P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered

October 9, 2020

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

RE: CCN: 245544
Cycle Start Date: September 3, 2020

Dear Administrator:

On September 22, 2020, we informed you that we may impose enforcement remedies.

On September 30, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 8, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 8, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 8, 2020.

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.

Also, this department is recommending the following:

- 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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 8, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Victory Health & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 8, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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

- 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.

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
Metro C 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: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 March 3, 2021 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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 (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

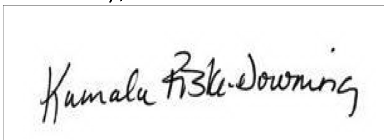
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING ______ B. WING ______	C 09/30/2020

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

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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 9/28/20 and 9/30/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility is IN compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS Victory Health and Rehabilitation Center is a Special Focus Facility (SFF) and received an abbreviated survey on 9/28/20 and 9/30/20, to conduct complaint investigations. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H544152C. Deficiency issued at F600 The following complaints were found not to be substantiated: H544153C H544154C In addition, A COVID-19 Focused Infection Control survey was conducted on 9/28/20 and 9/30/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 10/16/2020

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

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F 000	Continued From page 1 determined NOT to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R1) reviewed for abuse was free from verbal	F 600	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and	10/26/20

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F 600	Continued From page 2 abuse. Findings include: R1's quarterly Minimum Data Set (MDS) dated 9/22/20, indicated R1 was cognitively intact and did not experience difficulty with memory or delirium. R1's face sheet revised on 9/30/20 indicated R1 had diagnoses including post-traumatic stress disorder, major depressive disorder and unspecified anxiety disorder. R1's care plan dated 9/25/20, indicated R1 was a vulnerable adult due to R1's dependency on others for her cares. R1's care plan indicated R1's goal was to, "Remain safe in this environment." R1's care plan interventions include to, "remove resident from unsafe situations," and to, "engage [resident] calmly in conversation; if response is aggressive, staff walk calmly away, and approach later." When interviewed on 9/28/20, at 10:57 a.m. R1 stated, "I was going outside the front door to smoke and [administration clerical staff (AC)-D] tried to stop me and said, 'you are not going out. If you would stop being such a bitch, they would nice to you." R1 stated, "When she said that I was shocked, it made me feel bad to have a staff member say that." R1 stated she told AC-D she was going to call the police and AC-D stated, "go ahead, they can't do anything, I am a minor." R1 wanted to go out the front door to smoke as other residents in the normal smoking area bother her. An undated written statement from AC-D provided by the facility included, "On September 20th approximately at 6:10ish [R1] came up to the front desk while I was doing receptionist and	F 600	Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F 600 - Abuse R1 was interviewed by the social services director on 9/21/20 and ACP on 9/25/20, R1 reported feeling safe while in the facility. R1 vulnerable adult care plan was reviewed and interventions updated as needed. All other residents from survey exit who are at high risk for abuse were interviewed and all reported feeling safe while in the facility. Their care plans were reviewed and updated as needed. Residents will continue to be screened for vulnerability and their care plans created and reviewed per policy. Employee AC-D was suspended pending investigation on 9/21/20. Employee AC-D was terminated on 9/24/20. Facility staff will be in-serviced on the abuse policy with the focus on types of abuse and reporting requirements. Staff who are unable to attend the scheduled in-service will be in-serviced prior to the start of their shift. Social Services and/or designee will be responsible for compliance.	

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F 600	Continued From page 3 wanted to smoke out front. I of course said that she wasn't allowed to go out there. I then got up a nd stood i in the doorway. She then reached for the handicap button and i gently pushed her hand away. I then asked her why she didn't go smoke on the patio. She said if my little friend (talking about [R2]) wasn't rude to her she would. It then said if you didn't act like a b*** that they would be nice to you. (yes I know I shouldn't have said this.)" R1's investigative summary dated 9/25/20, included, "Per resident statement to the SW [social worker]: "she wanted to go out front to smoke, the receptionist attempted to redirect her to the smoking patio". "When reaching for the automatic door the receptionist slapped my hand away from the button." Resident stated: "She did not want to go to the smoking patio because she did not want to see [sic] was out there." Receptionist then stated to her well if you didn't act like a little bitch this would not be an issue." per the RN [registered nurse] who was called up to the front by the receptionist but did not witness the statement or physical touching per his statement. "However, the receptionist statement admits to the following statement to the resident "If you didn't act like a bitch they would be nice to you." Receptionist states in her statement: "I gently pushed her hand away". Receptionist terminated-statements included and new hire sign off acknowledgement." On 9/28/20 at 10:12 a.m. an attempt was made to interview AC-D by phone. AC-D did not respond and no return call was made. During interview on 9/28/20, at 12:36 p.m. nursing assistant (NA)-B indicated NA-B was not	F 600	Audits on vulnerable adult care plan intervention and staff response to abuse will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure compliance. Audits results will be reviewed by the Administrator and the Administrator will present audit results to QAPI committee for review and recommendations.	

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F 600	Continued From page 4	F 600		

aware of any abuse that has happened at the facility. NA-B stated NA-B had been educated on abuse but had not received education on abuse in the last two weeks.

During interview on 9/28/20, at 10:22 a.m. registered nurse (RN)-B stated RN-B had received training on how to recognize and report abuse on orientation and annually and was not aware of any form of abuse had occurred at the facility. RN-B stated there has not been education on abuse in the last two weeks.

During interview on 9/28/20, at 11:52 a.m. SW-A indicated on investigation of the incident AC-D had admitted to verbally abusing R1.

During interview on 9/28/20, at 1:48 p.m. the administrator stated he had conducted an investigation of the alleged staff to resident verbal abuse. AC-D had admitted to the verbal abuse and AC-D recorded the written statement including the abuse on 9/21/20. Administrator stated AD-D's employment with the facility was terminated as a result of the investigation.

When interviewed on 9/28/20, at 3:03 p.m. the director of nursing (DON) stated they were aware AC-D had verbally abused R1 on 9/30/20. The DON would expect R1's care plan to contain approaches for behavioral issues for deescalating, and staff should be re-educated on this.

When interviewed on 9/28/20, at 3:28 p.m. the assistant director of nursing (ADON) stated they were responsible for staff education. The ADON was aware R1 had been verbally abused and no abuse training had been provided to staff since

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F 600	Continued From page 5 this happened. AC-D's training record showed AC-D had been trained on the facility abuse policy on 6/5/20. Policy entitled, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, undated, identified definition a (i) Verbal Abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or with their hearing distance, regardless of age, ability to comprehend, or disability.	F 600		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		10/26/20

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F 880	Continued From page 6 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 7 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the CDC's recommendations to prevent the spread of COVID-19 in congregate settings for 1 of 5 employees (RN-C) observed to enter the facility without active screening for signs and symptoms of COVID-19, for 11 of 11 staff (NA-C, NA-D, NA-E, NA-F, NA-G, IP-A, RN-D, RN-C, administrator, PTA-A and SW-A) observed to be working in the resident care area without eye protection, and failed to quarantine 5 of 5 newly admitted residents (R4, R5, R6, R7, and R8). The facility practices had the potential to affect all 60 residents who resided in the facility. In addition, the facility failed to ensure hand hygiene was performed to prevent spread of infection for 5 of 5 residents (R9, R10, R11, R12 and R13) observed for water pass. Findings include: Active Screening of Staff During observation on 9/28/20, at 8:14 a.m. signage on the front door to the facility indicated all staff were required to be screened for signs and symptoms of COVID-19 prior to entry. During observation on 9/28/20, at 8:15 a.m. no screening staff were present at the registration desk, registered nurse (RN)-C was observed to enter the building and fill out the COVID-19 screening tool, Visitor Employee Daily Screening Log. RN-C recorded her temperature as 97.0.	F 880	F 880 Infection Control RN-C was educated on the procedure for staff screening on 9/28/20. NA-C, NA D, NA- E, NA-F, NA-G, IP-A, RN-D, RN-C , Administrator, PTA-A and SW A when alerted by surveyor, immediately placed eye protection on during resident care. All other staff were in-serviced and were provided eye protection during the survey visit. R4 and R7 were moved into private rooms. R5, R6 and R8 have been discharged from facility. Isolation carts were placed, and proper signage was hung. And remained in quarantine for the allotted 14-day period. R4, R7 MD and family representative was notified of this incident and their response will be recorded in the resident record. There were no adverse resident effects from this deficient practice. Future residents will be placed on contact precautions and the admission coordinator will discuss during morning meeting resident admissions and room assignment to ensure compliance. R9, R10, R11, R12 and R13 were assessed and no adverse effects from this handwashing deficient practice were experienced by the identified residents. R9, R10, R11, R12, and R13 MD and family were notified of this incident and their response will be documented in the resident s chart. All residents continue to be screened for COVID daily.	

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F 880	Continued From page 8 RN-C then entered the resident care area without having any actively screen her or taken her temperature. During observation on 9/28/20, at 8:17 a.m. administration clerical (AC)-E was performing active employee screening at the front desk directly inside the front door of the facility. When interviewed, AC-E stated, "When someone comes in they sanitize their hands, fill out the form and I question them if they have the symptoms listed on the form and I take their temperature. If I am not here then staffing coordinator [(SC)-F] does it. Staff are not supposed to sign themselves in. If no one is at the desk they should stay here until someone comes to the desk." When interviewed on 9/28/20, at 8:34 a.m. RN-C stated she had entered the facility without being actively screened. RN-C stated, "There was no one at the desk and I know I shouldn't have done that." RN-C stated, "I took my own temperature and wrote it down." RN-C stated the expectation is, "all staff are actively screened by another staff member at the front desk." When interviewed on 9/30/20, at 2:32 p.m. the director of nursing (DON) stated the expectation is that all staff are actively screened for COVID-19 symptoms when entering the facility. They should not enter the resident care area without being actively screened. Centers for Disease Control and Prevention (CDC) document dated 6/25/20, titled, Preparing for COVID-19 in Nursing Homes, included, "Screen all HCP (health care personnel) at the beginning of their shift for fever and symptoms of	F 880	The facility Quality Assurance and Performance Improvement Committee is scheduled to convene on 10/20 to conduct a root cause analysis to identify the problems that resulted in the deficiency develop a corrective action plan to prevent reoccurrence. Both the DON and ADON have completed the Centers for Disease Control and Prevention’s Nursing Home Infection Preventionist and training course, 19.3 contact hours on 10/16/20. The Infection Preventionist DON, ADON have reviewed the policy and procedures on donning/doffing PPE with current guidelines to include crisis standard of care, contingency standard of care and standard care. The Infection Preventionist have reviewed and implemented policies for staff and resident testing for COVID-19, including appropriate PPE to be worn during testing. The Infection Preventionist (DON) and back up Infection Preventionist (ADON) have reviewed policies regarding standard transmission-based precautions and revised as needed. The Infection Preventionist (DON) and back up Preventionist (ADON) have reviewed the facilities hand hygiene policies and procedures to ensure they meet CDC guidelines and were revised as needed. The Infection Preventionist (DON)/alternate Preventionist (ADON), have provided education and training to all staff providing care to residents, all staff entering resident rooms, either for dietary,	

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F 880	Continued From page 9 COVID-19. Actively take their temperature and document the absence of symptoms consistent with COVID-19. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace." A Facility policy titled, COVID-19 Facility Guidelines, dated 8/20/20, included, "All staff must be screened by another employee, prior to each shift." Eye protection Nursing assistant (NA)-C, NA-D and NA-E were observed to provide close personal cares for R16 on 9/28/20, at 3:49 p.m. R16 was not wearing a face mask for source control, NA-C, NA-D, and NA-E were not wearing any sort of eye protection. NA-F was observed on 9/30/20, at 3:24 p.m. in R17's room helping to reposition R17. NA-F did not have eye protection on. Infection preventionist (IP)-A was observed on 9/30/20, at 4:03 p.m. talking to R18 who had a face mask on below his mouth. IP-A was standing within 3 feet of R18 and was not wearing eye protection during the conversation. When interviewed on 9/30/20, at 8:47 a.m. NA-G, stated they had been told eye protection was not required when working in the building or with residents. When interviewed on 9/30/20, at 11:38 a.m. NA-H stated, "We were instructed we don't need to wear eye protection unless the resident has COVID-19."	F 880	cleaning or maintenance services. The training included standard infection control practices including but not limited to, transmission-based precautions, appropriate PPE use and donning doffing PPE. A documented competency testing of staff will be completed on facility staff. The Infection Preventionist/Assistant Preventionist have implemented competency assessments for staff on proper hand hygiene and have developed a system to ensure all staff have received the training and are competent. The Infection Preventionist (DON) has reviewed the hand hygiene policies and procedures to ensure they meet CDC guidelines and were revised as needed. Monitoring /Auditing: The Director of Nursing, the Infection Preventionist, and facility leadership will conduct audits on donning/doffing PPE with transmission-based precautions and droplet precautions. Audits will be conducted on all shifts four times a week for one week then twice weekly for 4 weeks. Audits will continue until 100% compliance is met. THE DON/Infection Preventionist/designee will review the results of audits and monitoring the Quality Assurance Improvement program as per scheduled.	

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F 880	Continued From page 10 When interviewed on 9/30/20, at 11:43 p.m. RN-D stated she had worked at the facility for 2 months and had never been required to wear eye protection during that time, even when providing direct care for residents. RN-D was not aware of the current CDC guidance to protect against COVID-19 to include eye protection. When interviewed on 9/30/20, at 10:12 a.m. the administrator stated they had been told eye protection was not necessary unless residents were positive for COVID-19. No staff were observed to be wearing eye protection at all during observation on all units 9/28/20 and 9/30/20, this was verified by the administrator. They had not been requiring the use of eye protection. When interviewed on 9/30/20, at 2:32 p.m. IP-A stated she was not aware of guidance recommending health care personnel (HCPs) wear eye protection when performing resident cares and when in resident care areas. IP-A stated, "I started with the facility on 7/29/20." "I've registered for the infection preventionist training. I just really haven't had the time to start the training." IP-A stated she does get in on the weekly education calls about COVID-19 provided by the state. However, was unaware staff should be wearing eye protection while in resident care spaces. IP-A's training transcript for infection prevention training noted IP-A had registered for the training, but had not completed any of it. IP-A was unable to provide any evidence of being trained in infection control, or training on COVID-19 response.	F 880		

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Facility education document COVID-19 Control and Prevention Methods, undated, indicated, "For residents on Contact Precaution, No MASK is needed. However, gloves and gown are required during resident's care."

A Center for Medicare/Medicaid Services (CMS) memo titled QSO-20-29-NH references CDC guidance document entitled, Preparing for COVID-19 In Nursing Homes, dated 6/25/20, which recommended HCPs use eye protection when in resident care areas and included, "HCP should leave patient care area if they need to remove their eye protection."

Cohorting and quarantining of new admissions.

A facility provided Electronic medical record report entitled, Resident List Report, dated 9/30/20, indicated 5 residents had been admitted to the facility in the last 14 days. This query listed those 5 residents as, R4, R5, R6, R7 and R8.

R4's entry tracking Minimum Data Set (MDS) indicated an admission date of 9/17/20. R4's face sheet identified R4 had been admitted to a private room on the West unit of the facility. R4's medical record lacked any evidence he had been placed on the required 14 day quarantine for COVID-19 precautions. During observation on 9/30/20, at 10:00 a.m. R4's room was noted to be interspersed among rooms of long term residents who were not recently admitted or on quarantine. There was no personal protection equipment (PPE) available for staff as they entered R4's room and no signage on the door to indicate R4 was on quarantine.

R5's entry tracking MDS noted he was admitted

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on 9/29/20. R5's face sheet noted an admission to a private room on the North unit of the facility. R5's medical record lacked any evidence he had been placed on the required 14 day quarantine for COVID-19 precautions. During observation on 9/30/20, at 10:00 a.m. R5's room was noted to be interspersed with other residents who did not require quarantine or isolation. There was no PPE available for staff as they entered R5's room and no signage on the door to indicate R5 was on quarantine.

R6's entry tracking MDS noted he was admitted to the facility on 9/28/20. R6's face sheet indicated he had been admitted to a private room on the East unit of the facility. R6's medical record contained no evidence he had been placed on the required 14 day quarantine for COVID-19. During observation on 9/30/20, at 10:05 a.m. R6's room was noted to be interspersed with other residents who did not require quarantine or isolation. There was no PPE available for staff as they entered R6's room or signage on the door to indicate R6 was on quarantine.

R7's entry tracking MDS noted he was admitted to the facility on 9/16/20. R7's face sheet indicated he had been admitted to a private room on the facilities North unit. R7's medical record contained no evidence he had been placed on the required 14 day quarantine for COVID-19. During observation on 9/30/20, at 10:05 a.m. R7's room was noted to be interspersed with other residents who did not require quarantine or isolation. There was no PPE available for staff as they entered R7's room or signage on the door to indicate R7 was on quarantine.

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F 880	Continued From page 13 R8's entry tracking MDS indicated she was admitted to the facility on 9/21/20. R8's face sheet indicated she was admitted to a private room on the West unit of the facility. R8's medical record contained no evidence she had been placed on the required 14 day quarantine for COVID-19. During observation on 9/30/20, at 10:05 a.m. R8's room was noted to be interspersed with other residents who did not require quarantine or isolation. There was no PPE available for staff as they entered R8's room or signage on the door to indicate R8 was on quarantine. During observation on 9/30/20, at 11:53 a.m. R6 was at the central desk standing within 3 feet of RN-D and talking to her. R6 was not wearing a face mask and no attempt was made by RN-D to direct R6 back to his room. During observation on 9/30/20, at 11:55 a.m. R6 was observed in the west hallway standing within 3 feet of physical therapy aide (PTA)-G and talking to her. No attempt was made to direct R6 back to his room. During observation on 9/30/20, at 11:52 a.m. NA-G delivered a food tray to R6, entering room with a face mask, but no eye protection or any other PPE. During observation on 9/30/20, at 2:48 p.m. NA-I entered R5's room and physically assisted R4 to reposition in bed. NA-I wore a face mask, but no eye protection, gown, or gloves. When interviewed on 9/30/20, at 11:58 a.m. R6 stated, "I am able to walk anywhere in the facility. There aren't any hallways in the facility that are	F 880		

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off limits to me." R6 denied being on any kind of quarantine since admission on 9/28/20.

When interviewed on 9/30/20, at 12:58 p.m. R5 stated, he is able to go any where in the facility and denied being on any kind of quarantine.

When interviewed on 9/30/20, at 12:50 a.m. licensed practical nurse (LPN)-A stated, "When I do cares with R7 in R7's room, I wear gloves, I don't wear a gown or eye protection." "They didn't tell us R7 was on any isolation precautions."

When interviewed on 9/30/20, at 2:50 p.m. NA-I stated, "R5 isn't on quarantine or any infection control precautions." "R5 showers in our shower down the hall." "They didn't tell us we would shower R5 differently than anyone else." "They didn't tell us he was on any precautions."

When interviewed on 9/30/20, at 10:12 a.m. the administrator stated, "With new admissions we kind of try to get them on the east wing if there is a private room available, it doesn't always work out." New admissions were not placed on the required 14 day quarantine for COVID-19 and were not cohorted with others on quarantine, however they try and place them in a private room.

When interviewed on 9/30/20, at 2:32 p.m. IP-A indicated, "Prior to today that is the first time I heard new residents need to be cohorted and quarantined." "When every new resident comes in, they are put in private room for 14 days." IP-A stated she had learned new admissions should be placed on 14 day quarantine and not leave their rooms, staff who care for these residents should wear full PPE including a gown, gloves,

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face mask, and eye protection. The residents are to be observed for signs and symptoms of COVID-19. It can take up to 14 days to show signs if they had been exposed to COVID-19 prior to admission. The IP-A verified no staff had been instructed to wear eye protection as they currently had no residents positive for COVID-19.

When interviewed on 9/30/20, at 3:11 p.m. social worker (SW)-A stated, "All the new admissions tested negative that we get that from the hospital. Staff know that from the change of shift report. All admits we have had in the last 14 days have been from the hospital. They are told they are in the private room for 14 days. They are instructed to stay in their room unless they are smokers and then they can use the smoking patio with the others, some of the people do come out of their rooms though."

A facility policy titled COVID-19 Guidelines dated 8/20/20, included, "Environment; Create a COVID wing or unit at the facility and seek staff who will be dedicated to this unit." "Resident Care/Surveillance; Resident admission/readmissions the facility will follow ACHA and Minnesota department of health (MSH) guidelines [hyperlinks to above SA and ACHA guidance]."

The State agency (SA) guidance, referenced by the facility policy, was entitled, Interim Guidance for Discharge to Home or New/Re-Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions, dated 7/30/20. The guidance included, "Patients or residents investigated for possible COVID-19 with a negative test; The resident should be placed in a single-person room with private bathroom or in a

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separate admission/re-admission observation area, for monitoring of signs and symptoms of COVID-19. Residents can be transferred out of the observation area to the main facility if they remain afebrile [without fever] and without symptoms for 14 days after admission. All recommended PPE (face mask, eye protection, gloves, and gown) should be worn during care of residents under observation, when PPE supplies allow. At minimum, face mask and eye protection should be worn by staff during care. Cloth face coverings are not considered PPE."

The facility policy reference to the American Health Care Association Guidance entitled, AHCA/NCAL Guidance included, "Accepting Admissions from Hospitals During COVID-19 Pandemic, dated 3/30/20, included, "We strongly urge LTC facilities to begin now creating separate wings, units or floors by moving current residents to handle admissions from the hospital and keep current resident separate, if possible." Under "Table 1: Accepting Hospital Admissions; Limit contact with other residents as much as possible; Cohort in rooms (and wings if possible) with similar residents (e.g. if COVID positive cohort with other COVID-19 positive residents or if unknown, cohort with other recent admissions from the hospital with similar status); Create separate wing/unit or floor to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible.

CMS memo titled QSO-20-38-NH references CDC guidance document entitled, Preparing for COVID-19 In Nursing Homes, dated 6/25/20, indicated, create a plan for managing new admissions and readmissions whose COVID-19

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F 880	Continued From page 17 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic SARS-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. hand washing During observation on 9/30/20, at 8:49 a.m. nursing assistant (NA)-A entered R9 and R10's room. NA-A was observed wearing gloves and picked up the pink water pitcher from R6 bedside table and brought the water pitcher out to the	F 880		

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F 880	Continued From page 18 hallway. NA-A picked up the ice scoop out of the ice cooler and scooped ice into the water pitcher. NA-A re-entered R9 and R10's room and placed R9 water pitcher back onto the bedside table. NA-A did not remove gloves, wash or sanitize hands. NA-A proceeded to go to R10's bedside table and picked up R10's pink water pitcher and brought the water pitcher out to the hallway. NA-A picked up the ice scoop out of the ice cooler and scooped ice into the water pitcher. NA-A re-entered R9 and R10's room and placed R10's water pitcher back onto the bedside table. NA-A did not remove gloves, wash or sanitize hands. NA-A entered R11 and R12's room. NA-A was observed wearing the same gloves and picked up the pink water pitcher from R11 bedside table and brought the water pitcher out to the hallway. NA-A picked up the ice scoop out of the ice cooler and scooped ice into the water pitcher. NA-A re-entered R11 and R12's room and placed R11 water pitcher back onto the bedside table. NA-A did not remove gloves, wash or sanitize hands. NA-A proceeded to go to R12's bedside table and picked up R12's pink water pitcher and brought the water pitcher out to the hallway. NA-A picked up the ice scoop out of the ice cooler and scooped ice into the water pitcher. NA-A re-entered R11 and R12's room and placed R12's water pitcher back onto the bedside table. NA-A did not remove gloves, wash or sanitize hands. NA-A was observed wearing the same gloves and picked up the pink water pitcher from R13 bedside table and brought the water pitcher out to the hallway. NA-A picked up the ice scoop out of the ice cooler and scooped ice into the water pitcher. NA-A re-entered R13's room and placed R13's water pitcher back onto the bedside table. NA-A did not remove gloves, wash or sanitize hands.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING ______ B. WING ______	C 09/30/2020

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

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F 880	Continued From page 19 When interviewed on 9/30/20, at 8:53 a.m. NA-A stated glove removal and hand washing/sanitizing should have been completed after filling each ice pitcher with ice prior to getting another water pitcher. NA-A verified glove removal/change and hand washing/sanitizing was not completed between filling each water pitcher with ice. When interviewed on 9/30/20, at 9:40 a.m. RN-A verified NA-A should have changed gloves and washed/sanitized hands between each water pitcher. A facility policy titled, Handwashing/Hand Hygiene, dated 10/29/19, indicated after contact with objects in the immediate vicinity of the resident staff are to use an alcohol-based hand rub or soap and water to prevent the spread of infections. The use of gloves does not replace hand washing/hand hygiene and the integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training,	F 882		10/26/20

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F 882	Continued From page 20 experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the acting infection preventionist (IP) had completed specialized training in infection prevention and control. This had the potential to affect all 60 residents residing in the facility. Findings include: An undated facility document entitled, Facility Administration, identified infection preventionist (IP)-A had the title of, "infection control." When interviewed on 9/30/30, at 1:47 p.m. the administrator, stated IP-A was the facility's designated infection preventionist. When interviewed on 9/30/20, at 2:32 p.m. IP-A stated, "I started with the facility on 7/29/20." "I've registered for the infection preventionist training. I just really haven't had the time to start the training." IP-A stated she had no specialized	F 882	F 882 Infection Preventionist (IP) completed infection control training on 10/16/20. IP will review the Infection Control Policy and COVID-19 Facility Guidelines with emphasis on #35 that gives guidance on resident quarantine procedures. IP will also review the designation of infection preventionist document. This document will be included in the employee employment file. IDT team and facility staff will be in-serviced on quarantine procedures, hand hygiene, proper use of PPE, isolation precaution room signage. Audits on IP training completion and facility audits on hand hygiene, use of Proper PPE, quarantine procedures, facility signage will begin 3x week for 3 weeks, then weekly x 2 weeks, then monthly to ensure compliance. Director of Nursing and/or designee is	

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F 882	Continued From page 21 training in infection prevention and control. IP-A stated she was not aware of the current Center for Disease Control (CDC) current recommendations on preventing the spread of COVID-19 in congregate settings such as staff wearing eye protection, residents wearing source control masks during care, or cohorting and quarantining newly admitted residents. IP-A's training transcript titled, TRAIN (national learning management system for health care professionals) indicated IP-A was registered for infection preventionist training. However, all training modules were listed as, "not started." A policy was requested, but not provided by the facility.	F 882	responsible for compliance. All audit results will be reviewed by the Administrator and the Administrator will present audit results to QAPI committee for review and recommendation.	
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms	F 886		10/26/20

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F 886	Continued From page 22 consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident’s testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state	F 886		

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F 886	Continued From page 23 and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to test facility staff on a weekly basis for COVID-19 based on the county positivity rate of over 5% each week, failed to contact state and local health departments to assist with testing equipment, and failed to maintain proper use of personal protective equipment (PPE) when collecting specimens. Findings include: When interviewed on 9/30/20, at 12:34 p.m. registered nurse (RN)-A stated today was the first day of staff testing for COVID-19. They had received test kits last month, but the kit did not come with a cable that worked with their printer. RN-A verified the facility did not start staff testing for COVID-19 on 9/2/20 and did not contact the local or state or health departments for help with the testing supplies or equipment. When interviewed on 9/30/20, at 1:05 p.m. the director of nursing (DON) stated the facility did not start staff testing for COVID-19 until today due to education required to perform the test, and the test kits had not arrived until last week. The DON verified the facility did not start staff testing for COVID-19 on 9/2/20. The DON stated, staff testing for COVID-19 was to be completed according to the county positivity rate which was 6.1%, therefore should be weekly. During observation on 9/30/20, at 2:35 p.m. registered nurse (RN)-A performed hand hygiene,	F 886	F 886 Staff were tested beginning 9/30/20 utilizing BinaxNOW COVID-19 Ag CARD. All test results were reviewed by the infection preventionist were negative. The facility positivity rate will be obtained weekly by the IP and based on the positivity rate, staff testing will be determined. The Administrator will obtain and maintain a record of testing equipment, supplies for testing and PPE and reach out to the Red Cap Survey department for additional testing equipment needs and PPE as needed. As of this date, the facility has performed weekly three times and is currently up to date with facility testing. IP, Administrator and DON will be in-serviced on how to obtain the county positivity rate, and nursing will be in-serviced on proper testing and PPE requirements for staff and residents. Audits on COVID-19 staff testing, proper PPE and social distancing during testing and positivity rate recording beginning 3x week for 3 weeks, then weekly x 2 weeks, then monthly to ensure compliance. Director of Nursing and/or designee is responsible for compliance. All audit results will be reviewed by the Administrator and the Administrator will present audit results to QAPI committee for review and recommendation.	

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F 886	Continued From page 24	F 886		

donned a surgical mask, eye protection, and gloves. Dietary cook (C)-A and C-B stood within approximately 12 inches of each other while RN-A placed the swab into C-A's left nostril for the COVID-19 test. RN-A did not direct C-A and C-B to stand 6 feet apart and did not don an isolation gown during the COVID-19 testing.

When interviewed on 9/30/20, at 2:42 p.m. RN-A stated he was not aware of the need to wear a gown, nor have the staff remain 6 feet apart while collecting specimens for COVID-19.

When interviewed via telephone on 9/30/20, at 4:34 p.m. the head of the state operations emergency center (SEOC) stated the facility had not reached out to them with concerns about supplies, or assistance with testing their staff.

The facility supplied a packing slip for COVID-19 test kits dated 8/26/20, which included 8 boxes with 30 test kits in each box which had been shipped to the facility and received on 8/26/20. When interviewed on 9/30/20, at 2:40 p.m. the administrator stated they had not used these testing supplies as there was no cord to connect to their printer. They did not know they should reach out to the state or local health departments with questions about the test kit, or help with testing. Last week they had ordered a different test kit that they liked better, it arrived and they just started testing today, over a month after receiving the original test kits. The administrator stated their medical director told them they had 60 days from the date of the CMS (Centers for Medicare and Medicaid Services) memo directing testing of nursing home staff, to start testing.

The facility supplied a packing slip for COVID-19

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F 886	Continued From page 25 test kits dated 9/21/20, which indicated 4 boxes of test kits had been shipped to the facility. The Centers for Medicare and Medicaid Services identified on 8/26/20, "To enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities are required to test residents and staff based on parameters set forth by the HHS [Health and Human Services] Secretary." "Routine testing should be based on the extent of the virus in the community, therefore facilities should use their county positivity rate in the prior week as the trigger for staff testing frequency." "During specimen collection, facilities must maintain proper infection control and use recommended personal protective equipment (PPE), which includes an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown, when collecting specimens." "When necessary, such as emergencies due to testing supply shortages, document that the facility contacted state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing of results." The guidance was published in the Federal Registar as effective 9/2/20. The Centers for Medicare and Medicaid Services (CMS) posted the COVID-19 County Positivity Rates for Hennepin County as: The week ending 9/2/20, 7.3%. The week ending 9/9/20, 6.5%. The week ending 9/16/20, 5.6%. The week ending 9/23/20, 6.1%. The week ending 9/30/20, 6.6%. The facility would have been required to test all staff each of these weeks for a county positivity rate over 5%.	F 886		

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F 886	Continued From page 26 A policy was requested, but not provided by the facility.	F 886		

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
October 9, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: 9RHC11

Dear Administrator:

The above facility was surveyed on September 28, 2020 through September 30, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

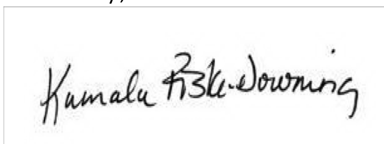
Karen Aldinger, Unit Supervisor
Metro C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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

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

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Licensing and Certification Program

Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments	2 000		

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 9/28/20 and 9/30/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure.

The following complaints were found to be UNSUBSTANTIATED: H5544153C and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/16/20

Minnesota Department of Health

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2 000	Continued From page 1 H5544154C The following complaints were found to be substantiated, however no licensing orders were issued: H5544152C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		