ge 55 imum Data Set (MDS), dated 57 had moderate cognitive strated no rejection of care(s) red extensive assistance to nal hygiene needs. Further, g in the electronic medical ed 2/10/22, identified R57's e as Medicaid. ted 2/9/21, identified R57 had activities of daily living (ADL) ed, "PERSONAL HYGIENE Cares in pairs (two staff at all However, the plan lacked any			CROSS-REFERENCED TO THE APPROP	fusals nts with g the n by as policy l o care ces l be ents olan then	
	not being addresse						

If continuation sheet Page 56 of 68

		AND HUMAN SERVICES <u>& MEDICAID SERVICES</u>					APPROVEI . 0938-039
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	CON	E SURVEY IPLETED
		245544	B. WING				C 10/2022
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
VICTOR	Y HEALTH & REHABIL	ITATION CENTER			2 49TH AVENUE NORTH INNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 791	recorded R57 had c appointment so the refusal were explain "[R57] verbally agre rescheduled." On 10/21/21, R57 w scheduled dental ag day, on 10/22/21, w having. However, R57's He - Nursing Home Vis 10/26/21, identified unable to make the appointment. The n and plan for R57 frc included, "11. Broke appointment was m was in hospital. NH follow up to ensure R57's medical recor evidence R57's mis been rescheduled, of despite the medical R57 missing the pre When interviewed c assistant (NA)-C sta R57 and explained with cares, including so she used only m NA-C verified R57 h palate and describe Further NA-C stated	ous director or nursing (DON) declined to go for his dental risks and benefits of the ned to him. The note recorded, ed to go to next visit if it is was recorded as having a opointment for the following hich R57 was aware of nnepin County Medical Center it Progress Note, dated R57 was hospitalized and	F 7	91			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (x1) PROVUER/SUPPLIER/LLAN JEXTIFICATION NUMBER 245544 (x2) MULTIPLE CONSTRUCTION A BUILDING (x3) DATE SUPPLIER COMPLETE 3 WING MAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZP CODE 512 49TH AVENUE NORTH MINREPOLIS, MIN 55430 STREET ADDRESS, CITY, STATE, ZP CODE 512 49TH AVENUE NORTH MINREPOLIS, MIN 55430 MAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZP CODE 512 49TH AVENUE NORTH MINREPOLIS, MIN 55430 STREET ADDRESS, CITY, STATE, ZP CODE 512 49TH AVENUE NORTH MINREPOLIS, MIN 55430 PHEFIN TAG SUBMARY STATEMENT OF DEPICIENCES (EACH OSFICHANT WASTE REPRECEED BY FULL (EACH OSFICHENC ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPHIATE DEFICIENCY) DREFUNCTION MINREPOLIS, MINREPOLIS, MINRE			AND HUMAN SERVICES				FORM	: 03/21/2022 APPROVED : 0938-0391
24554 B. WING 02/10/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, GTY, STATE, ZIP CODE STREET ADDRESS, GTY, STATE, ZIP CODE VICTORY HEALTH & REHABILITATION CENTER STREAM YEAR DERIVER OF DEPICIENCIES STREAM YEAR DEPICIENCY MUST BE PRECEDED BY FULL TOTAL TO STRUCT AND STATEMENT OF DEPICIENCIES STREAM YEAR DEPICIENCY MUST BE PRECEDED BY FULL PREFX PRECINCY OR USC DEPICIENCIES COMECTION SHOULD DE CROSS-REFERENCE OT THE APPROPRIATE COMECTION SHOULD DE CROSS-REFERENCY COMECTION SHOULD DE REFUSE NO. NO COMECTION SHOULD DE REFUSE NO. NO COMECTION SHOULC APROVEMENT NO. NO COMECTION SHOULD DE REFUSE NO. NO COMECTION							CON	IPLETED
VICTORY HEALTH & REHABILITATION CENTER 512 49TH AVENUE NORTH MINREAPOLIS, MN 55430 PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH ODEFICIENCY MUST BE PRECEDED BY FULL RECULTORY OR LSC IDENTIFYING INFORMATION) PREFX TAG CACORRECTION (EACH CORRECTION MOULD BE CACOSS-REFERENCE ACTION SHOULD BE CACOSS-REFERENCE ACTION THE CACOT ACTION SHOULD BE ACTION SHOULD BE CACOSS-REFERENCE ACTION SHOULD BE CACOSS ACTION SHOULD BE CA			245544	B. WING				
VICTORY HEALTH & REHABILITATION CENTER MINNEAPOLIS, MN 55430 (%1) ID PREEK TAS EMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE ENRICIDED BY FULL RESOLUTORY OR LSD DEMIFYING INFORMATION) ID PREEK PRECK RESOLUTORY OR LSD DEMIFYING INFORMATION) PRECK	NAME OF F	PROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
Mill Difference Summary Stratement of Deficiencies Image: Continued From Section 2017 Deficiency Mist Section 2017 <thd< td=""><td>VICTORY</td><td>YHEALTH & REHABII</td><td>LITATION CENTER</td><td></td><td></td><td></td><td></td><td></td></thd<>	VICTORY	YHEALTH & REHABII	LITATION CENTER					
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 to get one scheduled "right away" and added it was important to ensure dental appointment 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 drept 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 As a 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 812 3/12/22	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
(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 was under of the missed dental appointment to ensure dental appointment to ensure dental appointments were made and completed timely as 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 812Food Procurement, Store/Prepare/Serve-Sanitary	F 791	Continued From pa	ige 57	F 7	91			
F 812 Food Procurement, Store/Prepare/Serve-Sanitary F 812 3/12/22		(HUC)-A was interv the person response arrange appointme dental providers. Hi to, or had any recer scheduled or comp provider orders ask HUC-A stated she w R57's medical reco and 2022 appointm R57 had not been r dental appointment HUC-A stated she w away" and added it dental appointment timely as it was "im When interviewed of acting director of nu medical record and appointment was ne directed and reques provider. The DON appointments to be and recorded in the This was important issues could cause An undated Dental policy was provided would be offered de However, the policy guidance on how to would be reviewed	riewed and explained she was sible to help coordinate and ints with in-house and outside UC-A stated R57 had not been int dental appointments leted, despite the medical sing them to be arranged. was unaware of the note(s) in rd. HUC-A reviewed the 2021 ent calendars and verified rescheduled for the missed from 10/21/21. Further, would get one scheduled "right was important to ensure is were made and completed portant to your overall health." on 2/9/22 at 10:53 a.m., the ursing (DON) reviewed R57's verified the missed dental ot rescheduled, despite being sted by R57's medical voiced he would expect such made or, at minimum, offered progress notes if refused. to do as untreated dental infection. Examination/Assessment which directed each resident ental services as needed. (lacked any direction or o ensure missed appointments and/or tracked to ensure					
				F 8	12			3/12/22

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		AND HUMAN SERVICES			FORM A	03/21/2022 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE COMP	LETED
		245544	B. WING _			, 0/2022
NAME OF	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1	
VICTOR	Y HEALTH & REHABII	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 812	CFR(s): 483.60(i)(1 §483.60(i) Food sa)(2)	F 81	12		
	approved or consid state or local autho (i) This may include from local producer and local laws or re (ii) This provision d facilities from using gardens, subject to safe growing and fo (iii) This provision of from consuming for §483.60(i)(2) - Stor serve food in accor standards for food 3 This REQUIREMEN by: Based on observat review, the facility f were clean for 3 of observed to consur pitchers. Findings include: R13's admission M 11/29/21, indicated was independent w included malnutritio R35's quarterly MD had severely impain	e food items obtained directly rs, subject to applicable State egulations. oes not prohibit or prevent produce grown in facility compliance with applicable pod-handling practices. loes not preclude residents ods not procured by the facility. e, prepare, distribute and dance with professional		F 812 R 13, R 35 and R 28 water pitche straws were removed, washed, sa and filled with fresh water and redistributed. All other resident wa pitchers were immediately remove resident rooms, washed, sanitized filled with fresh water and redistrik There was no ill effects to R 13, R R 28 for this deficient practice. Nursing, dietary and the IDT team in-serviced on the Bedside Water Container policy with emphasis or shift collecting and replacing resid water pitchers and soiled contained be delivered to dietary department	anitized ater ed from d and buted. 35 and was was n night lent ers will	

Facility ID: 00166

If continuation sheet Page 59 of 68

245544 B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 02/10/20 VICTORY HEALTH & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (COMP	STATEMENT	OF DEFICIENCIES	KOMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE S12 49TH AVENUE NORTH S12 49TH AVENUE NORTH IMMEDIATION CENTER S12 49TH AVENUE NORTH IMMEDIATION PROVIDERS PLAN OF CORRECTION IMMEDIATION OF LSC IDENTIFYING INFORMATION) PROVIDER SPLAN OF CORRECTION F 812 Continued From page 59 F 812 Cleaning, The Director of Nursing and/or designee Will be responsible for compliance. 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. F 812 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, flaky, beige colored crust on both the inside and outside portion of the straw. On 2/8/22, at 2:22 p.m. R13's water pitcher and straw was observed to have a moderate amount of dried beige colored crust on both the inside and outside portion of the straw. On 2/8/22, at 2:23 p.m. Iiconsed practical nurse (LPN)-A			245544				
VICTORY HEALTH & REHABILITATION CENTER MINNEAPOLIS, MN 55430 (PA) IO PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDENTIFYING INFORMATION PROVIDENTIFYING INFORMATION ID PROVIDENTIFY INFORMATION PROVIDENTIFYING INFORMATION ID PROVIDENTIFYING INFORMATION PROVIDENTIFYING INFORMATION ID PROVIDENTIFY INFORMATION PROVIDENTIFYING INFORMATION ID PROVIDENTIFY INFORMATION PROVIDENTIFYING INFORMATION ID PROVIDENTIFY INFORMATION PROVIDENTIFYING INFORMATION ID PROVIDENTIFYING INFORMATION PROVIDENTIFYING INFORMATION ID PROVIDENTIFYING INFORMATION PROVIDENTIFYING INFORMATION ID PROVIDENTIFYING INFORMATION PROVIDENTIFYING INFORMATION PROVIDENTIFYING INFORMATION ID PROVIDENTIFYING INFORMATION PROVIDENTIFYING INFORMATION <th>NAME OF F</th> <th>PROVIDER OR SUPPLIER</th> <th></th> <th></th> <th>STREET ADDRESS, CITY, STATE, ZIF</th> <th></th> <th>10/2022</th>	NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		10/2022
PREFIX TAG (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMIT DEFICIENCY F 812 Continued From page 59 diagnoses included type II diabetes. F 812 F 812 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. F 812 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. F 812 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. F 812 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. F 8/12 On 2/9/22, at 8:27 a.m. R13's water pitcher and straw was observed 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 straw ware changed/cleaned. Image: Content the content the straw was there the treakfast daily. The kitchen was in charge of wa	VICTOR	(HEALTH & REHABI	LITATION CENTER				
 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 2/8/22, 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 rust on both the inside and outside portion of the straw. On 2/8/22, at 2:21 p.m. R35 water pitcher and straw was observed to have a moderate amount of dried beige colored rust 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 to make and 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, 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 	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
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	diagnoses included R28's significant ch indicated R28 had and was independed diagnoses include On 2/8/22, at 2:20 supplied water pitc re-usable plastic st moderate amount of crust on both the ir straw. On 2/8/22, at 2:21 supplied water pitc plastic straw was of amount of dried be inside and outside On 2/9/22, at 8:27 straw was observe previous observation During an interview licensed practical r assistants pass wa kitchen was in cha however, LPN-A wa pitchers and straws On 2/9/22, at 3:46 water pitcher was of re-usable plastic st dried orange film a the inside of the star replace it," adding,	d type II diabetes. hange MDS dated 12/21/21, moderately impaired cognition ent with eating. R28's acute respiratory failure. p.m. R13 had a facility her at their bedside. The raw was observed to have a of dried, flaky, beige colored haide and outside portion of the p.m. R35 had a facility her at bedside. The re-usable observed to have a moderate ige colored crust on both the portion of the straw. a.m. R13's water pitcher and d and was unchanged from the on on 2/8/22, at 2:23 p.m. hurse (LPN)-A stated nursing iter after breakfast daily. The rge of washing water pitchers, as unsure how often water s were changed/cleaned. p.m. R28's facility provided observed at bedside. The rraw was observed to have a nd some small black spots on raw. R28 stated, "They never "I clean it myself."	F 81	cleaning. The Director of Nursing a will be responsible for cor Audits on water delivery a cleanliness will begin wee then monthly to ensure co All audits will be reviewed Administrator and the Adr present the audit results t	npliance. Ind water pitcher okly x 4 weeks ompliance. by the ninistrator will o QAPI for	

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	-	AND HUMAN SERVICES				FORM	03/21/2022 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED	
		245544	B. WING				C 10/2022	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
VICTORY	YHEALTH & REHABII	LITATION CENTER			512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 812	water pass for R13 NA-D stated when observed to be dirt completed the wate pitcher from the kite NA-D added water	NA)-D stated she completed a and R35 earlier that morning. a residents water pitcher was y, the nursing assistant whom er pass would obtain a clean chen prior to providing water. pitchers were changed out	F 8	12				
	dirty first, especially then observed R13 was in the same co 2/8/22, and describ identified it needed	nowever, the straw usually got y after residents ate. NA-D 's water pitcher, which was ondition as when observed on ed the straw as "dirty" and to be cleaned despite already er pass for the resident.						
	director of nursing (assistants should p water pitcher and s provide a clean wat	on 2/9/22, at 9:27 a.m. the (DON) stated nursing rovide residents with a clean traw daily. It was important to ter pitcher and straw to prevent cher or straw would lead to a acteria.						
F 888 SS=D	10/2010, indicated, of water. Place the	tion of Facility Staff	F 8	388	3		3/12/22	
	must develop and i procedures to ensu- vaccinated for COV section, staff are co	tion of facility staff. The facility mplement policies and ire that all staff are fully /ID-19. For purposes of this onsidered fully vaccinated if it or more since they completed						

Facility ID: 00166

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/21/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245544	B. WING				C 10/2022
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VICTOR	Y HEALTH & REHABIL	ITATION CENTER			12 49TH AVENUE NORTH /INNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 888	a primary vaccinatic completion of a prin COVID-19 is define a single-dose vacci required doses of a §483.80(i)(1) Rega or resident contact, must apply to the for provide any care, tr the facility and/or its (i) Facility employe (ii) Licensed practif (iii) Students, traine (iv) Individuals who other services for th under contract or by §483.80(i)(2) The p section do not apply (i) Staff who exclusi telemedicine servic and who do not hav residents and other (1) of this section; a (ii) Staff who provid facility that are perfit the facility setting a contact with resider paragraph (i)(1) of the staff who have perfit staff who have perfit to facility that are perfit the facility setting a contact with resider paragraph (i)(1) of the staff who have perfit been granted, exemi-	on series for COVID-19. The nary vaccination series for d here as the administration of ne, or the administration of all multi-dose vaccine. rdless of clinical responsibility the policies and procedures ollowing facility staff, who eatment, or other services for a residents: es; tioners; es, and volunteers; and o provide care, treatment, or he facility and/or its residents, y other arrangement. policies and procedures of this y to the following facility staff: ively provide telehealth or es outside of the facility setting re any direct contact with staff specified in paragraph (i) and de support services for the pormed exclusively outside of nd who do not have any direct nts and other staff specified in	F 8	388			

If continuation sheet Page 62 of 68

TATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED
		245544	B. WING		C 02/10/2022	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
VICTOR	Y HEALTH & REHABII	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 888	delayed, as recommediated provided as received, at a minimediated provided at a minimediated provided as the section of the se	accination must be temporarily nended by the CDC, due to and considerations) have num, a single-dose COVID-19 dose of the primary for a multi-dose COVID-19 ff providing any care, services for the facility and/or ensuring the implementation of ons, intended to mitigate the pread of COVID-19, for all staff accinated for COVID-19; acking and securely OVID-19 vaccination status of paragraph (i)(1) of this acking and securely OVID-19 vaccination status of obtained any booster doses by the CDC; hich staff may request an e staff COVID-19 vaccination d on an applicable Federal law; racking and securely nation provided by those staff d, and for whom the facility emption from the staff tion requirements;				

	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II 7		ISTRUCTION		0. 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					MPLETED
							С
		245544	B. WING			02	/10/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CO	DE	
VICTOR	' HEALTH & REHAB	ILITATION CENTER		512 491 MINNE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 888	Continued From p	age 63	F 8	88			
	•	nd local laws, and for further	_				
	ensuring that such	documentation contains:					
	(A) All information	specifying which of the -19 vaccines are clinically					
		the staff member to receive					
		d clinical reasons for the					
	contraindications;						
		the authenticating practitioner					
		at the staff member be e facility's COVID-19					
v r		ements for staff based on the					
	recognized clinical						
		ensuring the tracking and					
		ation of the vaccination status of VID-19 vaccination must be					
		d, as recommended by the					
	CDC, due to clinic						
		cluding, but not limited to,					
		ute illness secondary to dividuals who received					
		dies or convalescent plasma					
	for COVID-19 trea						
	(x) Contingency pl vaccinated for CO	ans for staff who are not fully VID-19.					
	Effective 60 Days						
		process for ensuring that all					
		aragraph (i)(1) of this section d for COVID-19, except for					
		ve been granted exemptions to					
	the vaccination red	quirements of this section, or					
		m COVID-19 vaccination must					
	be temporarily dela CDC, due to clinication	ayed, as recommended by the all precautions and					
	considerations;						
		NT is not met as evidenced					
	by: Based on interview	w and document review, the		E	388		

If continuation sheet Page 64 of 68

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
	245544				
	240044			02/	10/2022
	LITATION CENTER		512 49TH AVENUE NORTH		
ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETIO DATE
policies and proced all staff including co the COVID-19 vaco religious and/or me in less than 100% s increases the poter residents who resid Findings include: Facility policy titled Center Mandatory V indicated the policy Victory. Employees vaccinated to have exemption. The pol contracted staff wh included in this prov During an interview staffing coordinator was not aware if the were not vaccinate we ask, but we dom no indication the fa attestations of vacc staff which included the facility residents During an interview administrator states screened upon entr which nurse would administrator states the facility only con other services.	dures included a process that ontractrated staff had received cination or were granted an edical exemption. This resulted staff vaccination rate which had of spreading COVID to ded at the facility. Victory Health and Rehab Vaccine Policy (undated) applied to all employees of were required to be fully a medical or religious licy did not identify that om provided care were cess. on 2/8/22, at 7:55 a.m. (SC)-A indicated the facility eir contracted staff were or d. SC-A stated, "Sometimes of get proof." Also, there was cility had received any sination from the contracted d hospice staff whom cared for s. on 2/8/22, at 2:10 p.m. the d contracted staff were rance. Further, he had "no idea be coming in." The d, to the best of his knowledge tracted with hospice and no	F 888	 facility attestation indicating that is contracted employee's will be set facility that have not obtained a view medical or religious exemption. If facility mandatory vaccine policy is reviewed and updated to include verbiage. The Staffing Coordinator was in-soon the updated policy and that core employee's that do not provide the necessary documentation will not allowed to enter the facility. The Director of Nursing and/or dewill be responsible for compliance Audits on completed attestation, and reporting of contracted staffing weekly x 4 weeks then monthly to compliance. All audits will be reviewed by the Administrator and the Administrator 	nt to the accine, the was this serviced intracted e to be esignee e. tracking will begin o ensure	
	PROVIDER OR SUPPLIER Y HEALTH & REHABIN SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa policies and proced all staff including co the COVID-19 vacor religious and/or me in less than 100% s increases the poter residents who resid Findings include: Facility policy titled Center Mandatory V indicated the policy Victory. Employees vaccinated to have exemption. The po contracted staff wh included in this pro During an interview staffing coordinator was not aware if th were not vaccinate we ask, but we dor no indication the fa attestations of vacor staff which included the facility residents During an interview administrator stated which nurse would administrator stated the facility only con other services.	DF CORRECTION IDENTIFICATION NUMBER: 245544 PROVIDER OR SUPPLIER Y HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF DENTIFICATION NUMBER: A. BUILDING 245544 B. WING PROVIDER OR SUPPLIER 245544 Y HEALTH & REHABILITATION CENTER JD SUMMARY STATEMENT OF DEFICIENCIES JD (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 888 Continued From page 64 F 888 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 facility residents. During an interview on 2/8/22, at 2:10 p.m. the administrator stated contrac	IC OF DEFICIENCIES (X1) PROVIDERSUPPLIERCULA (X2) MULTIPLE CONSTRUCTION DEF CORRECTION 24554 B. WING 24554 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE Y HEALTH & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES D (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) D Continued From page 64 PREVIDERS YLANOF CORRECTIVE ACTION SHOUL CROSS-REFERENCED THE APPRO- DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) F 888 Folicies 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. F 888 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. II audits will be resonsible for compliance. Ault is on compliance Audit results to QAPI review and recommendation. Was not aware if their contracted staff were or were not vaccinated, SC-A stated, "Sometimes we ask, but we dont get p	COP DEFICIENCIES (Y1) PROVIDERSUPPLIERCLA IDENTIFICATION NUMBER (X2) MUTTPLE CONSTRUCTION (X3) MUTTPLE CONSTRUCTION (X3) MUTTPLE CONSTRUCTION A BUILDING 245544 B. WING (Z2) PROVIDER OR SUPPLIER 245544 B. WING (Z3) Y HEALTH & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH (Z3) StREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH (Z3) WHALTH & REHABILITATION CENTER ID PROVIDERY ON LSC IDENTIFYING INFORMATION) PROVIDERY ON SECOND SHOULD BE CROSS REFERENCE TO THE APPROPRIATE Continued From page 64 policies and procedures included a process that all staff including contractated staff had received the COVID-19 vaccination or were granted an religious and/or medical or spreading COVID to residents who resided at the facility. F 888 Findings include: F F 818 Facility mandatory vaccine policy (undated) indicated the facility. F and on ot provide the necessary documentation will not be allowed to enter the facility. Findings include: F 312 49TH AVENUE NORTH Were or vaccinated. Staff whom provide dare were included in this process. F 818 During an interview on 2/8/22, at 7:55 a.m. on indicated the facility was not aware if their contracted staff were or vaccinated. Staff whom provide da

If continuation sheet Page 65 of 68

		AND HUMAN SERVICES			FORM	03/21/202 APPROVE 0938-039
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DAT COM	E SURVEY IPLETED
		245544	B. WING			C 10/2022
	PROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 888	contracted staff wh Further, "We know yet, but need to." During an interview administrator stated	vaccination status of o provide care to residents. we haven't started tracking on 2/10/22, at 4:05 p.m. the d the facility policy needed to lude all facility and contracted	F 88	8		
F 921 SS=D	CFR(s): 483.90(i) §483.90(i) Other Er The facility must pro- sanitary, and comfor residents, staff and This REQUIREMEN by: Based on observat review, the facility for clean and free from (R11, R53) reviewe Findings include: R11's quarterly Min 11/21/21, indicated R53's quarterly MD R53 was cognitively During an observat R11's radiator grate matter which was s the substance was	NT is not met as evidenced tion, interview, and document ailed to ensure radiators were a debris for 2 of 2 residents d for environment. imum Data Set (MDS) dated R11 was cognitively intact. S dated 1/26/22, indicated y intact. ion on 2/7/22, at 1:27 p.m. es were covered with a black ticky. R11 was unsure what and stated, "I've told ut it." R11 was unsure when	F 92	F 921 R 11 and R 53 radiators were c 53 was assessed for allergy syn The MD was notified and the M response will be recorded in the medical record. All other reside radiators were checked and cle needed. Resident rooms will be the maintenance log for monthl radiator cleaning. Housekeeping and Maintenanc in-serviced on the QOL Homelii Environment item #2 that the fa maximize the resident environn clean, sanitary and orderly envir Maintenance Director and/or de be responsible for compliance. Audits on radiator cleaning will weekly x 4 weeks then monthly	mptoms. D e resident ent room aned as e placed on y room e staff was ke incility will nent with a ronment. esignee will begin	3/12/22

Facility ID: 00166

If continuation sheet Page 66 of 68

	CONTRACTOR MEDICARE	& MEDICAID SERVICES	(X2) MULT	IPLF	E CONSTRUCTION		0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED
			D. MINIO				С
		245544	B. WING _			02/	10/2022
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 12 49TH AVENUE NORTH		
VICTOR	Y HEALTH & REHABI	LITATION CENTER			IINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROD DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 921	Continued From pa	66 and	F 92	21			
1 321	During an observat R53's radiator vent their room had a st	ion on 2/7/22, at 4:57 p.m. located below the window in icky black residue which was uched. The resident was all	F 92	21	All audits will be reviewed by the Administrator and the Administrator present the audit results to QAPI review and recommendation.		
	stated there was th	<i>i</i> on 2/7/22, at 4:55 p.m. R53 ick black mold, or something, 53 stated it was disgusting and ergies.					
	housekeeper (HSK were wiped down a was maintained by confirmed there wa	on 2/10/22, at 9:26 a.m. A stated resident radiators about twice a month and a log the supervisor. HSK-A as a black sticky residue on was unsure what the					
	housekeeping supe cleaning log, but ho tops of radiators ar by maintenance. Th verified there was b radiator and stated	on 2/10/22, at 2:05 p.m. the ervisor stated there was a busekeeping only cleaned the nd any deep cleaning was done he housekeeping supervisor black sticky residue on R53's , "Yeah, this needs to be ed, "It's so bad. It hurts my					
	p.m. the housekee maintenance was r Maintenance norm with air brushes mo	interview on 2/10/22, at 2:30 ping supervisor stated not available for an interview. ally scrubbed radiator vents ponthly, however, verified it s were not cleaned for awhile.					
	indicated the "facili	Safe Environment (undated) ty will provide a safe, and comfortable environment					

If continuation sheet Page 67 of 68

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION 245544 A. BUILDING C NAME OF PROVIDER OR SUPPLIER 245544 STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH	DEPAR	FORM	APPROVED							
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 245544 B. WING 02/10/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
245544 B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 02/10/2022						(X3) DATI COM	= SURVEY PLETED			
245544 B. WING 02/10/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				A BOILDIN	<u></u>		C			
			245544	B. WING _						
	NAME OF	PROVIDER OR SUPPLIER								
VICTORY HEALTH & REHABILITATION CENTER MINNEAPOLIS, MN 55430	VICTOR	Y HEALTH & REHABIL	LITATION CENTER		512 49TH AVENUE NORTH					
		SUMMARY STA				N	(NE)			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD) BE	COMPLETION			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	TAG	REGULATORY OR L	SCIDENTIFYING INFORMATION)	IAG		RIATE	DATE			
		1		ľ						
F 921 Continued From page 67 F 921	F 921	Continued From pa	ge 67	F 92	1					
for residents."		for residents."								

Facility ID: 00166

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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 <u>only a suggestion</u> 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

Victory Health & Rehabilitation Center February 28, 2022 Page 2

"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,

Kumala Fiske Downing

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

Victory Health & Rehabilitation Center February 28, 2022 Page 3 Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

		AND HUMAN SERVICES	F	554	44036	PRINTED: 03/14/2022 FORM APPROVED OMB NO. 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245544	B. WING			02/	08/2022	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
VICTORY	HEALTH & REHABI	ITATION CENTER			12 49TH AVENUE NORTH			
				Μ	IINNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 000	INITIAL COMMENT	ſS	K 0	00				
	FIRE SAFETY							
	conducted by the M Public Safety, State 02/08/2022. At the Health & Rehabilita compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F (NFPA) 101, Life Safe edition of National F (NFPA) 101, Life Safe edition of National F (NFPA) 101, Life Safe Existing Health Car NFPA 99, Health Car NFPA 99, Health Car THE FACILITY'S P ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O ONSITE REVISIT C CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA ACCORDANCE W PLEASE RETURN CORRECTION FO DEFICIENCIES (K-	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE. F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. THE PLAN OF R THE FIRE SAFETY TAGS) TO: IN THE E-POC PROCESS, A THE PLAN OF CORRECTION						
		ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	_	TITLE		(X6) DATE	
Electron	ically 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.

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	03/14/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245544	B. WING			02/	08/2022
NAME OF I	PROVIDER OR SUPPLIER	1		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VICTOR	(HEALTH & REHABI	LITATION CENTER			512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	 Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 55107 By email to: FM.HC.Inspections THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A detailed deso taken or planned to 2. Address the m place to ensure the 3. Indicate how the future performance 3. Indicate how the future performance 3. Indicate how the future performance 5. The actual or p the remedy. Victory Health & Re building with a part 1990 and was dete construction. This field separate smoke co fully protected throo sprinkler system. T system with smoke 	spections Division Suite 145 1-5145, OR @state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE	KO	00			

Facility ID: 00166

If continuation sheet Page 2 of 9

		AND HUMAN SERVICES				FORM	03/14/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245544	B. WING			02/	08/2022
NAME OF F	PROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY	(HEALTH & REHABII	LITATION CENTER			12 49TH AVENUE NORTH IINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 2	ĸ	000			
	The facility has a ca census of 51 at the	apacity of 87 beds and had a time of the survey.					
	is NOT MET as evi Hazardous Areas -	5	K	821			3/12/22
	Hazardous areas a having 1-hour fire ra- fire rated doors) or system in accordar When the approved system option is us separated from oth partitions and doors Doors shall be self- and permitted to ha protective plates the from the bottom of Describe the floor a hazardous areas th 19.3.2.1, 19.3.5.9 Area Separation N// a. Boiler and Fuel-F b. Laundries (larger c. Repair, Maintena d. Soiled Linen Roo e. Trash Collection (exceeding 64 gallo f. Combustible Stor (over 50 square fee	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					

Facility ID: 00166

If continuation sheet Page 3 of 9

		AND HUMAN SERVICES			FORM	: 03/14/2022 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245544	B. WING_		02/	08/2022
NAME OF I	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY	Y HEALTH & REHABII	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR(DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	by: Based on observation facility failed to main enclosures per NFF Safety Code, section These deficient find impact on the reside Findings include: 1. On 02/08/2022 and observation that the as a combustible stiffeet in size and did 2. On 02/08/2022 and observation that Rest that did not latch clear An interview with the these deficienct find Fire Alarm System CFR(s): NFPA 101 Fire Alarm System A fire alarm system accordance with an with the requirement Electric Code, and and Signaling Code acceptance, mainter available. 9.6.1.3, 9.6.1.5, NF This REQUIREMENT by: Based on a review	NT is not met as evidenced tion and staff interview, the ntain hazardous area PA 101 (2012 edition), Life ons 19.3.2.1 and 19.3.2.1.3. dings could have a patterned ents within the facility. t 10:00 AM, it was revealed by a beauty shop was being used torage room over 50 square not have a self-closing door. t 10:15 AM, it was revealed by bom 171 had a fire-rated door osed when tested. Testing and Maintenance is tested and maintained in approved program complying hts of NFPA 70, National NFPA 72, National Fire Alarm a. Records of system enance and testing are readily	К 34	K 321 Items in this storage area were r on 2/9/2022. All other storage an doors were tested and are fully operational Room 171 door was repaired on All other resident doors were tes all doors are fully operational. Monthly resident room and stora doors will be tested for full function repairs as needed. Maintenance director and/or des responsible for compliance.	reas 3/3/2022 ted and ge room on and ignee is	3/12/22

Facility ID: 00166

If continuation sheet Page 4 of 9

		AND HUMAN SERVICES & MEDICAID SERVICES		FC	TED: 03/14/2022 DRM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		245544	B. WING		02/08/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
VICTORY	' HEALTH & REHABII	ITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION E DATE
	edition), Life Safety NFPA 72 (2010 edit Signaling Code, see finding could have a residents within the Findings include: On 02/08/2022 at 9 review of available did not have docum inspection of the find An interview with th deficient finding at 0 Fire Alarm System CFR(s): NFPA 101 Fire Alarm - Out of Where required fire services for more th period, the authority notified, and the bu approved fire watch parties left unprotect fire alarm system h 9.6.1.6 This REQUIREMEN by: Based on a review and staff interview, fire alarm out of set (2012 edition), Life This deficient finding	 m system per NFPA 101 (2012 Code, section 9.6.1.3, and tion), National Fire Alarm and ction 14.3.1. This deficient a widespread impact on the facility. 2:30 AM, it was revealed by a documentation that the facility tentation of a semi-annual e alarm system. e Facility Director verified this the time of discovery. Out of Service Service alarm system is out of nan 4 hours in a 24-hour y having jurisdiction shall be ilding shall be evacuated or an the shall be provided for all cted by the shutdown until the as been returned to service. NT is not met as evidenced of available documentation the facility failed to establish a vice policy per NFPA 101 Safety Code, section 9.6.1.6. g could have a widespread 	K 34	 5 on 9/9 as per plan of correction submit 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-annuby ECSI. Maintenance director and/or designee responsible for compliance. 6 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 	ally is 3/12/22 s e
		g could have a widespread ents within the facility.		immediatly upon identifying an outage the facilities fire alarm system. NFPA requires notification to MDOH (the	to

Facility ID: 00166

If continuation sheet Page 5 of 9

		AND HUMAN SERVICES			FORM	03/14/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			E SURVEY PLETED
		245544	B. WING		02/	08/2022
NAME OF F	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH		
VICTORY	(HEALTH & REHABII	LITATION CENTER				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 346	Continued From pa	ge 5	K 346	3		
К 353	review of available did not have a curre policy which stated period. An interview with th Director verified this of discovery.	:30 AM, it was revealed by a documentation that the facility ent fire alarm out of service four hours within a 24-hour le Facility Maintenance s deficient finding at the time Maintenance and Testing	К 353	authority having Jurisdiction) if outa continues for more than 4 hours in a hour period. Facility staff will be in serviced on th policy with focus on performing fire activities should the system falter. Maintenance director and or design responsible for compliance	a 24 nis watch	3/12/22
	CFR(s): NFPA 101 Sprinkler System - Automatic sprinkler inspected, tested, a with NFPA 25, Stan Testing, and Mainta Protection Systems maintenance, inspe- maintained in a sec available. a) Date sprinkler s b) Who provided s c) Water system s Provide in REMARI any non-required of system. 9.7.5, 9.7.7, 9.7.8, a	Maintenance and Testing and standpipe systems are and maintained in accordance dard for the Inspection, aining of Water-based Fire s. Records of system design, action and testing are cure location and readily system last checked system test supply source KS information on coverage for r partial automatic sprinkler				
	by: Based on observat facility failed to mai sprinkler system pe	NT is not met as evidenced tion and staff interview, the ntain the automatic fire er NFPA 101 (2012 edition), ections 9.7.5 and 9.7.7 and		K353 The ceiling tile was replaced on 3/3 All other facility tiles were inspected replaced as needed.		

Facility ID: 00166

If continuation sheet Page 6 of 9

		AND HUMAN SERVICES				FORM	03/14/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245544	B. WING			02/	08/2022
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
VICTORY	YHEALTH & REHABII	ITATION CENTER			12 49TH AVENUE NORTH IINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	Inspection, Testing, Water-Based Fire F 4.1.5.2. This deficie isolated impact on f Findings include: On 02/08/2022 at 1 observation that the the hallway outside An interview with th Director verified this of discovery. Sprinkler System - CFR(s): NFPA 101 Sprinkler System - Where the sprinkle extent and duration determined, areas of inspected and risks recommendations a or designated repre- department and oth jurisdiction have be sprinkler system is hours in a 24-hour of the building affect approved fire watch system has been re 18.3.5.1, 19.3.5.1, 9 This REQUIREMEI by: Based on a review	 b. Standard for the and Maintenance of Protection Systems, section ent finding could have an the residents within the facility. 0:30 AM, it was revealed by ere was a missing ceiling tile in the kitchen area. b. Facility Maintenance s deficient finding at the time Out of Service Out of Service Out of Service r system is impaired, the of the impairment has been or buildings involved are are determined, are submitted to management esentative, and the fire mer authorities having the notified. Where the out of service for more than 10 period, the building or portion cted are evacuated or an is provided until the sprinkler 	K3		K 354 K 354	vill be ity. nee is	3/12/22
		the facility failed to establish a n out of service policy per			The Fire safety out of service policy as per email request on 1/9	/ was	

Facility ID: 00166

If continuation sheet Page 7 of 9

		AND HUMAN SERVICES				FORM	03/14/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245544	B. WING			02/	08/2022
NAME OF	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY	/ HEALTH & REHABII	LITATION CENTER			2 49TH AVENUE NORTH INNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	NFPA 101 (2012 ec section 9.7.6, and Standard for the las Maintenance of Wa Systems, Chapter 7 have a widespread the facility. Findings include: On 02/08/2022 at 9 available document have a current fire s for the automatic fir An interview with th Director verified this of discovery. Electrical Equipment CFR(s): NFPA 101 Electrical Equipment Extension Cords Power strips in a particular care-related (PCREE) assemble by qualified person 10.2.3.6. Power str may not be used for electronics), except rooms that do not u PCREE meet UL 13 strips for non-PCRE (outside of vicinity) care rooms, power standards. All pow	dition), Life Safety Code, NFPA 25 (2011 edition), spection, Testing, and ater-Based Fire Protection 15. This deficient finding could impact on the residents within 2:30 AM, it was revealed by tation that the facility does not sprinkler out of service policy re sprinkler system. The Facility Maintenance is deficient finding at the time of - Power Cords and Extens atient care vicinity are only	К 3		Facility staff will be in-serviced on th policy with focus on performing fire v activities should the system falter. The fire watch policy was amended include "Fire watch will be implement immediatly on identification of outag the facilities fire alarm and sprinkler system failure. If outage continues f greater then 4 hours facilty will report outage to MDOH as the Authority Ha Jurisdiction. Maintenance director and/or designed responsible for compliance.	watch to nted e in for rt aving	3/12/22

If continuation sheet Page 8 of 9

TATEMENT	CS FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	· · /	U938-U39 E SURVEY PLETED
		245544	B. WING		02/	08/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
K 920	Extension cords us immediately upon of which it was installed 10.2.4. 10.2.3.6 (NFPA 99) (NFPA 70), 590.3 (D This REQUIREMEN by: Based on observation facility failed to utiliz NFPA 99 (2012 edition) Code, sections 10.2 (2011 edition), Nation 400.8 and 590.3, and findings could have residents within the Findings include: 1. On 02/08/2022 and observation that a right phone room located 2. On 02/08/2022 and observation that a right phone shows the phone shows the s	wiring of a structure. ed temporarily are removed completion of the purpose for ed and meets the conditions of , 10.2.4 (NFPA 99), 400-8 0) (NFPA 70), TIA 12-5 NT is not met as evidenced tion and staff interview, the ze relocatable power taps per tion), Health Care Facilities 2.3.6 and 10.2.4, NFPA 70 onal Electrical Code, sections and UL 1363. These deficient a patterned impact on the	K 9	K920 Power tap cords were remove phone room and from behind machine Maintenance director inspecte for any other power tap cords were identified. Staff will be educated on use cords. Maintenance director and/or of responsible for completion.	the vending ed all areas . None other of power tap	

If continuation sheet Page 9 of 9

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00166	B. WING		02/1) 0/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VICTORY	(HEALTH & REHABIL	ITATION CENTEI	AVENUE NO POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	standard licensing s completed at your f Minnesota Departm facility was found N State Licensure.	TS: 2/9/22, and 2/10/22, a survey was conducted acility by surveyors from the nent of Health (MDH). Your OT in compliance with the MN				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 03/03/22

STATE FORM

ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		- (X3) DATE SURVEY COMPLETED		
	00166	B. WING			C 02/10/2022	
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
(HEALTH & REHABII	ITATION CENTER					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
Continued From pa	ige 1	2 000				
SUBSTANTIATED, were cited due to a facility prior to surve H5544291C (MN80 H5544293C (MN80 H5544298C (MN78 H5544301C (MN78 H5544292C (MN79 H5544295C (MN79 H5544297C (MN79 H5544300C (MN78	however, NO deficiencies ctions implemented by the ey: (457) (295) (3969) (3078) (3078) (3089), H5544294C (MN79726) (545), H5544296C (MN79288) (201), H5544299C (MN78490) (3337), H5544302C (MN78064) (3969), H5544304C (MN75790)	2				
correction that you	have reviewed these orders,					
the State Licensing Federal software. T assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state stat listed in the "Summ column and replace the correction order the findings which a statute after the stat as evidence by." For findings are the Sug and Time Period for You have agreed to	Correction Orders using Tag numbers have been tota state statutes/rules for the assigned tag number eff column entitled "ID Prefix atute/rule out of compliance is hary Statement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state attement, "This Rule is not met ollowing the surveyor 's ggested Method of Correction r Correction. participate in the electronic					
	OF CORRECTION PROVIDER OR SUPPLIER HEALTH & REHABIN SUMMARY STA (EACH DEFICIENCC REGULATORY OR L Continued From pa The following comp SUBSTANTIATED, were cited due to a facility prior to surve H5544291C (MN80 H5544293C (MN80 H5544293C (MN78 The following comp UNSUBSTANTIATED UNSUBSTANTIATED H5544292C (MN80 H5544292C (MN80 H5544292C (MN80 H5544292C (MN78 H5544292C (MN79 H5544300C (MN79 H5544303C (MN79 H5544303C (MN79 H5544303C (MN79 H5544303C (MN79 H5544303C (MN79 H5544303C (MN79 H5544303C (MN79 H5544303C (MN79 H5544303C (MN79 H5544305C (M Please indicate in y correction that you and identify the dat Minnesota Departm the State Licensing Federal software. T assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state stat listed in the "Summ column and replace the findings which a statute after the stat as evidence by." Fo findings are the Sug and Time Period fo You have agreed to	OF CORRECTION IDENTIFICATION NUMBER: 00166 00166 PROVIDER OR SUPPLIER STREET A 7 HEALTH & REHABILITATION CENTEI 512 49TH MINNEA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES 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) H5544291C (MN80457) H5544293C (MN80295) H5544293C (MN78078) The following complaints were found to be UNSUBSTANTIATED: H5544292C (MN78038), H5544294C (MN79726) H5544297C (MN78078) The following complaints were found to be UNSUBSTANTIATED: H5544297C (MN79201), H5544299C (MN79288) H5544297C (MN79201), H5544299C (MN78490) 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 compli	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00166 B. WING	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00166 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ID I(EACH THE REHABILITATION CENTEI) ID SUMMARY STATEMENT OF DEFICIENCIES ID I(EACH DEFICIENCY MUST BE PRECIDED BY FULL ID REGULATORY OR LSC IDENTIFYING INFORMATION) D The following complaints were found to be SUBSTANTIATED, however, NO deficiencies were cited due to actions implemented by the facility prior to survey: H5544293C (MN80457) H5544293C (MN78059) H5544293C (MN78059) H5544299C (MN780457) H55442920C (MN78078) H5544299C (MN78080), The following complaints were found to be UNSUBSTANTIATED: H5544292C (MN80457) H5544299C (MN78080), H5544292C (MN78078) H5544299C (MN78080), H5544292C (MN78024), H5544299C (MN78064), H5544292C (MN78024), Please indicate in your electronic plan of correction that you have reviewed these orders, and H5544305C (MN778024). Please indicate in your electronic plan of correction that you have reviewed these orders,	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: 00166 00165 00166 00165 00166 00165 00166 00165 00166 00165 00166 00165 00166 00165 00166 00165 00166 00165 00166 00165 00166 00165 00166 00165 00166 00166 00166 00166 00166 00166 00166 00166 00166 00166 00166 00166 00166 00166 00166 00166 00166 001	

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
	00166	5. 1110		02/	10/2022
PROVIDER OR SUPPLIER					
(HEALTH & REHABII	ITATION CENTEI				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLET DATE
Continued From pa	ige 2	2 000			
obul.htm. The State delineated on the a Department of Hea you electronically. is necessary for Sta enter the word "CO available for text. Ye electronic State lice heading completion be corrected prior to the Minnesota Depa is enrolled in ePOC not required at the state form. PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	e licensing orders are ttached Minnesota Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please RRECTED" in the box ou must then indicate in the ensure process, under the n date, the date your orders wil o electronically submitting to artment of Health. The facility c and therefore a signature is bottom of the first page of ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				
	-	2 265			3/12/22
policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the have criteria which	aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the				
	OF CORRECTION PROVIDER OR SUPPLIER HEALTH & REHABIN SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa Informational Bullet http://www.health.s obul.htm. The State delineated on the a Department of Hea you electronically. is necessary for Sta enter the word "CO available for text. Y electronic State lice heading completion be corrected prior t the Minnesota Dep is enrolled in ePOC not required at the state form. PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA MN Rule 4658.008: Resident Health Sta A nursing home mu policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, a attending physician development of the have criteria which	OF CORRECTION IDENTIFICATION NUMBER: 00166 00166 PROVIDER OR SUPPLIER STREET AI * HEALTH & REHABILITATION CENTEI 512 49TH MINNEAI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES Continued From page 2 Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.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 wil 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. 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 inv	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00166 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST 512 49TH AVENUE NOF MINNEAPOLIS, MN 55 SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG Continued From page 2 2 000 Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.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. 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WING 'ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 'HEALTH & REHABILITATION CENTEI 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREVIDER'S PLAN OF (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREVIDER'S PLAN OF (EACH DEFICIENCY WIST BE PRECEDED BY FULL TAG Continued From page 2 2 000 Continued From page 2 2 000 Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.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 ont required at the bottom of the first page of state form. 2 265 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. 2 265 MN Rule 4658.0085 Notification of Chg in Resident Health Status 2 265 A nursing home must develop and implement polici	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00166 B. WING 02/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 512 497H AVENUE NORTH MINEAPOLIS, MN 55430 ID PROVIDER'S PLAN OF CORRECTION 02/ SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE Continued From page 2 2 000 Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/Inf DEFICENCY) Continued From page 2 2 000 Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/Inf DEFICENCY) Continued From page 2 2 000 Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/Inf DEFICENCY) Continued From page 2 2 000 Informational Bulletin offst the splatuse splate splatuse splate splatuse splatuse splatuse splatuse splatuse splatuse splatuse

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		00166	B. WING		C 02/10/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
VICTOR	Y HEALTH & REHABIL	ITATION CENTEI	AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLET DATE
2 265	results in injury and physician intervention B. a significant physical, mental, o example, a deterior psychosocial status conditions or clinical C. a need to all example, a need to of treatment due to begin a new form of D. a decision the resident from the new E. expected and This MN Requirement by: Based on observati review, the facility fa provider and/or resi wound or need to a unavailability of a puresidents (R55, R28 condition. Findings include: Stage II pressure un skin with exposed of viable, pink or red, na a an intact or rupto Adipose (fat) is not	has the potential for requiring on; change in the resident's r psychosocial status, for ation in health, mental, or in either life-threatening complications; ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment; o transfer or discharge the	2 265	corrected		

If continuation sheet 4 of 41

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
					С	
		00166	B. WING		02/	10/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
/ICTOR)	(HEALTH & REHABI	I ITATION CENTEL	I AVENUE NOI POLIS, MN 55			
(X4) ID	_	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 265	Continued From pa	age 4	2 265			
	1/29/22, indicated I	nimum Data Set (MDS) dated R55 was severely cognitively id indication of any skin issues.				
	the potential to dev immobility and diag skin to be intact, fre discoloration. The o interventions to hel	ted 5/24/21, indicated R55 had elop a pressure ulcer due to gnoses. R55 goal was for their ee from redness, blisters, or care plan listed several p R55 meet their goal which g/documenting/reporting atus.				
		ted 1/26/22, at 11:36 p.m. "a blister of size smaller than on the left buttock."				
	any evidence the n	ord was reviewed and lacked ewly developed area had been he physician despite the area 1/26/22.				
	licensed practical n clear, fluid-filled bli coccyx area (1/26/2	a 2/10/22, at 10:06 a.m. hurse (LPN)-E explained a ster was noted on R55's 22) and verified R55's the doctor was notified of the				
	was observed with LPN-B. At this time R55's left buttocks was pink and moist drainage. The Stag	10 a.m. R55's personal care nursing assistant (NA)-A and e, a Stage II pressure ulcer on was observed. The wound bec t with a small amount of ge II pressure ulcer measured n) x 1 cm. LPN-B verified the e II pressure ulcer.				
		n 2/10/22, at 10:25 a.m. the (DON) stated the R55's				

Minneso	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00166	B. WING			C 10/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VICTORY	(HEALTH & REHABIL	ITATION CENTEI	AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 5	2 265			
		the physician should had been alteration to obtain a treatment				
	indicated he had dia	ecord printed 2/10/22, agnoses including cancer, age), dementia, and				
		ange Minimum Data Set /21, indicated R28 was ely impaired.				
	R28 had a toe infect prescribed cefuroxi	lers printed 2/10/22, indicated ction to his right side and was me axetil (antibiotic) 500 h twice daily for 10 days at 8:00 p.m.				
	revealed the followi - 1/18/22, at 8:10 p. deliver today (cefur billing reasons. The delivered the follow - 1/19/22, at 8:32 a. available. - 1/19/22, at 7:50 p. available. - 1/20/22, at 11:18 a	m. the pharmacy could not oxime axetil) today due to medication was to be				
	the facility notified t	edical record lacked evidence he physician R28 did not inister antibiotics as ordered 20/22.				
Vinnesota D	indicated the facility	ted 1/20/22, at 1:34 p.m. / received a call from the hem R28 was admitted due to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		BERTH TOX TOT TOMBER.	A. BUILDING:	A. BUILDING:			
		00166	B. WING	B. WING		C 02/10/2022	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
ICTOR	(HEALTH & REHABI	I ITATION CENTEI	HAVENUE NOF POLIS, MN 55				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 265	Continued From pa	age 6	2 265				
	cellulitis of the right	t leg.					
	director of nursing	n 2/10/22, at 12:43 p.m. the (DON) confirmed the facility R28's prescribed antibiotic.					
	practitioner (NP)-C R28's antibiotics w	n 2/10/22, at 3:23 p.m. nurse stated she was not informed ere not administered. She aff to update her and it was lo do so.					
	policy dated 2/2022 notify the resident's						
	administrator, direc designee, could de policies and procec physician is notified change in a resider to alter treatment; f requirements. The	THOD OF CORRECTION: The ctor of nursing (DON), or velop/revise and implement dures to assure the resident's d of hospitalization, significant nt's condition, and/or the need then, educate staff on these quality assessment and tee could perform random ompliance.	•				
	TIME PERIOD FO (21) days	R CORRECTION: Twenty-one					
2 550	MN Rule 4658.040 Resident Assessm	0 Subp. 4 Comprehensive ent; Review	2 550			3/12/22	
	home must examir	f assessments. A nursing ne each resident at least revise the resident's					

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Minnesc	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPL	
		00166	B. WING		C 02/10)/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VICTOR	(HEALTH & REHABII	ITATION CENTEI	AVENUE NO			
			POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 550	Continued From pa	ige 7	2 550			
		essment to ensure the y of the assessment.				
	by:	ent is not met as evidenced				
	review, the facility f Data Set (MDS) wa resident (R17) who	ion, interview, and document ailed to ensure the Minimum is accurately coded for 1 of 1 m received oxygen and 1 of 3 iewed for pressure ulcers.		corrected		
	Findings include:					
	12/3/21, indicated F had a diagnoses of MDS lacked indicat	inimum Data Set (MDS) dated R17 was cognitively intact and acute respiratory failure. The tion R17 received oxygen seven-day lookback period /3/21.				
		harge orders dated 11/26/21, oxygen at 2 liters (L) nasal bedtime.				
	registered nurse RI	on 2/10/22, at 9:23 a.m. N-C verified coding oxygen 7's admission MDS and a ded.				
	1/29/22, lacked indi issues, including pr	imum Data Set (MDS) dated ication of any current skin essure or non-pressure an observation period which				
		ted 1/26/22, at 11:36 p.m. of size smaller than a dime oft buttock."				
Minnesota D	epartment of Health					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00166	B. WING			C 10/2022
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CTORY	HEALTH & REHABI		HAVENUE NOI POLIS, MN 55			
X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 550	Continued From pa	ige 8	2 550			
	was observed with licensed practical n which was pink and drainage was noted centimeters (cm) x area was a Stage I During an interview registered nurse (R MDS dated 1/29/22 and a modification II pressure injury. Facility policy titled 9/10, indicated "The and/or interdisciplin	on 2/10/22, at 8:33 a.m. (N)-C stated R55's quarterly (2, was submitted incorrectly was needed to reflect a Stage MDS Error Correction dated e assessment coordinator nary assessment team will ed processes for making				
	director of nursing educate the nursing Minimum Data Set Resident Assessme They could then au compliance.	THOD OF CORRECTION: The (DON), or designee, could g staff on completion of the (MDS) in accordance with the ent Instrument (RAI) manual. dit to ensure ongoing R CORRECTION: Twenty-one				
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			3/12/22
		omprehensive plan of care I personnel involved in the t.				

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If continuation sheet 9 of 41

Minneso	ota Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	
		00166	B. WING		C 02/1	; 0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VICTOR	Y HEALTH & REHABII	ITATION CENTEI	AVENUE NO			
	· ···	MINNEAP	OLIS, MN 5	5430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 9	2 565			
	by: Based on observati review, the facility f comprehensive car reflect assessed an continuity of care for reviewed for dental	e plan was developed to id identified needs to promote or 2 of 4 residents (R57, R17)		corrected		
	Findings include:					
	2/2/22, identified R impairment, demon	imum Data Set (MDS), dated 57 had moderate cognitive estrated no rejection of care quired extensive assistance to nal hygiene needs.				
	in bed in his room. expressed he had s led to several chipp discussed fixing the further action had b teeth and hygiene of					
	Home Visit - Progre identified R57 was being hospitalized. labeled, "Physical E dentition." Further, "Assessment and F medical complication Broken teeth Ora missed NH [nurs follow up to ensure	bunty Medical Center Nursing ess Note, dated 10/26/21, seen at the nursing home after The note included a section Exam," which outlined, "Poor a section labeled, Plan," identified R57's various ons which included, "11. al surgery appointment was ing home] staff was asked to appointment is rescheduled." on 2/9/22 at 9:44 a.m., nursing				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	or connection	IDENTIFICATION NOWBER.	A. BUILDING: B. WING			
		00166				C 02/10/2022
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	' HEALTH & REHABI	UTATION CENTEL 512 49TH	AVENUE NO	RTH		
		MINNEA	POLIS, MN 55	430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 10	2 565			
	assistant (NA)-C st R57 and provided r allowed them. NA-C missing teeth and with a toothbrush. S she would just prov adding, "I always m mouthwash." NA-C were doing R57's c manner adding, "th However, R57's ca any identified probl specific intervention care despite having several teeth and c tooth brush resultin wash for hygiene. On 2/9/22 at 10:53 nursing (DON) was R57's care plan an verified the care pla interventions for R8 and stated it "shoul expressed he was using mouthwash t Further, the DON r "assignment sheets for care guide) and or interventions on needs. The DON s assignment sheets dentition and oral h	tated she routinely cared for morning cares to him, if he C explained R57 had several would often refuse oral cares So, as a result, NA-C stated vide him some mouth wash nake sure we use the C stated she believed all staff oral care and hygiene in this	1			
	R17's admission M 12/3/21, indicated I had diagnoses of a	linimum Data Set (MDS) dated R17 was cognitively intact and in acute fracture of the lower e respiratory failure. R17				

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TATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00166		CONSTRUCTION	СОМ	E SURVEY PLETED C 10/2022
					02/	10/2022
	PROVIDER OR SUPPLIER	UTATION CENTEL 512 49TH	DDRESS, CITY, S ⁻ I AVENUE NOI POLIS, MN 55	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 11	2 565			
		e to support and balancing MDS lacked indication of				
		harge orders dated 11/26/21, oxygen at 2 liters (L) nasal bedtime.				
		nary Report dated 12/1/21, non weight bearing on their ty.				
	corresponding nurs 1/14/22, lacked evi	re plan dated 12/2/21, and sing assistant care sheet dated dence of goal(s), or specific ed to R17's mobility and oxyger				
	nursing assistant (I	v on 2/9/22, at 10:23 a.m. NA)-B stated she did not R17 and was unaware of any reds R17 had.				
	licensed practical r mobility was limited LPN-B confirmed F	v on 2/9/21, at 10:51 a.m. hurse (LPN)-B stated R17's d and R17 worked with therapy R17 was received oxygen wher vever, this was not addressed				
	director of nursing lacked indication of mobility. The DON	v on 2/10/21, at 12:27 p.m. the (DON) verified R17's care plan f R17's oxygen needs and stated the information needed R17's care plan to ensure R17's				
	Person-Centered r	Care Plan, Comprehensive evised 2016, indicated a re plan that meets the				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED C 02/10/2022	
		00166	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VICTOR	Y HEALTH & REHABII	ITATION CENTEI	AVENUE NO POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE
2 565	Continued From pa	ge 12	2 565			
		psychosocial, and functional ed for each resident.				
	director of nursing (review and/or revise procedures to ensu developed and indir The DON, or design	HOD OF CORRECTION: The (DON), or designee, could e applicable policies and ire resident care plans are vidualized; then, educate staff. nee, could then perform audits dents care plan is developed				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			3/12/22
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident n bed.				
	by: Based on interview facility failed to perf cause analysis whic	ent is not met as evidenced and document review, the form a comprehensive root ch identified individualized risk we likelihood of subsequent		corrected		

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STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00166	B. WING		02/	10/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	(HEALTH & REHABI	ITATION CENTEI	I AVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 13	2 830			
	falls for 1 of 1 resid accidents.	ent (R56) reviewed for				
	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.					
	1/5/22, indicated Ra and turning the opp stabilize. A subsequidentified R56 receinsulin which could unsteadiness. The	rea Assessment (CAA) dated 56 was unsteady when walking posite direction, but able to uent Falls CAA dated 2/2/22, ived narcotic, anti-anxiety, and lead to weakness and CAA directed to review the sponding interventions.				
	- On 1/14/22, at 12 by the west unit me R56's left knee and was bleeding. R56 slippery ground in t his stomach. R56 s skin break to the rig - 1/29/22, at 10:33 tripped, and fell bac	ogress notes revealed: :00 a.m. staff met R56 sitting edication cart. It was noted I the right side of his lower leg indicated he slipped on the he smoking area and fell on sustained a bruise and minor ght side of his lower leg. p.m. R56 was feeling weak, ckwards as he was walking.				
	office. Bleeding wa - 2/9/22, at 4:22 p.r 7:00 a.m. when he	vall near the social workers s noted to R56's right knee. n. R56 stated he fell outside at went outside to smoke. The ed and no injury was noted.				

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STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00166	B. WING			C 10/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
/ICTOR	Y HEALTH & REHABI	I ITATION CENTEI	I AVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 14	2 830			
	indicated R56 was documented goal of through the review 1/14/22 and 1/29/22 reviewed and/or up During an interview stated a few weeks a cigarette and fell	are plan dated 12/20/21, at low risk for falls with a of, "Resident will be free of falls date." Despite R56's falls on 2, R56's care plan was not odated until 2/10/22. on 2/7/22, at 12:08 p.m. R56 ago, he went outside to have in the smoking area. R56 put salt down and his feet er him.				
	stated he did not ta time of his first fall medications impac did not feel the staf at the facility. R56 s	a 2/9/22, at 1:28 p.m. R56 ke pain medications at the (1/14/22) and did not feel ted his balance. R56 stated he f salted the sidewalks or patios stated he, "fell outside today" hable to see ice on the the building.				
	registered nurse (R management form, (NP), informed the when a resident fel conducted for every happened and to p interventions to pre again. RN-A review record (EHR) and c additional intervent on 1/14/22 and 1/2	2/10/22, at 11:24 a.m. RN)-A stated staff opened a risk called the nurse practitioner supervisor, and updated family I. A root cause analysis was y fall to determine why it opulate appropriate went the fall from happening ved R56's electronic health confirmed there were no ions identified after R56's falls 9/22. A fall demanded a risk time and no risk assessments ch of R56's falls.				
		2/10/22, at 12:43 p.m. the (DON) stated when a resident				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		BERTH TO THOMBEN.	A. BUILDING:			
		00166	B. WING			C 10/2022
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	(HEALTH & REHABI	I ITATION CENTEI	HAVENUE NOI POLIS, MN 55			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 15	2 830			
2 830	provider, completed and updated the ca re-occurrence. The to smoke wearing s concrete. After the concrete on the pat there should had be every fall R56 had interventions added on 1/14/22 and 1/29 During interview on administrator stated the morning clinica cause analysis was were added to the stated R56 did not	DON stated R56 went outside slippers and fell on icy fall, staff put salt out on the tio area. The DON reaffirmed een an updated care plan for and verified there were no new d to R56's care plan after falls	,			
		HR lacked Fall Incident ise Analysis for falls on 1/14/22	2			
	dated 3/18, identified attending physician resident-centered f the specific risk fac at risk or with a hist identified if falling of interventions, staff	all prevention plan to reduce ctor(s) of falls for each resident tory of falls. Further, the policy occurs despite initial will implement additional or ons, or indicate why the current				
	director of nursing develop, review, an	THOD OF CORRECTION: The (DON), or designee, could nd/or revise policies and to performing fall risk	;			

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STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00166	B. WING			10/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VICTOR	(HEALTH & REHABIL	ITATION CENTEI	AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 16	2 830			
	analysis. The DON appropriate staff on The DON or design	omprehensive root cause or designee could educate all the policies and procedures. ee could develop monitoring ongoing compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 900	MN Rule 4658.0528 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			3/12/22
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstra	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	ho has pressure sores / treatment and services to event infection, and prevent /eloping.				
	by: Based on observati review, the facility fa assess and implem promote healing an complications for a	newly developed State II of 3 residents (R55) reviewed		corrected		

If continuation sheet 17 of 41

STATEMEN	ota Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C	
		00166	B. WING		02/	10/2022
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S			
VICTOR	Y HEALTH & REHABII	ITATION CENTEI	AVENUE NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ige 17	2 900			
	Findings include:					
	skin with exposed of viable, pink or red, as an intact or rupto Adipose (fat) is not	lcer: partial-thickness loss of dermis. The wound bed is moist, and may also present ured serum-filled blister. visible and deeper tissue is tion tissue, slough and eschar,				
	1/29/22, indicated F impaired and required	imum Data Set (MDS) dated R55 was severely cognitively red extensive assistance of obility and toileting. The MDS any skin issues.				
	the potential to dev immobility and diag maintaining intact s blisters, and discolo identified several in the goal which inclu- monitoring/docume	nting/reporting changes in re plan lacked indication of any				
	p.m. indicated, "a b dime was noted on documentation of th	es dated 1/26/22, at 11:36 lister of size smaller than a the left buttock." Despite ne skin condition, R55's most n Check dated 2/5/22, n was intact.				
	evidence treatment comprehensive wo	essment was completed for the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00166	B. WING			C 10/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
VICTOR	(HEALTH & REHABII	ITATION CENTEI	I AVENUE NOI POLIS, MN 55			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ige 18	2 900			
	licensed practical n clear, fluid-filled blis coccyx area. LPN-E not sought for the n On 2/10/22, at 10:1 was observed with LPN-B. At this time seen on R55's left k pink and moist with sanguineous draina centimeters x 1 cm was a State II press During interview on	age. The wound measured 0.5 . LPN-B verified the open area sure ulcer. 2/10/22, at 10:25 a.m. the	;			
	director of nursing (document the size a on the wound asse medical record (EM	(DON) stated the LPN should and characteristics of a wound ssment form in the electronic IR). The DON verified facility aplemented for R55's skin				
	Clinical Protocol da nurse shall describe following: 1. Full assessment location, stage, leng of exudates or necr 2. Pain assessmen 3. Resident's mobil	t ity status its, including support surfaces				
	SUGGESTED MET director of nursing (review/revise policie	THOD OF CORRECTION: The (DON), or designee, could es/procedures for pressure d care, educate staff, and ther				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3)	DATE SURVEY COMPLETED
			A. BOILDING		С
		00166	B. WING		02/10/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
VICTOR	(HEALTH & REHABI	LITATION CENTEI	HAVENUE N POLIS, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLET DATE
2 900	Continued From pa	age 19	2 900		
	perform audits to e	nsure compliance.			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one			
21134	MN RULE 4658.06 Sanitation, storage	70 Supb. 2. Dishwashing;	21134		3/12/22
	must be thoroughly surfaces of utensil given sanitization to in such a manner a contamination. Cle	e. All utensils and equipment v cleaned, and food-contact s and equipment must be reatment and must be stored as to be protected from eaned and sanitized equipment be handled in a way that contamination.			
	by: Based on observat review, the facility f were clean for 3 of	ent is not met as evidenced ion, interview, and document failed to ensure water pitchers 4 residents (R13, R35, R28) me water from facility provided		corrected	
	Findings include:				
	11/29/21, indicated was independent w	inimum Data Set (MDS) dated R13 had intact cognition and /ith eating. R13's diagnoses on and adult failure to thrive.			
	had severely impai	S dated 1/3/22, indicated R25 red cognition and needed ce with eating. R25's I type II diabetes.			

If continuation sheet 20 of 41

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00166	B. WING			C / 10/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
/ICTOR	Y HEALTH & REHABI	I ITATION CENTEI	HAVENUE NO POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21134	Continued From pa	age 20	21134				
	indicated R28 had and was independe	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.					
	supplied water pitc re-usable plastic st moderate amount o	p.m. R13 had a facility her at their bedside. The raw was observed to have a of dried, flaky, beige colored iside and outside portion of the	•				
	supplied water pitc plastic straw was o amount of dried be	p.m. R35 had a facility her at bedside. The re-usable bserved to have a moderate ige colored crust on both the portion of the straw.					
		a.m. R13's water pitcher and d and was unchanged from the on on 2/8/22.	9				
	licensed practical r assistants pass wa kitchen was in chai however, LPN-A wa	on 2/8/22, at 2:23 p.m. hurse (LPN)-A stated nursing ter after breakfast daily. The rge of washing water pitchers, as unsure how often water s were changed/cleaned.					
	water pitcher was o re-usable plastic st dried orange film a	p.m. R28's facility provided observed at bedside. The raw was observed to have a nd some small black spots on raw. R28 stated, "They never "I clean it myself."					
	nursing assistant (I water pass for R13	on 2/9/22, at 8:27 a.m. NA)-D stated she completed a and R35 earlier that morning. a residents water pitcher was					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		—	
		00166	B. WING			C 10/2022
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	Y HEALTH & REHABI	I ITATION CENTEI	AVENUE NO			
		MINNEA	POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21134	Continued From pa	age 21	21134			
	completed the wate pitcher from the kit NA-D added water almost every day, h dirty first, especially then observed R13 was in the same co 2/8/22, and describ identified it needed completing the wat During an interview director of nursing assistants should p water pitcher and s provide a clean wa infection. A dirty pit resident taking in b Facility policy titled 10/2010, indicated, of water. Place the easy reach of the r next to the water pitcher SUGGESTED MET The dietary manag update/create polic ensuring residents then educate staff dietary manager, o audits periodically, protocols.	Serving Drink Water dated , Offer the resident a fresh cup water pitcher and cup within esident. Place flexible straws	t			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3)	DATE SURVEY COMPLETED	
		00166	B. WING		C 02/10/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
/ICTOR)	(HEALTH & REHABII	ITATION CENTEI	AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
21325	Continued From pa	ge 22	21325			
21325	MN Rule 4658.072 Emergency Oral He	5 Subp. 1 Providing Routine & ealth Ser	21325		3/12/22	
	needs of each resid include dental exam fillings and crowns, oral surgery, bridge orthodontic procedu that are provided for community at large reimbursement poli This MN Requireme by: Based on observati review, the facility f appointments were hygiene and reduce	ental services to meet the dent. Routine dental services ninations and cleanings, root canals, periodontal care, es and removable dentures, ures, and adjunctive services or similar dental patients in the , as limited by third party icies. ent is not met as evidenced ion, interview, and document ailed to ensure missed dental rescheduled to promote oral e the risk of complication for 1) reviewed for dental care and		corrected		
	R57's quarterly Min 2/2/22, identified R4 impairment, demon behavior, and requi complete his perso R57's Census listin record (EMR), print current payer source R57's care plan, da	ted 2/9/21, identified R57 had				
	self care and direct ROUTINE: Set-up,	activities of daily living (ADL) ed, "PERSONAL HYGIENE Cares in pairs (two staff at all However, the plan lacked any				

Minneso	ta Department of He	ealth			FORM	APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00166	B. WING			C 10/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
VICTORY	(HEALTH & REHABII	ITATION CENTER	I AVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21325	Continued From pa	ge 23	21325			
	developed problem interventions for R5 hygiene.	s, goals, or specific 57's dentition and/or oral				
	in bed in his room. expressed he had s previous months ar result in several spe his teeth and had s present on his uppe seen a dentist for th they needed to be f action had been tak remove them. R57 dentist to get them nursing home "lazin not being addresse	, R57 was observed laying R57 was interviewed and sustained several falls over the nd "chipped my teeth" as a ots. R57 showed the suveyor everal missing or broken teeth er palate. R57 stated he had nem awhile back who voiced fixed, however, no further ken since then to repair or stated he would like to see a fixed and expressed the ness" was to blame for them d so far.				
	On 8/30/21, a previ recorded R57 had o appointment so the refusal were explain "[R57] verbally agre rescheduled." On 10/21/21, R57 v	ous director or nursing (DON) declined to go for his dental risks and benefits of the ned to him. The note recorded, eed to go to next visit if it is vas recorded as having a	,			
		ppointment for the following hich R57 was aware of				
	- Nursing Home Vis 10/26/21, identified unable to make the appointment. The n	ennepin County Medical Center sit Progress Note, dated R57 was hospitalized and scheduled dental note included an assessment om the medical provider which				

	NT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00166	B. WING			C 10/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
VICTOR	Y HEALTH & REHABIL	ITATION CENTEI	I AVENUE NOF POLIS, MN 554			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21325	included, "11. Broke appointment was m was in hospital. NH follow up to ensure R57's medical reco evidence R57's mis been rescheduled, despite the medical R57 missing the pre When interviewed of assistant (NA)-C sta R57 and explained with cares, including so she used only m NA-C verified R57 H palate and describe Further NA-C stated had been to dentist addressed. On 2/9/22 at 9:53 a (HUC)-A was interv the person respons arrange appointment dental providers. HI to, or had any recer scheduled or comp provider orders ask HUC-A stated she w R57's medical reco and 2022 appointment HUC-A stated she w away" and added it dental appointment	ge 24 en teeth Oral surgery issed on 10/22 as the patient [nursing home] staff asked to appointment is rescheduled." rd was reviewed and lacked sed dental appointment had or offered and declined, provider's recorded entry and evious appointment. on 2/9/22 at 9:44 a.m., nursing ated she routinely cared for he "sometime" did refuse help g oral cares with a toothbrush, outhwash to clean his teeth. had missing teeth on his top ed them like "an open space." d she was "not aware" if R57 to have his missing teeth , the health unit secretary iewed and explained she was ible to help coordinate and nts with in-house and outside JC-A stated R57 had not been ht dental appointments leted, despite the medical ing them to be arranged. was unaware of the note(s) in rd. HUC-A reviewed the 2021 ent calendars and verified escheduled for the missed from 10/21/21. Further, vould get one scheduled "right was important to ensure s were made and completed portant to your overall health."				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:				
		00166	B. WING			C 02/10/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
VICTORY	Y HEALTH & REHABII	ITATION CENTER 512 49TH	AVENUE NOF	RTH			
noron		MINNEA	POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21325	Continued From pa	ge 25	21325				
	acting director of nu medical record and appointment was n directed and reques provider. The DON appointments to be and recorded in the This was important issues could cause An undated Dental policy was provided would be offered de However, the policy guidance on how to	Examination/Assessment I which directed each resident ental services as needed. / lacked any direction or o ensure missed appointments and/or tracked to ensure					
	director of nursing (develop, review, an procedures to ensu provided. The DON all appropriate staff procedures. The DO	THOD OF CORRECTION: The (DON), or designee, could id/or revise policies and ure dental services are I, or designee, could educate on the policies and ON, or designee, could systems to ensure ongoing					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21390	MN Rule 4658.080	0 Subp. 4 A-I Infection Control	21390			3/12/22	
	control program mu procedures which p A. surveillance	and procedures. The infection ust include policies and provide for the following: based on systematic data / nosocomial infections in					

	IDENTIFICATION NUMBER:	A. BUILDING:			LETED
	00166	B. WING		C 02/10/2022	
ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HEALTH & REHABI	ITATION CENTER				
(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLET DATE
Continued From pa	ge 26	21390			
B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service en- prevention and com E. a resident h immunization progra defined in part 465 procedures of resid the prevention and F. the develop employee health po- practices, including defined in part 4656 G. a system for H. a system for products which affect disinfectants, antise incontinence produ I. methods for	s of infectious diseases; d precautions systems to smission of infectious agents; ducation in infection trol; ealth program including an ram, a tuberculosis program as i8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of plicies and infection control a tuberculosis program as 8.0815; r reviewing antibiotic use; r review and evaluation of ect infection control, such as eptics, gloves, and cts; and maintaining awareness of				
by: Based on interview facility failed to ens policies and proced all staff including co COVID-19 vaccinat religious and/or me in less than 100% s increases the poter residents who resid	and document review, the ure COVID-19 vaccination dures included a process that portract staff had received the tion or were granted an edical exemption. This resulted staff vaccination rate which ntial of spreading COVID to		corrected		
-					
	HEALTH & REHABIN SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From par residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service e prevention and con E. a resident h immunization progr defined in part 465 procedures of resid the prevention and F. the develop employee health po practices, including defined in part 465 G. a system fo H. a system fo products which affed disinfectants, antised incontinence produ I. methods for current standards c This MN Requirem by: Based on interview facility failed to ens policies and procect all staff including co COVID-19 vaccinal religious and/or me in less than 100% s increases the poter residents who resid Findings include:	HEALTH & REHABILITATION CENTEI 512 49TH MINNEAR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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	HEALTH & REHABILITATION CENTEI 512 49TH AVENUE NO MINNEAPOLIS, MN 53 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 26 21390 continued From page 26 21390 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 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: Findings include:	HEALTH & REHABILITATION CENTEI 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY WIGT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIN (EACH OPRECTIVE APPRO DEFICIENCY) 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. corrected 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. corrected Findings include: Findings include: Findings include	Build and the second

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING:			С	
		00166	B. WING			02/10/2022	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ICTORY	HEALTH & REHABI	ITATION CENTER					
(X4) ID	SUMMARY STA		POLIS, MN 55	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLET	
21390	Continued From pa	age 27	21390				
	indicated the policy Victory. Employees vaccinated to have exemption. The po	Vaccine Policy (undated) applied to all employees of were required to be fully a medical or religious licy did not identify that om provided care were cess.					
	staffing coordinator was not aware if th were not vaccinate we ask, but we dor no indication the fa attestations of vacc	on 2/8/22, at 7:55 a.m. (SC)-A indicated the facility eir contracted staff were or d. SC-A stated, "Sometimes 't get proof." Also, there was cility had received any cination from the contracted d hospice staff whom cared for s.					
	administrator stated screened upon ent which nurse would administrator stated	on 2/8/22, at 2:10 p.m. the d contracted staff were rance. Further, he had "no idea be coming in." The d, to the best of his knowledge tracted with hospice and no					
	infection prevention started tracking the contracted staff wh	on 2/9/22, at 1:04 p.m. the hist stated the facility had not vaccination status of o provide care to residents. we haven't started tracking					
	administrator state	on 2/10/22, at 4:05 p.m. the d the facility policy needed to lude all facility and contracted to residents.					
		THOD OF CORRECTION: The or designee, could review	•				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00166	B. WING		02/10/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
VICTORY	/ HEALTH & REHABIL	ITATION CENTEI	I AVENUE NO POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	
21390	their infection contra and procedures are process for ensurin vaccinated for COV exemption; then, in and procedure, and	ge 28 ol program to ensure policies e established to include a g contracted staff have been 'ID-19 or have a valid service staff regarding policy I audit to ensure compliance. R CORRECTION: Twenty-one	21390			
21610	and Preparation Are Subpart 1. Storage must store all drugs under proper tempe	e of drugs. A nursing home s in locked compartments erature controls, and permit sing personnel to have	21610		3/12/22	
	by: Based on observati review, the facility f medication carts ob	ent is not met as evidenced on, interview, and document ailed to secure 3 of 4 pserved for medication he potential to affect all d access unsecured		corrected		
	observed unlocked Hallway. The medic of the nurses' static Registered nurse (F medication cart at 1 not common practic unlocked, however,	a.m. a medication cart was and unattended in the East cation cart was located outside on and out of view of staff. RN)-A returned to the 11:52 a.m. and stated it was be to leave a medication cart he went to provide a resident fed residents passed by the				

If continuation sheet 29 of 41

	T OF DEFICIENCIES OF CORRECTION	CAITH (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _			С	
		00166	B. WING	B. WING		02/10/2022	
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE			
CTORY	HEALTH & REHABI	ITATION CENTER					
	SUMMARY STA		POLIS, MN 55	PROVIDER'S PLAN OF		(XE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21610	Continued From pa	ige 29	21610				
	unlocked medicatio	on cart prior to RN-A's arrival.					
	observed unlocked of the South Hallwa medication aide (TI medication cart and provide a resident r important to keep th prevent residents fit the cart. TMA-A stat the hallway when s resident was obser TMA-A's return to t On 2/10/22, at 7:18 observed unlocked	p.m. a medication cart was and unattended at the far end ay. At 1:59 p.m., trained MA)-A returned to the d stated she stepped away to medications. She stated it was he medication cart locked to rom accessing medications in ited there were no residents in he left. One unidentified ved in the hallway prior to he medication cart. a.m. a medication cart was and unattended in the middle y. Upon return at 7:20 a.m.,					
	licensed practical n stepped away from something, but ack locked the medicat unidentified residen the hallway.	the medication cart to look for nowledged she should had ion cart when she left. One at was observed ambulating in on 2/10/22, at 12:43 p.m. the					
	director of nursing (must be locked whe	(DON) stated medication carts en unattended as residents could open the cart and take					
	11/20, identified con limited to, drawers, cart, and boxes) co were locked when i	Storage of Medication revised mpartments (including, but not cabinets, room, refrigerators, intaining drugs and biological's not in use. Unlocked ere not to be left unattended.					
		THOD OF CORRECTION: The ctor of nursing (DON), or)				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	E SURVEY PLETED C	
		00166	B. WING			02/10/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
VICTOR	(HEALTH & REHABI	ITATION CENTEI	HAVENUE NO				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
21610	Continued From pa	ige 30	21610				
	policies and proceed medications; educa policies and proceed regular basis to ens	velop, review, and/or revise lures for proper storage of ate all appropriate staff on the lures; and, conduct audits on sure ongoing compliance. R CORRECTION: Twenty-one					
	(21) days.						
21665	MN Rule 4658.140	0 Physical Environment	21665			3/12/22	
	functional, comforta environment, allow	ust provide a safe, clean, able, and homelike physical ing the resident to use s to the extent possible.					
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview, and document ailed to ensure radiators were a debris for 2 of 2 residents ad for environment.		corrected			
	Findings include:						
		imum Data Set (MDS) dated R11 was cognitively intact.					
	R53's quarterly MD R53 was cognitively	S dated 1/26/22, indicated y intact.					
	R11's radiator grate matter which was s the substance was	ion on 2/7/22, at 1:27 p.m. es were covered with a black ticky. R11 was unsure what and stated, "I've told ut it." R11 was unsure when were cleaned.					

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00166	B. WING			C 02/10/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
		UTATION CENTEL 512 49TI	AVENUE NO	RTH			
/ICTOR	/ HEALTH & REHABI	MINNEA	POLIS, MN 55	430			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21665	Continued From pa	age 31	21665				
	R53's radiator vent their room had a st	tion on 2/7/22, at 4:57 p.m. t located below the window in ticky black residue which was buched. The resident was all					
	stated there was th	v on 2/7/22, at 4:55 p.m. R53 nick black mold, or something, 53 stated it was disgusting and ergies.	1				
	housekeeper (HSk were wiped down a was maintained by confirmed there wa	v on 2/10/22, at 9:26 a.m. ()-A stated resident radiators about twice a month and a log the supervisor. HSK-A as a black sticky residue on was unsure what the					
	housekeeping supe cleaning log, but he tops of radiators ar by maintenance. T verified there was he radiator and stated	v on 2/10/22, at 2:05 p.m. the ervisor stated there was a busekeeping only cleaned the nd any deep cleaning was done he housekeeping supervisor black sticky residue on R53's l, "Yeah, this needs to be ed, "It's so bad. It hurts my	9				
	p.m. the housekee maintenance was r Maintenance norm with air brushes mo	interview on 2/10/22, at 2:30 ping supervisor stated not available for an interview. ally scrubbed radiator vents onthly, however, verified it s were not cleaned for awhile.					
	indicated the "facili	Safe Environment (undated) ty will provide a safe, and comfortable environment					

STATE FORM

8YIY11

If continuation sheet 32 of 41

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C	
		00166	B. WING		02/	02/10/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
/ICTOR	Y HEALTH & REHABII	ITATION CENTEI	AVENUE NOF POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21665	Continued From pa	ge 32	21665				
	director of maintena develop and implen to ensure that the n in a safe, clean, fur homelike manner.	HOD OF CORRECTION: The ance, or designee, could ment policies and procedures ursing home was maintained actional, comfortable and The director of maintenance, then monitor staff for policies.					
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one					
21825	MN St. Statute 144 Residents of HC Fa	651 Subd. 9 Patients & ac.Bill of Rights	21825			3/12/22	
	Residents shall be complete and current their diagnosis, treat prognosis as require duty to disclose. The terms and language be expected to und accompanied by a chosen representat shall include the like psychological result alternatives. In case inadvisable, as doc physician in a resid information shall be guardian or other p resident as a represent right to refuse this in Every resident su	Iffering from any form of be fully informed, prior to or at on and during her stay, of all					

Minneso	ta Department of He	alth			T OTAM AT THOTED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		(X3) DATE SURVEY COMPLETED
		00166	B. WING		C 02/10/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
VICTORY	(HEALTH & REHABII	ITATION CENTEI	AVENUE NO POLIS, MN 5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
21825	Continued From pa	ge 33	21825		
	including surgical, r chemotherapeutic t	hysician is knowledgeable, adiological, or reatments or combinations of risks associated with each of			
	by: Based on interview facility failed to allo	ent is not met as evidenced and document review, the w a resident to participate in s for 1 of 1 resident (R27) se.		corrected	
	Findings include:				
	indication R27 had Power of Attorney (ecord dated 2/10/22, lacked a legal guardian or durable DPOA). R27's diagnoses d dementia without behavioral			
	(MDS) dated 12/21	ange Minimum Data Set /21, indicated R27 was rely impaired and received			
	received hospice ca	ed 12/15/21, indicated R27 are with a listed intervention to ights to make decisions.			
	Treatment (POLST R27 had a do-not-re however, the docur	ers for Life-Sustaining) dated 12/14/21, indicated esuscitate (DNR) order, nent was not signed by R27. signed by family member			

Minnesota Department of Health STATE FORM

		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00166	B. WING			C 10/2022
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
' HEALTH & REHABII	ITATION CENTEI				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	ige 34	21825			
signed by FM-A on document titled Adr a box marked with wording "Patient un hand written note w	12/14/21. A corresponding mission Consent (hospice) had an "x" to the immediate left of nable to sign due do to" with a <i>t</i> hich indicated "increased				
evidence had a lega paperwork. Addition lacked evidence a l	al guardian or DPOA nally, R27's medical record licensed physician or court had				
stated, "I don't wan sign any paperwork	t to be on hospice, nor did l to be on hospice."				
administrator stated on a previous date Further, the admini	d R27 was sent to the hospital for an emergent situation. strator stated he initiated a				
R27 again confirme care and stated, "I	ed she did not want hospice want the staff to do everything				
assistant director or had threw a hospic approached about I incident, the hospic	f nursing (ADON) stated R27 e worker out of her room when hospice services. Due to the e worker was asked to come				
	A document titled H signed by FM-A on document titled Adv a box marked with wording "Patient ur hand written note w confusion." The doc FM-A. R27's medical reco evidence had a leg paperwork. Addition lacked evidence a l determined R27 lac own decisions. Upon interview on a stated, "I don't wan sign any paperwork Additionally, "I don' Upon interview on a stated, "I don't wan sign any paperwork Additionally, "I don' Upon interview on a stated, "I don't wan sign any paperwork Additionally, "I don' Upon interview on a stated, "I don't wan sign any paperwork Additionally, "I don' Upon interview on a stated, "I don't wan sign any paperwork Additionally, "I don' Upon interview on a stated, "I don't wan sign any paperwork Additionally, "I don' Upon interview on a administrator stated on a previous date Further, the admini DNR request for R2 Upon a second inter care and stated, "I possible to keep m Upon interview on a assistant director o had threw a hospic approached about incident, the hospic back at a later time	THEALTH & REHABILITATION CENTEI 512 49TH MINNEAR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 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," 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	S12 49TH VENUE NOI INNEADULS, MN 25SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGContinued From page 3421825A 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." 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 interview on 2/8/22, at 2:34 p.m. the assistant director of nursing (ADDN) stated R27 had threw a hospice worker out of her room when approached about hospice services. Due to the incident, the hospice worker out of her room when approached about hospice services. Due to the incident, the hospice worker out of her room when approached about hospice services. Due to the incident, the hospice worker out of her room when approached about hospice services. Due to the incident, the hospice worker out of her room when approached about hospice services. Due to the incident, the hospice worker out of her room when approached a	THEALTH & REHABILITATION CENTEI SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTIFYING INFORMATION) ID PREVIDER'S PREVIDER'S PLAN OF C (EACH ORRECTIVE ACTIVE TAG DROVIDER'S PLAN OF C (EACH ORRECTIVE ACTIVE CACH ORRECTIVE ACTIVE TAG Continued From page 34 21825 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 2/17/22, at 6:04 p.m. R27 stated, "I don't want to be a DNR" Upon interview on 2/22, 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 de verything 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 was asked to come back at a later time to conduct an evaluation and complete admission paperwork. K27 was again	HEALTH & REHABILITATION CENTEI 512 49TH AVENUE NORTH MINRAPOLIS, MM 55430 IRACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ATOR) SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 34 21825 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 2/1/22, 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 2/10/22, 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 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 was asked to come back at a later time to conduct an evaluation and complete admission paperwo

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:			
		00166	B. WING			C 10/2022
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ICTORY	HEALTH & REHABI	I ITATION CENTEI	AVENUE NO			
		MINNEA	POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21825	Continued From pa	age 35	21825			
	and R27 was "fairly The ADON verified maker. The ADON FM-A had signed R admission paperwo Upon interview on 2 manager stated R2 services. Further, h individual had a DF signing. During an interview hospice registered assessed R27 on 1 "alert and oriented. explained they were repeatedly stated "h room. RN-E stated R27's hospice adm R27 did not sign do however, had later Upon interview on 2 stated she signed a admission paperwo verified she was no FM-A stated hospice and paperwork nee eligible for hospice explained R27 wou on for hospice serv Upon interview on 2 services director (S	2/9/22, at 1:15 p.m. a hospice 27 initially refused hospice hospice normally verified an 20A prior to a representative 4 on 2/9/22, at 3:25 p.m. nurse, (RN)-E stated they 12/14/21 and noted R27 was "Further, when RN-E e from hospice, R27 nope" so RN-E had left R27's FM-A had already signed hission paperwork and verified boumentation (consent), verbally agreed. 2/9/22, at 3:55 p.m. FM-A a POLST and hospice bork on behalf of R27. FM-A ot a guardian or DPOA for R27. ce affiliates explained a POLST eded to be signed for R27 to be services. Further, the facility ald get extra help when signed	•			
		t sign any of their paperwork.				
	Upon a second interpartment of Health	erview on 2/10/22, at 10:50				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
		00166	B. WING		02/	10/2022
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
/ICTOR)	(HEALTH & REHABI	ITATION CENTEI	I AVENUE NOF POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21825	Continued From pa	ige 36	21825			
	initially went to the an assessment on did not want hospic hospice manager s facility and spoke w and date and R27 s however, stated R2 the visit. Subseque and asked for hosp services again with hospice manager v hospice admission to sign due to his p	anager stated, hospice RN-F facility on 11/19/21 to conduct R27. R27 had verbalized she se services at that time. The tated he also went to the vith R27 at an unknown time said "okay" to services, 27 was confused at the time of ntly, the ADON again called sice to return review hospice R27 [on 12/14/21]. The the erified R27's POLST and paperwork was sent to FM-A revious assessment of R27 to sign paperwork.				
	A policy regarding grequested, howeve	guardianship and DPOA was r, not provided.				
	The administrator, designee, could rev procedures regardi could then be educ	THOD OF CORRECTION: director of nursing, or /iew and/or revise policies and ng consent for services. Staff ated on policy and procedures itoring system to ensure e.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21880	MN St. Statute 144 Residents of HC Fa	.651 Subd. 20 Patients & ac.Bill of Rights	21880			3/12/22
	shall be encourage their stay in a facilit to understand and patients, residents,	nces. Patients and residents d and assisted, throughout y or their course of treatment, exercise their rights as and citizens. Patients and e grievances and recommend				

STATEMENT OF DEFICIENCIES(X1) PROVIDER/SUPPLIER/CLIAAND PLAN OF CORRECTIONIDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		A. BUILDING:		C	
	00166	B. WING			10/2022
ME OF PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	ATE, ZIP CODE		
CTORY HEALTH & REHABI	LITATION CENTEL	I AVENUE NOF POLIS, MN 554			
X4) ID SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
REFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(THE APPROPRIATE	COMPLE DATE
21880 Continued From pa	age 37	21880			
and others of their interference, coerci- including threat of of grievance procedur well as addresses a Office of Health Fa- nursing home ombi- Americans Act, sec posted in a conspice Every acute care residential program 253C.01, every nor facility employing m provides outpatient have a written inte at a minimum, sets followed; specifies limits for facility res or resident to have advocate; requires grievances; and pro an impartial decisio otherwise resolved residential program 253C.01 which are treatment programs centers with section health maintenance 62D.11 is deemed	and services to facility staff choice, free from restraint, ion, discrimination, or reprisal, discharge. Notice of the re of the facility or program, as and telephone numbers for the acility Complaints and the area udsman pursuant to the Older ction 307(a)(12) shall be cuous place. e inpatient facility, every n as defined in section nacute care facility, and every nore than two people that e mental health services shall rnal grievance procedure that, forth the process to be time limits, including time sponse; provides for the patient e the assistance of an a written response to written povides for a timely decision by on maker if the grievance is not . Compliance by hospitals, ns as defined in section hospital-based primary s, and outpatient surgery n 144.691 and compliance by e organizations with section to be compliance with the written internal grievance				
This MN Requirem by:	ent is not met as evidenced				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00166		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVE COMPLETED C 02/10/202		
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
		512 4 9TI	H AVENUE NO			
ICTORY	HEALTH & REHABI	LITATION CENTEI MINNEA	POLIS, MN 55	5430		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T		COMPLE DATE
IAO			IAG	DEFICIENC		
21880	Continued From pa	age 38	21880			
		•				
		ke prompt efforts to resolve				
		6 residents (R158, R52, R59,				
	RIUI, RIUZ, and F	(3) reviewed for grievances.				
	Findings include:	Findings include:				
	Review of the facility Grievance Log revealed:					
		cerns related to infection				
		ain management, and call ligh	t			
		10/22/21. Follow-up was				
		er, not documented.				
		cern related to call light				
		10/25/21, and bathing				
	preferences on 11/	2/21. Follow-up was				
	requested, but not					
		cern related to call light				
		11/5/21. A corresponding				
		ated 11/5/21, contained a				
		ncern, but did not include				
		a complaint resolution.				
		ncern related to call light 11/17/21. Follow-up was				
	requested, but not					
		ncern related to her				
		tive behavior on 12/1/21. A				
		evance Form dated 12/1/21,				
		ary of the concern, but did not				
		tion of a complaint resolution.				
		ern related to podiatry services	6			
		nent on 12/12/21. A				
		evance Form dated 12/13/21,				
		ary of the concern, but did not				
	include documenta	tion of a complaint resolution.				
	During an interview	v on 2/9/22, at 12:44 p.m. the				
		d all grievances should be				
		e daily interdisciplinary team				
		assigned department head				
	should address the	e concern and bring a				
	completed Grieven	ice Form with a documented	II.			1

If continuation sheet 39 of 41

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
		00166	B. WING		02/	10/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	Y HEALTH & REHABII	ITATION CENTEI	I AVENUE NOI POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21880	Continued From pa	ige 39	21880			
	social worker was r completed Grievan added all grievance within 5-days of the administrator stated R52, and R101 wer not know if the com R3 were addressed During an interview	ily IDT meeting. The facility responsible for maintaining the ce Forms. The administrator es should have a resolution e verbalized concern. The d Grievance Forms for R158, re "missing." Further, he did cerns in which R59, R102, and d/resolved.				
	residents should ha	ave investigative steps and a nted on a Grievance Form. and R102 had discharged and				
	R52 was unavailab to be interviewed.	le for interview and R3 refused				
	dated 2/14/21, direct staff will make prom grievances to the s and/or representati grievance and/or co will review and inver- submit a written rep Administrator within receiving the grievar resident, or person complaint on behal- informed (verbally a the investigation an to correct any ident all grievances files will be maintained of	Grievance/Complaints, Filing cted, "The Administrator and npt efforts to resolve atisfaction of the resident ve." "Upon receipt of a complaint, the Grievance Officer estigate the allegations and bort of such findings to the n five (5) workings days of ance and/or complaint." "The filing the grievance and/or f of the resident, will be and in writing) of the findings of ad the actions that will be taken ified problems." "The results o [sic] investigated and reported on file for a minimum of three ance of the grievance	F			

8YIY11

If continuation sheet 40 of 41

Minnesota Department of Health						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00166	B. WING		02/1) 0/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VICTOR	(HEALTH & REHABI		AVENUE NO POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	D BE	(X5) COMPLETE DATE
21880	Continued From pa	age 40	21880			
	SUGGESTED MET director of nursing inservice staff rega concerns, both void addressed with sat then audit to ensure	THOD OF CORRECTION: The (DON) or designee could rding making sure identified ced and in writing, are isfaction in a timely manner;				
Minnesota D	epartment of Health					