Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 3, 2023

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

RE: CCN: 245544
Cycle Start Date: January 13, 2023

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 January 13, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant 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. Because your facility is designated as a Special Focus Facility (SFF). CMS's policy of progressive enforcement means that your facility would not be given an opportunity to correct before remedies are imposed. Since your facility meets the criterion remedies will be imposed immediately. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 18, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 18, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 18, 2023.

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.

This Department is also recommending that CMS impose:

• 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 $11,292; 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 February 18, 2023, 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 February 18, 2023. 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 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.

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:

Nathan Schreier, 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: nate.schreier@state.mn.us
Office: Mobile (651)392-2726

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 July 13, 2023 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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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.

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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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February 3, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: C5MK11

Dear Administrator:

The above facility was surveyed on January 9, 2023 through January 13, 2023 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:

Nathan Schreier, 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: nate.schreier@state.mn.us
Office: Mobile (651)392-2726

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@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 01/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 1/9/23-1/13/23, during a recertification survey. The Condition of Participation 483.73: Establishment of the Emergency Program was found not met. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	E 000		
E 009 SS=C	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts	E 009		2/20/23

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

Electronically Signed | 02/11/2023

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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E 009	Continued From page 1 to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure documentation of collaboration efforts with local and state emergency preparedness authorities. This had the potential to effect all 54 residents who reside at the facility. The facility emergency preparedness plan reviewed on 1/12/23, identified local, county, and federal emergency contacts, but lacked documentation of coordination and collaboration efforts with the pertinent authorities. During an interview on 1/13/22, at approximately 2:30 p.m. the Administrator lacked any knowledge of coordination/collaboration with local, county, and/or federal emergency contacts.	E 009	E 009 The emergency preparedness plan was updated to include the process how collaboration with state, local and federal agencies will occur. Copies of the Emergency Management Plan was presented during the fire marshal visit on 01/10/2023 and a copy delivered to the local fire department per facility policy on 02/20/2023. Facility is awaiting further comments and/or feedback to this plan. The IDT team was in-serviced on the Coordination with Emergency Management Agencies policy and procedure with emphasis on item #5 which list how coordination can occur. The Administrator and/or Designee is responsible for compliance. Audits on MN track bed daily reporting, monthly MDH preparedness website for updates and month changes to the emergency communication plan contact agencies and documented updates being	

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E 009	Continued From page 2	E 009	delivered to outside entities will begin 1x a month then quarterly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation.	
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.542(c)(7), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A	E 034		2/20/23

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E 034	Continued From page 3 means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness communication plan included a means of providing information about the facility's occupancy needs and it's ability to provide assistance to the authority having jurisdiction, the incident command center, or designee. On 1/13/23, at approximately 2:30 p.m. the emergency preparedness plan was reviewed and failed to include a policy/procedure related to the communication of the facility's occupancy and needs. The administrator lacked knowledge of any plan.	E 034	The facility IDT team held an emergency QAPI on (INSERT DATE) to discuss this deficiency. The emergency preparedness facility plan was reviewed and updated to ensure all aspects of facility occupancy needs during an emergency were addressed and outside entities that will assist during an emergency will be recorded in the emergency management plan policy and procedure. This plan will be communicated via email to local emergency responder personnel and a copy will also be available in the facility emergency preparedness binder. The administrator along with the entire IDT team will be in-serviced on the entire Emergency Facility Assessment policy and procedure with emphasis on item #1 that the facility conducts an annual assessment and as needed facility wide assessment to determine the needs specific to the facility resident population and the emergency communication plan was updated to include MN Trac as an alternative to tracking and needs of the facility during disasters. Audits on MN track bed daily reporting, monthly MDH preparedness website for updates and month changes to the emergency communication plan contact agencies and documented updates being delivered to outside entities will begin 1x a	

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E 034	Continued From page 4	E 034	month then quarterly to ensure sustained compliance. Administrator and/or designee is responsible for compliance. Audit results will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and recommendation. Compliance:	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the	E 039		2/20/23

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E 039	Continued From page 5 actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.	E 039		

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VICTORY HEALTH & REHABILITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 6 (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a	E 039		

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E 039	Continued From page 7 facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group	E 039		

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E 039	Continued From page 8 discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion,	E 039		

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E 039	Continued From page 9 using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to	E 039		

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E 039	Continued From page 10 challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.	E 039		

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E 039	Continued From page 11 *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.	E 039		

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E 039	Continued From page 12 *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by:	E 039		

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E 039	Continued From page 13 Based on interview and document review, the facility failed to ensure they conducted exercises to test their emergency plan at least annually, including participation in a full scale and table top exercise. During a review of the facility's emergency preparedness plan on 1/13/23, it lacked documentation of participation in a full scale or table top exercise. During an interview on 1/13/23, at approximately 2:30 p.m. the administrator stated she was only aware of one emergency preparedness exercise that had been completed on heat loss.	E 039	The facility will conduct a mock disaster training drill on bomb threat tentatively schedule for 2/18/2023. For future training, the facility will conduct mock drills annually per facility policy. The IDT team will be in-serviced on the Disaster Training policy with emphasis on #4 that training exercise drills will be conducted at least annually to test the emergency preparedness plan and identify opportunities for improvement. Each mock drill conducted will have a documented response of staff performance along with any updates to the plan and re-education as needed. Administrator and/or designee is responsible for compliance. Audits on mock disaster training and employee participation will begin 1x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 2/20/2023	
F 000	INITIAL COMMENTS On 1/9/23 - 1/13/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated:	F 000		

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F 000	Continued From page 14 H55446642C (MN00089249), however no deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be unsubstantiated, however related deficiencies were cited. H55447039C (MN00089595) with a deficiency cited at F689. The following complaints were found to be unsubstantiated: H55447297C (MN00088893) and H55447298C (MN00088903). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		2/20/23

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F 584	Continued From page 15 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to maintain comfortable sounds levels due to frequent use of an overhead paging system for 2 of 2 residents (R2 and R53)	F 584	R2 met with the facility social service designee and a new PTSD screen tool was completed. R2 care plan focused for ineffective coping will be created. R53	

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F 584	Continued From page 16 who had complaints of noise level with the facility paging system. Findings include: R2's admission Minimum Data Set (MDS) dated 12/18/22, indicated moderately impaired cognition and no behaviors during the reference period. R2's diagnoses included anxiety disorder. R2's care plan revised on 9/21/22, included, "The resident has a mood problem r/t [related to] failure to thrive and aggressive behavior." The care plan included corresponding interventions which included, "Monitor/record mood to determine if problems seem to be related to external causes i.e., medications, treatments, concern over diagnosis." During an interview on 1/10/23, at 3:19 p.m. R2 described the staff's use of the overhead paging system as "loud." R2 added, "It happens even at night while I'm in bed. It wakes me up." Between 3:19 p.m. - 3:23 p.m., during R2's interview, 3 overhead pages were heard. R2 was observed cringing each time an overhead page occurred and stopped talking until the page was completed. R53's admission Minimum Data Set (MDS) dated 12/30/22, indicated intact cognition and no behaviors during the reference period. R53's diagnoses included post-traumatic stress disorder (PTSD) (a mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations), and major depressive disorder.	F 584	has discharged from the facility. Existing residents were interviewed related to the paging system and any concerns voiced will be placed on a grievance form. Future facility paging systems will be utilized per the facility policy. The facility staff was in-service on the Noise control policy and procedure with emphasis on item #5 that the paging system will be utilized for emergencies only. The facility will meet with the resident's council monthly and add overhead paging to the agenda items and will address any concerns brought forth. Administrator and/or designee is responsible for compliance. Audits on use of the paging system and resident paging system/environmental concerns will begin 2 x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance:2/20/2023	

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F 584	Continued From page 17 R53's care plan printed 1/13/23 did not address the diagnosis of PTSD or related symptoms or triggers. During an interview on 1/11/23, at 3:58 p.m. R53 stated "loud noises" triggered his PTSD symptoms and identified the overhead paging system as one of the loud noises which bothered him and caused increased anxiety. The following observations were conducated of the faciltiy overhead paging system: On 1/10/23 from 3:20 p.m. - 5:00 p.m. a total of 9 overhead pages were heard. On 1/11/23 from 9:00 a.m. - 5:00 p.m. a total of 25 overhead pages were heard. On 1/12/23 from 8:30 a.m. - 5:00 p.m. a total of 18 overhead pages were heard. On 1/13/23 from 8:00 a.m. - 1:00 p.m. a total of 13 overhead pages were heard. During an interview on 1/13/23, at 12:12 p.m. the administrator stated a homelike environment is important to make the nursing home feel less institutionalized and ensuring the residents have as much say in their life as possible. Additionally, the administrator described the overhead paging system as, "very outdated" and decreased the facility's homelike environment. The facility policy, "Homelike Environment" (undated), included, "The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include: a. overhead paging."	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		2/20/23

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F 609	Continued From page 18 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure allegations of potential abuse were reported timely to the State agency (SA) for 2 of 2 residents (R56 and R28) who were reviewed for allegations of resident-to-resident abuse. Findings include:	F 609	A risk management incident was created for the resident/resident abuse for R56 and R28. This incident will be thoroughly investigated, and a root cause identified. R56 and R28 care plan for vulnerability was also reviewed and updated as needed. As of this writing, there have been no facility incidents noted for	

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F 609	Continued From page 19 R56's admission Minimum Data Set (MDS) dated 12/14/22, included intact cognition, independence with transfers, ambulation, and no behaviors identified in the reference period. R56's diagnoses included major depressive disorder. R56's care plan revised 12/14/22, included, "The resident is a vulnerable adult due to mental health, cognition, physical impairment, SNF [skilled nursing facility] placement. Physical altercation on 12/8/22." A corresponding intervention dated 12/9/22, informed, "Report and investigate any allegations of abuse or maltreatment as per facility policy and state/federal regulation. Offer residents support as appropriate. Complete VA [vulnerable adult] assessment as per family [sic] policy." R28's significant change MDS dated 11/23/22, included moderately impaired cognition, independence with transfers and ambulation, and no behaviors identified in the reference period. R28's diagnoses included major depressive disorder and adjustment disorder with anxiety. R28's care plan revised on 12/9/22 included, "VULNERABLE ADULT: My safety is at risk and there is a potential for abuse due to: Chemical Dependency, Mental Illness, Physical limitations, SNF placement. Conflict 12/8/22." R28's care plan lacked information related to reporting allegations of abuse to the state agency or law enforcement. The Nursing Home Incident Report (NHIR) submitted to the state agency indicated a physical altercation occurred between R56 and R28 on 12/8/22, at 10:00 p.m. The report included, "[R28]	F 609	timeliness reporting. Future resident/resident incidents will be reported within 2 hours of an allegation of abuse or serious bodily injury.. The Facility staff will be in-serviced on the Resident/Resident Altercation policy and procedures with emphasis on item #3 that incidents will be promptly reported to the administrator and the administrator and/or designee will report allegations of abuse to state and local agencies per reporting policy. Administrator and/or designee is responsible for compliance. Audits on all allegations of abuse and reporting allegations timely will begin 1x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 2/20/2023	

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F 609	Continued From page 20	F 609		

reported that his roommate [R56] came in the room shouting at him and physically punched him in the face. At the time of the report made by the resident, he was bleeding from his nose and had swelling of right eye." The NHIR was submitted on 12/9/22, at 10:01 a.m., 12 hours after the altercation occurred. Additionally, the NHIR indicated the police were notified of the altercation on 12/9/22.

R28's progress note dated 12/9/23, at 3:02 a.m. stated, "At 10pm, [R28] came to the nursing station and reported to staffs that he got attacked by his roommate [R56]." The progress note continued, "[R28] was bleeding from his nose, bruises and swelling to right eye. Writer administered iced pack and resident said it was effective. Resident's roommate was relocated to a different room." "Don [director of nursing], Physician, and family member were notified."

R28's progress note dated 12/9/22, at 3:39 p.m. included, "[P]honed police this morning regarding resident-to-resident altercation. Police came to the facility and a report was filed."

During an interview on 1/12/23, at 2:38 p.m. the administrator stated all allegations of abuse, including resident-to-resident abuse, need to be reported to the state agency and the police within 2 hours. The administrator stated the altercation between R28 and R56 should have been reported to the state agency and the police within 2 hours. The administrator added, "this was not reported timely."

A facility policy, "Reporting Abuse to Facility Management" (updated 9/4/20), included, "All allegations of abuse will be reported immediately,

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F 609	Continued From page 21 but not later than 2 hours after the allegation is made."	F 609		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including	F 676		2/20/23

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F 676	Continued From page 22 (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure activities of daily living (ADLs) including weekly baths or showers and nail care were provided for 1 of 1 residents (R38) who needed staff assistance with bathing and nail care. Findings include: R38's admission Minimum Data Set (MDS) dated 12/22/22, indicated R38 was cognitively intact, and required assist of one staff for bathing, personal hygiene, and dressing. The MDS included diagnoses of cancer, fracture, lung disease and indicated R38 exhibited no behaviors or rejection of cares. R38's care plan dated 12/18/22, indicated R38 had a self-care performance deficit and required staff assistance for showering/bathing and personal hygiene but lacked indication of level of assistance needed. The care plan lacked any evidence of refusal of showering/bathing and personal hygiene. During observation on 1/9/23, at 1:53 p.m. R38 was observed seated on the side of his bed with greasy-looking hair and fingernails approximately between 1/8 and 1/4 inch long, with dark brown matter under the nails approximately halfway up toward the tip. He stated staff did not help him cut or clean his nails and he did not like it. R38's Weekly Skin Check dated 12/19/22,	F 676	R38 has since been discharged from the facility. All Existing residents who require bathing assistance ADL care plans were reviewed and their grooming preferences were reviewed and updated as needed. Future residents who require bathing assistance, the facility will follow the care services plan for the resident per facility policy. Licensed nurses and nurse aides will be in-serviced on the ADL support policy with focus on item #2 that appropriate care and services will be rendered for residents who are unable to carry out ADL's independently. DON and/or designee is responsible for compliance. Audits on ADL assistance and grooming completion (bathing, nailcare, hair care) will begin 2 x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 2/20/2023	

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F 676	Continued From page 23 indicated R38 had a bed bath but did not have his fingernails or toenails trimmed or filed. R38's orders printed 1/13/22, included an order for nursing to complete skin audit weekly on bath day, with R38 scheduled to receive bath/shower every Monday AM. The order included "please offer to trim nails and document". Review of R38's bathing documentation did not identify if he had a bath or his nails trimmed from 12/19/22, through 1/13/23. R38's Kardex for nursing assistants (NA) to follow to provide cares dated 1/13/22, indicated R38's preferred bath time was Monday mornings, but did not identify how much staff assistance was needed. The Kardex included R38's fingernails should be kept short to avoid scratching, and to monitor any behavior symptoms. During interview on 1/12/23, at 4:19 p.m. licensed practical nurse (LPN)-C stated nursing assistants trimmed residents' nails on bath days if needed, unless the resident was diabetic. During interview on 1/12/23, at 4:24 p.m. NA-A stated she looked at the Kardex and the assignment book to determine who needed a bath or shower on her shift. She stated if a resident refused, she told the nurse, reproached later, and if the resident continued to refuse, she documented it and a bath or shower would be offered another time. She stated R38 had not been in the facility very long but thought he might have taken a shower. During interview on 1/13/23, at 8:15 a.m. NA-C stated there was a shower schedule at the desk	F 676		

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and staff documented the showers in the electronic documentation system. She stated she trimmed residents' nails when she saw the need for it and most resident's wanted them trimmed. She stated the aides tried to clean the residents' hands with a washcloth, soap, and water and sometimes R38 refused, but the nurses knew about "the crud" under his fingernails. She thought R38 normally did not refuse showers.

During interview on 1/13/23, at 10:03 a.m. RN-A stated nails should be checked weekly on bath days and trimmed as needed. She stated she had also noticed many residents needed their fingernails trimmed and cleaned, and ADL care of residents could be improved. She stated some of the residents refused, however the refusals should have been documented but she was not aware that R38 refused cares.

On 1/13/23, at 10:17 RN-B observed R38's soiled fingernails and identified they should be cleaned and trimmed.

During interview on 1/13/23, at 10:43 a.m. director of nursing (DON) stated residents had a scheduled weekly bath day and resident nail care was done when bathed. She stated bathing and nail care were important for infection control, and any refusals after re-approach were expected to be documented. The DON identified she was not aware if R38 refused cares.

The facility policy Activities of Daily Living, Supporting (undated) indicated residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living

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F 676	Continued From page 25 independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine personal grooming, bathing and cleanliness for 2 of 2 residents (R13 and R48) who were dependant on staff for their hygiene care. Findings include: Resident #13 R13's admission minimum data set (MDS) dated 12/8/22, indicated he was cognitively intact, did not refuse cares, was totally dependent on two staff for bed mobility, transfers, grooming, and toilet use, and included diagnoses of arthritis. R13's diagnoses did not include diabetes. R13's care plan dated 12/6/22 included R13 had a self-care performance deficit and included R13 required total assistance with personal hygiene and instructed staff to check nail length and trim and clean on bath day and as necessary. The care plan did not address facial hair removal. On 1/9/23, at 1:33 p.m. R13 was observed lying in bed with a full beard of two to three inches and	F 677	R13 was given a bath and grooming was performed on 1/16/2023. R48 was given a bath and grooming was performed on 1/16/2023. R13 and R48 ADL care plan was reviewed for bathing and grooming preference and was reviewed and updated as needed. All Existing residents who require bathing assistance ADL care plans were reviewed and their grooming preferences were reviewed and updated as needed. Future residents who require bathing assistance, the facility will follow the care services plan for the resident per facility policy. Licensed nurses and nurse aides will be in-serviced on the ADL support policy with focus on item #2 that appropriate care and services will be rendered for residents who are unable to carry out ADL's independently. DON and/or designee is responsible for compliance. Audits on grooming (bathing, nail care, hair care) will begin 2x week for 4 weeks the monthly to ensure sustained compliance.	2/20/23

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F 677	Continued From page 26 his moustache hanging over his top lip by approximately one inch. He had fingernails approximately 1/4 inch long with black matter underneath. He stated he could not clip them himself because he could not use his right hand due to neuropathy and the nursing assistants did not assist him in cleaning underneath his nails. He stated he did not like the beard and was normally clean shaven at home, but nobody had asked him if he wanted to shave despite mentioning it to several nursing staff. R13's physician orders, dated 12/19/22 included nursing to complete skin audit weekly on bath day, scheduled every Monday evening, and offer to trim nails and document starting 12/19/22. R13's Behavior Symptoms Task 30 day look back report dated from 12/14/23 through 1/12/23, indicated he did not refuse cares in the past 30 days. During interview on 1/12/23, at 4:19 p.m. licensed practical nurse (LPN)-C stated R13 normally got a bed bath daily. LPN-C stated the aides trimmed fingernails for residents without diabetes, but nurses cut nails for diabetic residents. She stated she noticed R13's fingernails were long one day, but he refused to have them cut and when she reproached the next day he also declined. She stated she was unable to reproach again later because he was sleeping. She stated shaving was normally completed by one of the nursing assistants (NA's), and she did not think R13 generally refused shaving. During interview on 1/12/23, at 4:24 p.m. NA-A stated R13 was usually cooperative and well-liked and did not refuse cares. If a resident did refuse,	F 677	Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 2/20/2023	

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she reproached, and if they still refused, she documented it in the electronic documentation record. She stated she had not shaved any residents at the facility but suggested some of the other aides might do it. She stated the NA's trimmed fingernails for residents who were not diabetic, but she had not clipped R13's nails.

During interview on 1/12/23, at 4:49 p.m. NA-E stated he had spoken with R13, acknowledged the lengthy facial hair and nails, and would address them the following day.

During interview on 1/13/23, at 8:15 a.m. NA-C stated the aides tried to clean the residents' hands with a washcloth, soap, and water, and trimmed residents' nails when she saw the need for it. She stated most resident wanted them trimmed. She stated most of the time one of the other aides did the shaving, and R13 had never refused shaving or nail care.

Resident #48

R48's admission MDS dated 12/17/22, indicated he was mildly cognitively impaired, required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene, totally dependent on one staff for bathing, and required partial/moderate assistance with oral hygiene. R48 was incontinent of bowel and used a urinary catheter. His diagnoses included stroke and seizure disorder, and he had no behaviors or rejection of cares.

R48's care plan dated 12/17/22, indicated R48 had an activities of daily living (ADL) self-care deficit and included interventions of assist of one

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F 677	Continued From page 28 staff with showering, personal hygiene, and oral care. R48's Kardex printed 1/13/23, indicated R48's baths were scheduled for Tuesday evenings and R48 required assist of one staff for personal hygiene and oral care. The Kardex also instructed staff to monitor behaviors, there was no indicated R48 refused cares as a behavior. R48's physician order dated 12/20/22, included R48's bath day was scheduled every Tuesday evening. R48's task documentation indicated he had a bed bath on 12/14/22, and refused a shower on 12/20/22. R48's medical record lacked evidence of any bathing between 12/20/22, and 1/13/23. R48's behavior symptoms task documentation from 12/14/22, and 1/12/22 did not identify there was any rejection of cares. On 1/9/23, at 2:09 p.m. R48 was observed lying in bed with blankets covering his body and wearing a hospital gown. His teeth were yellow in color and had facial hair approximately ¾ inch long was observed above his upper lip and below his lower lip across his jawline. His hair appeared disheveled, greasy, and approximately 4-6 inches long. R48 stated he was bedridden and had not had any showers or baths since his arrival (12/6/22) and would appreciate an opportunity to take a shower. He stated he had not had his hair washed and described it as a "horrible problem" and "disgusting". He stated his hair was way too long and he was way overdue for a haircut, and	F 677		

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he would normally have a haircut by then. He reiterated, it needed shampooing "so badly". He further stated he "obviously" needed a shave and preferred to be clean shaven.

R48 stated he had not been provided a toothbrush or tooth paste since he arrived at the facility. With permission from R48, his drawers, closet, and bathroom were searched for a toothbrush and toothpaste, but none were found. The bathroom contained one emesis basin with two dry razors sitting in it but no other hygiene supplies.

The facility nursing schedule indicated NA-A and NA-B were scheduled on R48's wing on the evening of Tuesday, 1/10/22, R48's scheduled bath day.

During interview on 1/12/23, at 11:15 a.m. NA-B stated she knew which residents needed a bath and what type by reviewing the Kardex in the resident's closet or looking at the assignment sheet at the nurse's desk. She stated the residents' hair can also be washed even if giving a bed bath. She stated the aides were also responsible for shaving residents when requested, trimming fingernails on non-diabetic residents, and helping them brush their teeth. NA-B looked through R48's room and bathroom and verified R48 did not have a toothbrush or toothpaste. She stated she did not know if she forgot to help him brush his teeth, but everyone was supposed to have their teeth brushed in the morning. She stated she did not recall when R48 had a shower, but if he refused, she would chart it at the end of the shift. NA-B was unaware of when R48 had a bath/shower.

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F 677	Continued From page 30 During interview on 1/12/23 at 4:24 p.m. NA-A stated she looked at the Kardex and the assignment book to identify who needed a bath on her shifts and if they refused, they would be offered a shower again prior to the next bath day. She stated she had given R48 a shower in the past, but she did not remember washing his hair, nor helping him brush his teeth. NA-A looked throughout R48's room and bathroom and verified he did not have a toothbrush or toothpaste. R48's hair was observed to be greasy-looking and unkempt. R48 stated he had still not had his hair washed or teeth brushed. NA-A was unaware of when R48 had a bath/shower. During interview on 1/13/23, at 08:15 a.m. NA-C stated there was a shower list at the desk, and if a resident refused any care, she documented it. NA-C stated she had not helped R48 with his teeth, but if a resident refused, she documented that as well. NA-C was unaware of when R48 had a bath/shower. During interview on 1/13/23, at 8:26 a.m. R48 stated he still had not had a shower, and his hair was "so grubby". R48's was observed continued to have facial hair approximately ¾ inch long above his upper lip and below his lower lip across his jawline. His hair appeared disheveled, greasy, and approximately 4-6 inches long and teeth remained yellow and unkept. During interview on 1/13/23, at 10:43 a.m. director of nursing (DON) stated her expectation was residents should be shaved if that was their preference, and one of the NA's usually did that. She stated residents had a scheduled weekly bath day and resident nail care was done when bathed, and bathing and nail care were important	F 677		

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F 677	Continued From page 31 for infection control. Any refusals after re-approach were expected to be documented. The DON was unaware of when R48 had a bath/shower. The facility policy Activities of Daily Living, Supporting (undated) indicated residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed routinely assess skin conditions and implement interventions for 2 of 2 residents (R38 and R48) reviewed for none pressure related skin injuries. In addition, the facility failed to monitor weight gain for fluid overload for 1 of 1 resident (R61) who had heart failure and failed to monitor 1 of 2 residents physical condition after a fall.	F 684	R13 was given a bath and grooming was performed on 1/16/2023. R48 was given a bath and grooming was performed on 1/16/2023. R13 and R48 ADL care plan was reviewed for bathing and grooming preference and was reviewed and updated as needed. All Existing residents who require bathing assistance ADL care plans were reviewed and their grooming preferences were reviewed and updated	2/20/23

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F 684	Continued From page 32 None Pressure Skin: Resident #38 R38's admission Minimum Data Set (MDS) dated 12/22/22, indicated R38 was cognitively intact, and required assist of one staff for bathing, personal hygiene, and dressing. The MDS included diagnoses of cancer, fracture, lung disease, anxiety, and depression, and indicated R38 exhibited no behaviors or rejection of cares. R38's Braden Scale dated 12/15/22, indicated he was at risk for pressure ulcers. R38's medical record lacked evidence of weekly Braden Scale assessments after 12/15/22. R38's orders printed 1/13/22, included an order for a Braden Scale skin assessment every week for four weeks starting 12/15/22, and nursing to complete skin audit weekly on bath day, with R38 scheduled to receive bath/shower every Monday morning starting 12/26/22. R38's care plan dated 12/18/22, indicated R38 had a self-care performance deficit and required staff assistance for bed mobility, showering/bathing and personal hygiene but lacked indication of level of assistance needed. The care plan lacked a skin integrity focus and interventions to protect skin integrity. R38's Weekly Skin Check dated 12/19/22, indicated R38 had a bed bath, his skin was clear and intact, and received no skin and ulcer treatments. R38's medical record lacked evidence of weekly skin checks or resident refusal of skin checks between 12/19/22, and 1/13/23.	F 684	as needed. Future residents who require bathing assistance, the facility will follow the care services plan for the resident per facility policy. Licensed nurses and nurse aides will be in-serviced on the ADL support policy with focus on item #2 that appropriate care and services will be rendered for residents who are unable to carry out ADL's independently. DON and/or designee is responsible for compliance. Audits on grooming (bathing, nail care, hair care) will begin 2x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 2/20/2023 F 684 Non-Pressure Skin R 38 has since been discharged from the facility. R 48 was given a bath; a skin check was performed and skin alterations were documented on 1/14/2023. R 48's bath was recorded on the weekly bath audit. R 48 had a new Braden assessment completed and the R 48 skin care plan was reviewed and updated to include elevated heels. The existing resident weekly bath schedule and Braden assessment was reviewed, and a weekly bath audit was created, and skin care plan updated as needed. Future residents will have a weekly bath audit assessment, Braden and skin care plan initiated.	

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F 684	Continued From page 33 R38's CAA (care area assessment) Triggers Summary dated 12/26/22, indicated R38 was at risk for pressure ulcers. R38's Skin Observation task documentation lacked identification of skin concerns between 12/16/22, and 1/12/23. During interview on 1/9/23, at 1:20 p.m. R38 was observed sitting up in bed and had three open and bleeding areas, approximately ¼ inch in diameter each on his left earlobe. R38 stated he scratched that area when he got anxious, and someone put a cream of some sort on it once. On 1/10/23, at 8:57 a.m. R38 was observed in his room with three partially scabbed areas on his left earlobe. On 1/11/23, at 12:58 p.m. R38 was observed in his room with one scab and two red, slightly open areas on his left earlobe where the previously scabbed area was. During interview on 1/12/23, at 4:11 p.m. licensed practical nurse (LPN)-C stated each resident had a skin assessment at admission and weekly on bath days, and if someone refused their bath or shower, sometimes they would still let the nurses check their skin. She stated refusals were document on the assessment form in the electronic documentation record. LPN-C stated R38 was scheduled for a weekly bath and skin assessment on Monday evenings, but only had one on 12/19/22. She stated she was not aware of any abrasions or open areas on his left ear. During interview on 1/12/23 at 4:24 p.m. nursing	F 684	Licensed nurses and nurse aides will be in-serviced on Pressure Injury Risk Assessment Policy in its entirety and specifically focus on frequency of risk assessment and documentation related to resident refusals. DON and/or designee is responsible for compliance. Audits on weekly bathing audits will begin 2x week for 4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Weights R 61 has since been discharged from the facility. Existing resident who has daily weights with physician ordered parameters were reviewed and the physician was notified/updated per order. Future residents who have physician order daily and weekly weights, the licensed nurse will follow the facility weight policy for notification. Licensed nurses will be in-serviced on the Medication Treatment Orders with focus on item 9f, that any medication monitoring will follow physician orders and on the Nutrition Weight Clinical Protocol that all significant weight losses or gains , the physician will be notified. DON and/or designee is responsible for compliance. Audits on following physician order parameters audits will begin 2x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the	

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F 684	Continued From page 34 assistant (NA)-A stated she looked at the Kardex and the assignment book to identify who needed a bath on her shifts. She stated R38 did not refuse baths or showers, and nurses checked residents' skin during showers. During interview on 1/13/23, at 8:33 a.m. registered nurse (RN)-B stated a head-to-toe skin assessment was completed by the nurse upon admission and weekly on shower days. He stated the NAs sometimes called nurses to assess skin during showers, but they were "hit and miss", and the skin assessment needed to be completed regardless. He stated if a resident refused a skin assessment, staff reapproached or had another nurse try, but it needed to get done to make sure potential problems that could lead to unhealthy outcomes were caught. RN-B stated he was not sure why R38 had an order for skin cream, but thought it was for overall dry skin. He stated he was not aware of any skin issues for R38 and had not seen any open areas on his left earlobe. During interview on 1/13/23, at 9:55 a.m. RN-D stated if she noticed a skin concern, she would measure it, call the provider, write a progress note, and update the family. She helped R38 regularly but did not notice any skin concerns on his left earlobe. On 1/13/23, at 10:17 a.m. RN-B observed and verified R48's previously identified open areas on his left earlobe, with one additional area of approximately 0.5 cm on the side of R48's face. Two reddish brown blood-like spots were noted on R48's pillowcase, one approximately 2cm by 3cm, and another approximately 1cm by 4cm. R38 confirmed the spots were from the sores on	F 684	Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Monitoring R 112 has since been discharged from the facility. All resident falls from survey exit until present were reviewed and a root cause was identified and recorded in the risk management incident, care plan updated as needed and interventions implemented. Future residents who fall will be monitored per facility policy. Licensed nurses will be in-serviced on the Falls and their Causes Policy with emphasis on item #5 that residents will be monitored for 48 hrs. (vital, neuro check, post fall injuries, delayed complications) and the physician will be notified. A root cause will be attempted within 24hrs post incident. DON and/or designee is responsible for compliance. Audits on fall monitoring 48 hours post documentation, root cause and immediate fall intervention will begin 2x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 2/20/2023	

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F 684	Continued From page 35 his ear and face. Resident #48 R48's admission MDS dated 12/17/22, indicated he was mildly cognitively impaired, required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene, and totally dependent on one staff for bathing. R48 was incontinent of bowel and used a urinary catheter. His diagnoses included cirrhosis (a degenerative disease of the liver resulting in scarring and liver failure), history of urinary tract infections, stroke, and had no behaviors or rejection of cares. R48's Braden Scale dated 12/6/22, indicated he was at risk for pressure ulcers. R48's Nursing Admission/Readmission dated 12/6/22, indicated he had a 3 centimeter (cm) by 3 cm pressure ulcer on his left heel, and identified a skin assessment was unsuccessful due to resident refusal to cooperate having tried multiple times and may try again later. However, a quarter-sized pressure ulcer was noted in his left knee. R48's care plan dated 12/7/22, included R48 had a stage II pressure ulcer to the left heel and potential for pressure ulcer development related to immobility and included administer treatments as ordered, turn, and reposition at least every two hours and as needed, and foam boots to bilateral feet. R48's Weekly Skin Check dated 12/9/22, indicated he had redness on his coccyx.	F 684		

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R48's Pressure Ulcer/Injury CAA Worksheet dated 12/22/22, indicated he had a stage 2 pressure ulcer and was at risk for pressure ulcers.

R48's orders included nursing to complete skin audit weekly on bath day, every Tuesday evening starting 12/20/22.

R48's medical record lacked evidence of weekly skin assessments, or refusal of skin assessments, between 12/9/22, and 1/13/23.

R48's Kardex printed 1/13/22, directed staff to monitor behavior symptoms including rejection of cares.

R48's behavior symptoms between from 12/14/22, and 1/12/23 lacked evidence there were any rejection of cares.

On 1/9/23, at 2:09 p.m. R48 was observed lying supine in bed with blankets covering his body. He stated he was "bedridden" and had a sore on his heel and one on his knee.

During interview on 1/11/22, at 3:27 p.m. RN-C stated the wound care team did not complete a head-to-toe skin assessment on R48's skin, however they were monitoring and treating multiple skin concerns.

During interview on 1/12/23, at 11:15 a.m. NA-B stated when she gave a shower or bath to a resident, she called the nurse in to check the resident's skin.

During interview on 1/13/23, at 08:15 a.m. NA-C stated there was a shower list at the desk, and

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the nurses came to the shower area to assess the residents' skin, but most of the time it was hard to find someone. She stated if a resident refused any care, she documented it.

During interview on 1/13/23, at 10:03 a.m. RN-A stated residents skin assessments were completed weekly on bath days and were documented when completed or if refused. She stated it was important to assess to make sure residents had no pressure ulcers, open areas, or other skin issues because if they weren't identified they could go from a stage one to stage 2, 3, or 4 rather quickly. RN-A reviewed R38's and R48's medical records and confirmed both only had one skin assessment since admission and stated there should have been more. She stated she was not aware of any skin concerns on R38's left ear, however R48 had numerous skin concerns identified and was being monitored by a wound care team.

During interview on 1/13/23, at 10:43 a.m. director of nursing (DON) stated she expected skin assessments to be completed on shower day as outlined on the bath schedule at the nurse's station, even if the resident refused a shower. If still unable after reapproaching, the nurses should be documenting the refusal. She stated residents can change over time and the assessments were required to ensure any wound, pressure ulcers, rashes, and dry skin were identified so they could be treated prior to becoming a larger concern.

The facility policy Pressure Ulcer/Skin Breakdown - Clinical Protocol dated 7/12/22, indicated the staff and practitioner will examine the skin of newly admitted residents for evidence of existing

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pressure ulcers or other skin conditions. The policy lacked directive for continual periodic (weekly) monitoring of skin to identify potential areas of concern.

Weights

R61's admission Minimum Data Set (MDS) dated 11/16/22, included diagnoses of congestive heart failure (the heart muscle doesn't pump blood as well as it should. When this happens, blood often backs up and fluid can build up in the lungs, causing shortness of breath.), chronic obstructive pulmonary disease with (acute) exacerbation (a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, mucus (sputum) production and wheezing), acute and chronic respiratory failure with hypoxia (the lungs cannot release enough oxygen into your blood, which prevents your organs from properly functioning. It also occurs if your lungs cannot remove carbon dioxide from your blood.), and presence of automatic (implantable) cardiac defibrillator. It further included R61 had intact cognition, required extensive assistance with walking in her room and corridor, and required supervision with locomotion on/off unit. R61 was also on oxygen.

R61's physician's orders dated 11/12/22 included: "Weight every day before breakfast. Notify Twin Cities Physicians (TCP) if 2 pounds (lbs) weight gain in 24 hours or 5 lb weight gain in one week, in the morning related to UNSPECIFIED SYSTOLIC (CONGESTIVE) HEART FAILURE."

R61's weights included:
-11/16/2022, 09:08 327.8 Lbs

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F 684	Continued From page 39 -11/16/2022 08:56 321.6 Lbs -11/14/2022 15:51 322.9 Lbs -11/12/2022 12:54 316.9 Lbs -11/11/2022 10:21 315.6 Lbs R61's care plan initiated 11/14/22, included resident was at risk for impaired nutritional status due to congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), acute on chronic kidney disease (a condition characterized by a gradual loss of kidney function), hypertension (high pressure in the arteries (vessels that carry blood from the heart to the rest of the body), history of angina (chest discomfort or shortness of breath caused when heart muscles receive insufficient oxygen-rich blood), cardiac pacemaker with an intervention to monitor weight as ordered. R61's progress note dated 11/14/22, included "Resident reports she has an heart failure and she gain her weight a lot". R61's progress note dated 11/16/22, included "Resident came to nursing station crying stating that she can't breath. Resident had oxygen (O2) on at 2 Liters (L) with O2 saturations (sats) at 95%. She is short of breath (SOB) and having difficulty speaking. She is continuing to the front door. Writer called 911 related to SOB and weight gain of 12 lbs in 5 days. When writer went out in the front of the building to offer resident her inhaler, resident was smoking a cigarette. O2 was off her face but still on the tank. Writer took O2 tank into the building. Ambulance arrived and resident went to North Memorial hospital." R61's medical record lacked any documentation the physician had been notified of her weight	F 684		

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F 684	Continued From page 40 gain. During an interview on 1/13/23, at 9:50 a.m. Registered Nurse (RN)-A stated nurses were responsible for notifying the physician of a weight gain when the resident has an order to do so. RN-A further stated the nurses responsible for caring for R61 each shift should be checking (her weight) everyday and calling the physician if her weight was not within the parameters of the order. RN-A also stated the nurse could let her know and she would also be able to call the physician. RN-A verified the physician had not been notified of R61's weight gain and stated "I can't believe I didn't write a note, I usually update the (medical doctor) MD. Let me look on the portal (website where the facility and provider can communicate)." PA-A was sitting next to us at the nursing station and RN-A asked her if there was a way to look up messages for a discharged resident in the portal. PA-A looked up R61 in the portal and verified she hadn't been notified of R61's weight gain. During an interview on 1/13/22, at 2:01 p.m. The Director of Nursing (DON) stated nurses are responsible for notifying the physician regarding a residents weight gain when they have an order to do so. The DON further stated the nurses should have notified R61's physician of her weight gain. Monitoring: R112's quarterly Minimum Data Set (MDS) dated 10/21/22, included diagnoses of osteoporosis (a condition in which bones become weak and brittle), repeated falls, wedge compression fracture of unspecified thoracic vertebra, and initial encounter for closed fracture. It further	F 684		

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F 684	Continued From page 41 included R112 was cognitively intact and independent with all activities of daily living (ADL). There was no history of falls. R112's fall incident report dated 12/8/22, indicated R112 had an unwitnessed fall in his room while attempting to transfer into his wheelchair. R112's progress noted dated 12/8/2022, included "At 1600-hour[s], staff alerted writer that resident was on the floor in his room. Resident noted lying on his right side. According to the resident, he was trying to sit in his wheelchair and the chair rode away from him landing him on his bottom. No injury noted, resident was able to move his upper and lower extremities. Vitals obtained and recorded. Message left for Nurse Practioner (NP), family informed, and director of nursing (DON" updated.") R12's medical record lacked any documentation he had been monitored or reassessed following a fall which occurred on 12/8/22, and when he was sent to the hospital on 12/11/22 for an oxygen saturation of 72% and complaints of shortness of breath (SOB) while at the hospital was diagnosed with new onset rib fractures. During an interview on 1/12/23, at 3:02 p.m. Licensed Practical Nurse (LPN)-A stated after a resident falls, the nurse should assess the resident for injuries, take vital signs (VS), complete a neurological exam, try to determine the cause, and look at the environment. LPN-A further stated there was a protocol for checking a residents neurological status which involved checking them every 15 minutes for 1 hour, then every 30 minutes for 1 hour, and finally, every	F 684		

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F 684	Continued From page 42 hour for 4 hours. LPN-A stated when the nurses are completing their neurological assessment they should also be reassessing the resident for injuries and pain and all assessments should be documented. During an interview on 1/13/23, at 9:14 a.m. Registered Nurse (RN)-D stated after a resident falls, the nurse should assess the resident for injuries, pain, ask how it happened, and complete a "neuro check." RN-D further stated there was a protocol for checking a resident's neuro's. LPN-D was unsure of the frequency of the checks but she stated there was a form they fill out with that information. RN-D stated nurses should always re-assess the resident after they fall which included not only checking their neurological status but also pain, injuries, mobility, and vital signs.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess falls, identify causal factors, and implement interventions to decrease the risk of additional falls for 1 of 2 residents (R1) reviewed for falls.	F 689	R 1 risk management incident was thoroughly reviewed, and a root cause was recorded in the risk management incident. R1's had a new fall incident completed and R1's care plan was reviewed and updated as needed. All	2/20/23

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F 689	Continued From page 43 Findings include: R1's significant change Minimum Data Set (MDS) dated 12/19/22, indicated he was moderately cognitively impaired, required extensive two person assist for bed mobility, transfers, dressing, toilet use, and included diagnoses of fracture and malnutrition. R1's Resident Fall Risk dated 9/8/22, indicated R1 was at moderate risk for falls. A progress note dated 11/12/22, indicated the smoking aide reported to nurse R1 was unable to move at all. R1 told nurse he fell two days earlier and could not remember how. He stated he had not reported it previously but was having pain in both hips. Provider was contacted who ordered x-rays. A progress note dated 11/12/22, indicated R1 was sent to the hospital and admitted for a right broken hip. R1's Fall Incident/Accident Root Cause Analysis dated 11/12/22, included action taken to prevent further incidents of this kind as "Evaluate for pain" and current intervention of "Call light in use". The root cause analysis was identified as "resident not able to explain how the fall happened." R1's care plan initiated on 11/12/22, included R1 had an actual fall with serious injury due to poor balance, psychoactive drug use, and unsteady gait, and included interventions of continue previous interventions, monitor resident for 72 hours, pharmacy consult to evaluate medicates, PT consult for strength and mobility, and provide	F 689	resident falls from survey exit until present were reviewed and a root cause was identified and recorded in the risk management incident, care plan updated as needed and interventions implemented. Future residents who are admitted to the facility will have a fall assessment completed and interventions will be implemented upon admission. In addition, residents who fall will have a root because identified per policy. Licensed nurses will be in-serviced on the Falls and their Causes Policy with emphasis on identifying possible causes to the resident fall and from the root cause implemented immediate interventions to decrease residents falls. DON and/or designee is responsible for compliance. Audits on falls, identifying risk, root cause and immediate interventions will begin 1x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 2/20/2023	

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F 689	Continued From page 44 activities that promote exercise and strength building. A progress note dated 11/18/22, indicated R1 returned to the facility after treatment of right hip fracture. R1's Resident Fall Risk dated 11/29/22, indicated R1 was at moderate risk for falls. A progress note dated 12/2/22, 10:15 pm indicated R1 fell with no bleeding or injury noted. Resident was taken to bed and had an oxygen saturation (O2 sat) of 60% on room air (RA) with the O2 sat monitor on his right middle toe. The note identified he appeared unconscious and was placed on 2 liters of oxygen which brought O2 sat to 65% and 911 was called. R1 was sent to the hospital via ambulance at 8:35 pm. and the DON and provider were notified. Review of R1's progress notes, vital signs EMR (electronic medical record) dated 12/2/22,) lacked any information about the time of the fall, location, position R1 was found in or post-fall vital signs and monitoring from the fall to the arrival of emergency medical services. A progress note dated 12/5/22, indicated R1 returned to the facility at 1:15 p.m. with no noted skin breaks or injury, and a post surgical incision on the right hip from un-witnessed fall on 11/16/22. A progress note dated 12/20/22, indicated R1 had an unwitnessed fall with no injuries and provider was notified. There was no assessment to determine what occurred, where they were found, or a root cause analysis to determine what	F 689		

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F 689	Continued From page 45	F 689		

interventions could be implemented to decease R1's risk of falling. Also, there was no indication of post-fall vital signs or any monitoring after the fall.

R1's Resident Fall Risk dated 12/22/22, indicated R1 was at high risk for falls.

R1's care plan lacked additional interventions after the falls on 12/2/22, and 12/20/22.

R1's medical record lacked a root cause analysis for falls dated 12/2/22, and 12/20/22.

During observation and interview on 1/9/23, at 2:55 p.m. R1 stated he broke his hip recently after a fall. R1 observed in bed and the bed was not in low position and there was not a mat on the floor.

During interview on 1/12/23, at 11:15 a.m. nursing assistant (NA)-B stated she knew who was at risk for falls because the care plan told staff to watch them, or the resident would have their bed in low position or a mattress on the floor next to the bed. She stated R1 was at risk for falling. She stated staff watched him and assisted him to bed if requested to help avoid a fall.

During interview on 1/12/23, at 12:51 p.m. NA-D stated if a resident was at risk for falls there would be a mat on the floor, and it would be in the care plan, on the Kardex, and in the resident's closet in their room.

During interview on 1/12/23, at 12:54 p.m. trained medication aide (TMA)-A stated a resident was at risk for falls if they were always in bed rolling toward the edge, attempting to stand up when

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F 689	Continued From page 46 they were unstable, or sometimes the nurses let her know. She stated she thought maybe R1 fractured his hip trying to self-transfer, but she was not sure. She stated she did not know if he had fallen again since then and did not know if there were additional interventions. During interview on 1/12/23, at 4:02 p.m. licensed practical nurse (LPN)-C stated when a resident fell, she informed the family, provider, and DON, wrote a progress note, completed an assessment, and obtained resident vital signs. She stated if the fall was unwitnessed, she tried to determine what happened and filled out a form which instructed staff to monitor the resident by completing vital signs and neurological status checks every 15 minutes for one hour, and additional checks as outlined on the form. She stated the completed form was either placed in the paper chart or uploaded into the electronic documentation system. She stated she also completed a post-fall note, a risk management electronic form, and a new falls risk assessment. She stated she did not add interventions to resident care plans, and only the MDS nurse did that. LPN-C stated R1 had a fall in November, but staff did not know about it until two days later when R1 told them he had hip pain. R1 was sent to the hospital, diagnosed with a hip fracture, had surgery, and returned to the facility. She stated R1 had another fall in early December. She stated R1 and some other residents were in the dining room and another resident was heard calling out for staff. Staff returned and found R1 on the floor. He was taken to his room where they completed vital signs and he subsequently became unconscious. She stated another nurse ran in and he was placed on oxygen, an ambulance was called, and he was taken to the	F 689		

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F 689	Continued From page 47	F 689		

hospital. She was unable to locate documentation of neurological status for R1's unwitnessed falls.

During interview on 1/12/23, at 1:10 p.m. registered nurse (RN)-A stated all residents had a falls risk assessment completed upon admission, quarterly, and after each fall. She stated the nurse on duty at the time of the fall completed the falls assessment which gave the resident a score, in addition to a post fall assessment and a root cause analysis for every fall. She stated any new falls interventions would depend on the circumstances around the fall. She stated all nurses can add interventions and it was the MDS nurse's job to update the care plan. RN-A confirmed there was no post fall assessment, root cause analysis, or interventions added to the care plan after either of the falls on 12/2/22, and 12/21/22. She confirmed R1 was at high risk for falls and stated she would "definitely" have added interventions. She stated resident falls were discussed in meetings every morning and falls risk was communicated to staff, including nursing assistants, during report and through the paper Kardex in the resident rooms. Upon review of the Kardex in R1's room, RN-A confirmed it was dated 6/18/2022 and was for a different resident, not R1.

During interview on 1/13/23, at 8:33 a.m. RN-B stated he reviewed resident falls risk assessments and residents who were at risk wore a wrist band for identification. He stated if a resident fell, he found out what led to the fall and added interventions appropriate to the situation.

During interview on 1/13/22, at 10:43 a.m. director of nursing (DON) stated staff were made aware of resident fall risk through verbal report,

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F 689	Continued From page 48 the care plan, and the Kardex. DON stated if a resident fell, she expected staff to notify DON, family, and provider, complete a risk management report, write a progress note, and complete a falls assessment with each fall. She stated for any unwitnessed fall staff were expected to complete neurological checks and vital signs every 15 minutes for the first hour, every 30 minutes for the second hour, and as directed on the neuro check form, and one set of vital signs was not enough. Once completed the form was placed in the paper chart. She stated she expected a new fall risk assessment and a root cause analysis to be completed for each fall to identify the circumstances and determine appropriate interventions, and any interventions should be added to the care plan and the Kardex. She stated she heard R1 had a fall with a fracture and confirmed additional interventions should have been added to the care plan after the falls on 12/2/22, and 12/20/22 to help try to prevent further falls. The facility policy Falls and Fall Risk, Managing dated 12/27/22, indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. If falling occurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. The policy lacked instruction regarding post-fall assessment of residents after unwitnessed falls.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		2/20/23

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F 695	Continued From page 49 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure respiratory care and services consistent with professional standards of practice were provided to 1 of 1 resident (R25) reviewed for oxygen use. Findings include: R25's quarterly Minimum Data Set (MDS) dated 12/30/22, identified R25 had a diagnosis of chronic obstructive pulmonary disease (COPD) (irreversible damage to the lungs that block airflow and make it difficult to breathe), cocaine abuse, respiratory failure, and hospitalization for congestive heart failure (CHF) 9/19/22. In addition, the MDS indicated R25 was receiving oxygen therapy and had moderate cognitive impairment. R25's care plan with start date of 8/5/22, stated "The resdent has oxygen therapy r/t CHF O2 per NC at 3L continuous" and directed staff of "OXYGEN SETTINGS: O2 via nasal prongs @ 3L continuously". R25's physician orders dated 11/3/22, direct staff to change oxygen tubing every week and date the tubing.	F 695	R 25 received new oxygen tubing on 1/18/2023. R 25's oxygen order and care plan were reviewed and updated as needed. All other residents who receive oxygen therapy oxygen tubing was checked and replaced as needed and their orders and care plans were reviewed and updated as needed. Future residents will have oxygen tubing changed weekly per facility policy. Licensed nurses were in-serviced on the Department of Therapy policy and procedure with emphasis on item #7 in the procedure steps that oxygen tubing and cannulas will be changed every 7 days and as needed. DON and/or designee is responsible for compliance. Audits on oxygen tubing change dates will begin 1x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 2/20/2023	

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F 695	Continued From page 50 Observation on 1/9/23 at 3:33 p.m. indicated oxygen humidifier unit attached to large oxygen tank had a label with a date of 12/28/22, and tubing from tank to resident was not dated or labeled. During observation and interview on 1/13/23 at 9:36 a.m. registered nurse (RN)-A stated the oxygen tubing leading to the resident had a label on it which was unable to be read. RN-A stated the humidifier unit had no label with date on it and was unable to determine if and when the tubing was labeled. RN-A stated that it is important to know when the tubing was changed to reduce or eliminate infection especially in R25 with a history of respiratory failure. When interviewed on 1/13/23 at 2:28 p.m., the director of nursing (DON) stated clinical staff were expected to get new oxygen tubing weekly and should be labeling it and the humidifiers also. Facility policy titled Oxygen Administration reviewed 8/4/21 did not address labeling or dating oxygen tubing or humidifier.	F 695		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced	F 699		2/20/23

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F 699	Continued From page 51 by: Based on observation, interview and document review, the facility failed to develop a comprehensive person-centered care plan goals and interventions to include monitoring of PTSD (post traumatic stress disorder) for 1 of 1 resident (R53) who was reviewed for trauma-informed care. Findings include: R53's admission Minimum Data Set (MDS) dated, 12/30/22, indicated R53 had a diagnosis of depression and PTSD. Further review of the MDS revealed R53 had intact cognitive function. R53's care plan dated 1/13/23, failed to identify PTSD and individualized triggers and measurable objectives, interventions, and timeframes for how staff are expected to meet R53's desired goals and outcomes concerning his PTSD. During interview on 1/9/23, at 5:09 p.m. R53 stated his triggers for PTSD was loud noises and people being "real loud" causing him to feel anxious and wanting to walk away and leave the immediate area. During interview with registered nurse (RN)-B on 1/13/23 at 8:24 a.m., RN-B stated R53's care plan did not identify a diagnosis of PTSD and what R53's triggers were and that "we can't take care of his trauma if we do not know what it is." During interview with RN-A on 1/13/23 at 8:33 a.m., RN-A stated a diagnosis of PTSD should have a care plan to explain how to approach and care for R53. RN-A stated there was nothing in R53's care plan to identify or address his PTSD.	F 699	R 53 has since discharged from the facility. Existing resident will be reviewed for trauma related incidents, an assessment completed, and a care plan will be initiated to address the identified trauma incident. Future residents will continue to be screened for Trauma and a care plan will be developed per facility policy. The facility social services designee will be in-serviced on the Trauma Informed Culturally Competent Care policy and procedure with emphasis on initiating a care plan to address resident trauma and implementing appropriate interventions. Social Services and/or designee is responsible for compliance. Audits on trauma screening upon admission, care plan initiation and developing interventions will begin 1x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 2/20/2023	

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F 699	Continued From page 52 Review of Primary Care PTSD Screen dated 12/23/22, by social worker (SW)-A assessed R53 as: a. having nightmares or thought of the trauma; b. constantly on guard, watchful, or easily startled; c. trying hard to not think of the trauma or attempt to go out of my way to avoid situations that remind him of it. Interview with social worker, (SW)-A on 1/13/23 at 9:52 a.m., confirmed R53 was admitted to facility on 12/23/22 with a diagnosis of PTSD. SW-A stated she screened R53 upon admission but did not put anything into R53's care plan about her screening results including triggers and suggested approaches by staff. SW-A stated R53's care plan pertaining to R53's measurable objectives and timeframes to meet his medical, nursing, mental, and psychosocial needs including trauma-informed care was not completed as of 1/13/23 despite the fact that R53 discharged on that date. SW-A stated R53's care plan should inform the clinicians what to do. SW-A stated, "my part is not done." Interview with physician assistant (PA)-A on 1/13/23 at 10:16 a.m., confirmed R53's care plan lacked diagnosis, goals and interventions to address R53's PTSD. PA-A stated the facilities' lack of addressing this can "affect his mental and emotional state." Interview with director of nursing (DON) on 1/11/23 at 1:15 p.m., stated the expectation of clinical staff to was to follow the care plan and interventions.	F 699		

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F 699	Continued From page 53 Review of facility policy titled, Trauma-Informed and Culturally Competent Care reviewed 10/18/22, indicated the facility's responsibility to develop individualized care plans that address past trauma and to identify and decrease exposure to triggers that may re-traumatize the resident.	F 699		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure grab bars were assessed to determine safety for 4 of 4 residents (R9, R10, R13, and R24) who were observed to	F 700	R 9 was assessed for grab bars on 1/27/2023. Bed rail consent was obtained, uploaded into the resident chart and the resident bed mobility care plan was	2/20/23

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F 700	Continued From page 54 have grab bars/side rails affixed to their beds. Findings include: R9's quarterly Minimum Data Set (MDS) dated 10/28/22, identified R9 had moderately impaired cognition and required extensive assistance with bed mobility and transfers. R9's diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (disrupted blood flow to the brain) affecting right dominant side. R9's care plan included a goal revised on 12/18/22, "[R9] will demonstrate the appropriate use of grab bar to increase ability through the next review date." Additionally, the care plan included a corresponding intervention dated 9/18/21, "BED MOBILITY: [R9] is able to: perform bed mobility with the assistance of 1 staff and grab bars." During observation on 1/9/23, at 4:34 p.m. R9 had grab bars affixed to the right and left sides of the bed. R9's medical record lacked evidence an assessment had been completed to determine the necessity and safety for the use of the affixed grab bars to the bed. There was no indication the resident was educated on potential risk of having a grab bar on her bed. R10's significant change MDS dated 12/15/22, identified R10 had moderately impaired cognition, extensive assistance with bed mobility, and supervision with transfers. R10's diagnoses	F 700	reviewed and updated as needed. R 10 was assessed for grab bars on 1/27/2023 Bed rail consent was obtained, uploaded into the resident chart and the resident bed mobility care plan was reviewed and updated as needed. R 13 was assessed for grab bars on 1/27/2023 Bed rail consent was obtained, uploaded into the resident chart and the resident bed mobility care plan was reviewed and updated as needed. R 24 was assessed for grab bars on 1/272023 Bed rail consent was obtained, uploaded into the resident chart and the resident bed mobility care plan was reviewed and updated as needed. All other existing residents were reviewed for bed rail consent, bed rail alternatives that were attempted, assessment and bed mobility care plans were reviewed and updated. Future residents will be screened upon admission, consent obtained, and care plan created and implemented. Licensed Nursing, Maintenance and Social Service Designee was in-serviced on the bed safety policy with emphasis on item #8 residents must be informed of bed rail complications and consent must be obtained prior to grab bars/side rails or bed rails are installed to a resident bed. DON and/or designee is responsible for compliance. Audits on bed rail education, consent and care plan intervention will begin 2x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will	

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F 700	Continued From page 55 included Alzheimer's disease (brain disease which affects memory, thinking, and behavior) and muscle weakness. R10's care plan lacked any information regarding the use of grab bars on the bed. During observation on 1/9/23, at 4:43 p.m. R10 had grab bars were affixed to the right and left sides of the bed. R10's medical record lacked evidence an assessment had been completed to determine the necessity and safety of grab bars affixed to her bed. R10's medical record lacked evidence the resident was educated on potential risk of having a grab bar on her bed. R13's admission minimum data set (MDS) dated 12/8/22, indicated he was cognitively intact, was totally dependent on two staff for bed mobility, transfers, grooming, and toilet use. R13's Medical Diagnoses as of 1/13/23, included diagnoses of lung disease, depression, bipolar (mental health condition which causes extreme mood swings) , and anxiety. R13's care plan lacked any information regarding the use of side rails on the bed. During observation and interview on 1/9/23, at 1:37 p.m. R13 was observed lying in bed with his head up at a 35-40 degree angle with half siderails attached to bed bilaterally. Padding was covering the inner sides of the rails toward the mattress. R13 stated he did not use them, but they were "nice to hang things on".	F 700	take the audit results to QAPI for review and recommendation. Compliance: 2/20/2023	

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F 700	Continued From page 56 R13's medical record lacked evidence an assessment had been completed to determine the necessity and safety of side rails affixed to his bed. R13's medical record lacked evidence the resident was educated on potential risk of having a grab bar on her bed. R24's quarterly MDS dated 12/22/22, identified R24 had intact cognition, extensive assistance with bed mobility and total dependance for transfers. R24's diagnoses included morbid obesity and muscle weakness. R24's care plan lacked any information regarding the use of side rails on the bed. During observation on 1/12/23, at 3:37 p.m. R24 had half siderails attached to the right and left side of the bed. Padding was covering the inner sides of the rails toward the mattress. R24's medical record lacked evidence an assessment had been completed to determine the necessity and safety of side rails affixed to his bed. R24's medical record lacked evidence the resident was educated on potential risk of having a grab bar on her bed. During an interview on 1/11/23, at 12:42 p.m. licensed practical nurse (LPN)-C identified the physical therapists are responsible for ensuring grab bars and side rails are assessed to determine if they were safe using the device. During an interview on 1/11/23, at 1:22 p.m. registered nurse (RN)-A stated an assessment was completed prior to grab bars or side rails being placed on a resident's bed but did not know if the devices/equipment needed to be	F 700		

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F 700	Continued From page 57	F 700		

reassessed on any specific schedule or if they were reassessed if the resident had a change in physical or mental condition to ensure they were safe to use the device/equipment.

During an interview on 1/11/23, at 3:32 p.m. LPN-D stated the assessment for grab bars or side rails would be completed by physical or occupational therapy. LPN-D added grab bars or side rails would need to be periodically re-assessed to ensure they are still helpful and are still safe for the resident.

During an interview on 1/12/23, at 8:25 a.m. RN-D stated the admitting nurse should complete the assessment to determine if grab bars or side rails would be helpful for the resident. RN-D added all residents should have a grab bar assessment completed upon admission but did not know if the bars needed to be reassessed on any specific schedule or if the resident experienced a change in physical or mental condition.

During an interview on 1/12/23, at 9:39 a.m. physical therapist (PT)-A stated he was not a part of assessing the need or safety for the use of the resident grab bar or side rails. PT-A added, an assessment of the resident should be completed prior to affixing anything to the bed to ensure safety. PT-A expressed concern about entrapment risk when using side rails. "There is no way it could be safe." PT-A also stated grab bars need to be reassessed after a resident experiences any change in mobility, cognition, or strength decline to determine continued appropriate and safety.

During an interview on 1/12/23, at 10:14 a.m. the

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F 700	Continued From page 58 director of nursing (DON) stated some of the beds arrive at the facility with grab bars already attached. The DON said she was unsure if therapy or nursing completed an assessment to determine need or safety for a resident's use of grab bars. DON added while there is risk of entrapment with side rails but grab bars do not pose any safety risk and do not need to be assessed prior to use. The facility policy, "Bed Safety and Bed Rails" (2021) included, "For the purpose of this policy "bed rails" include: 1. Side rails; b. safety rails; and c. grab/assist bars." The policy also included, "The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent." The policy further instructed, "If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: 1. An evaluation of alternatives to bed rails that were attempted and how these alternatives failed to meet the residents needs; b. the resident's risk associated with the use of bed rails; c. input from the resident and/or representative; and d. consultation with the attending physician."	F 700		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality	F 770		2/20/23

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F 770	Continued From page 59 and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide laboratory services for urinalysis and urine culture in a timely manner to meet the needs of 1 of 1 resident (R9) reviewed painful urination. Findings include: R9's quarterly Minimum Data Set (MDS) dated 10/28/22, identified R9 had moderately impaired cognition, was frequently incontinent of bladder, and required extensive assistance for toilet use. R9's physician order dated 12/29/22 instructed to monitor resident for increased urinary pain every shift and if resident has concerns of pain obtain a urinalysis and urine culture. R9's physician order dated 1/6/23 instructed to collect urinalysis and urine culture. R9's treatment administration record (TAR) 1/6/23 identified licensed practical nurse (LPN)-C documented the UA/UC (urinalysis/urine culture) order completion as "other/see nurses notes." R9's medical record lacked additional documentation to clarify the recorded response. During an interview on 1/9/23, at 6:32 p.m. R9 stated, last week she told the doctor it hurts when she urinates. R9 stated she had since informed her nurses that it still hurts during and after	F 770	R 9□s laboratory results were received, and the MD notified on 1/12/2023. All other residents with pending laboratory orders were reviewed to ensure results were obtained and documented MD notification. Future residents who have physician orders for laboratory testing will be implemented upon MD order receipt. Licensed nurses will be in-serviced on the Lab and Diagnostic Test result policy and procedure that all laboratory requests must be processed when ordered and MD notification per MD preference. Director of Nursing and/or designee is responsible for compliance. Audits on MD laboratory orders, nurse processing orders timely and physician notification of lab results will begin 1x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 2/20/2023	

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F 770	Continued From page 60 urination. During observation on 1/11/23, at 12:38 p.m. R9 was tearful in the hallway as she told LPN-C she was still experiencing pain and was struggling to urinate. R9 stated, "It hurts so bad I don't know what to do." LPN-C gave R9 a glass of water and encouraged her to increase her fluid intake. During observation on 1/11/23, at 12:41 p.m. R9 remained tearful in the hallway. R9 yelled, "It hurts" and "I need some help." LPN-C again, encouraged R9 to drink the glass of water. During an interview on 1/11/23, at 12:44 p.m. LPN-C stated R9 was "having trouble peeing" and the doctor wanted her to drink a lot of water. LPN-C stated she planned to call and updated the doctor and request something to treat R9's pain. During the interview R9, still tearful, reproached LPN-C screamed, "Help me!" and threw the cup of water at the nurse. During an interview on 1/11/23, at 1:03 p.m. LPN-C reviewed R9's TAR noting there was an order for a UA/UC on 1/6/23. LPN-C stated she documented "other/nurses notes" since she was unable to complete the order as R9 was temporarily moved off her room assignment so the treatment should have been done by a different nurse. LPN-C added she forgot to put a nurses note in R9's medical record. LPN-C stated it looked as if the UA/UC had not been completed as order, "Nobody did anything about it." LPN-C stated if a treatment is unable to be completed as ordered the nurse should document in the progress notes and inform the doctor. LPN-A stated R9's medical record did not indicate the doctor had been updated the UA/UC had not	F 770		

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F 770	Continued From page 61 been completed as ordered. During a follow-up interview on 1/11/23, at 1:26 p.m. R9 rated her pain was a 7 out of 10. R9 stated that she felt her pain was getting worse and that the nurses are not listening to her. R9 added, "It's like they don't care." During an interview on 1/11/23, at 1:37 p.m. registered nurse (RN)-A stated a treatment order, such as a UA/UC order, should be completed the day the order is received. If the nurse is unable to complete the treatment as ordered there should be a progress note entered in the resident's medical record and the doctor should be updated. RN-A added, not completing treatment orders for a UA/UC timely could cause the resident to get very sick, have increased pain, and possible need to go to the hospital. During an interview on 1/13/23, at 9:30 a.m. physician assistant (PA)-A stated R9 told her about 1 week ago she was experiencing burning pain with urination. On 1/6/23 she wrote an order for a UA/UC to be completed. On 1/11/23 she received a request for orders to complete a UA/UC due to continued pain. At that time, she was informed the first UA/UC had not been completed. PA-A stated she expected treatments be completed within 24 hours of being ordered. If a nurse is unable to complete the treatment as order the medical provider needs to be updated. During an interview on 1/13/23, at 11:19 a.m. the director of nursing (DON) stated treatment orders should be acted on immediately when received. If a treatment is not able to be completed as ordered the DON stated she would expect the nurse to enter a progress note in the resident's	F 770		

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F 770	Continued From page 62 medical record and pass the information to the next shift's nurse for additional follow up. A facility policy regarding laboratory services was requested but not provided.	F 770		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to store and label food to prevent potentially degraded food from being served to residents. This had the potential to affect all 54 residents as all residents received food from the kitchen. Findings included:	F 812	All food items identified during survey have since been destroyed. Items destroyed will be re-ordered and stored per facility policy. No residents were affected by this deficient practice. The dietary department will be in-serviced on the Food Storage policy that explains all items that are left over must be stored in covered containers, dated, and	2/20/23

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F 812	Continued From page 63 On 1/9/23 at 11:58 a.m., an initial kitchen tour was conducated with Cook (C)-A. Dietary Manager, (DM) was not available during this time. The following was observed: Upright Cooler: - yellow sliced cheese aproximately 20 slices in plastic container with cracked lid - undated - mayonnaise gallon jar ¼ cup remaining - open date 12/26/22. - pan of red pasta sauce -covered and dated 12/27/22. - shredded yellow cheese, in plastic container, lid cracked - open date 12/19/22. Dry storage: - large jug of picante sauce - unopened - expiration date 11/22/22 - 9 green peppers soft and wrinkled - packed on 12/22/22- undated - 2 bananas -visible brown discoloration, both were split open and available for resident consumption On 1/9/23 at 5:15 p.m., a kitchen tour was completed with the dietary manager (DM) and the previous undated items were now labeled. The bananas and green peppers were removed. When interviewed during the tour, DM stated when a food item has been opened or prepared, staff should clearly label it with the date. DM stated food borne illness may happen if expired food is served or a resident may get sick. DM stated she checks the food every 5 days. Although DM identified food was checked every	F 812	discarded after 7 days. Weekly, the dietary manager and/or cook will audit and destroy items that are undated and Inservice the dietary team after every occurrence of undated items to ensure sustained compliance. Dietary Manager and/or designee is responsible for compliance. Audits on storage of refrigerated items for proper containers and date will begin 1x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 2/20/2023	

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F 812	Continued From page 64 five days, there was no indicaiton the facility had a system to ensure this was completed on an ongoing basis to prevent food born illness. Also, there was no indication they reviewed the dry storage area for expiration dates to ensure residents did not consume expired food products. The facility policy, "Food Receiving and Storage", revised July 2017, informed: "Food in designated dry storage areas shall be kept off the floor (at least 18 inches) and clear of sprinkler heads, sewage/waste disposal pipes and vents." "Dry foods that are stored in bins will be removed from original packaging, labeled, and dated. Such foods will be rotated using a 'first in-first out' system." "All foods in the refrigerator or freezer will be covered, labeled, and dated."	F 812		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a process for antibiotic review in order to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance. This had the potential to	F 881	All resident infections from December 2022 and January 2023 were recorded on the Infection Tool Tracker form with all appropriate line listing elements completed. There was no resident ill	2/20/23

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F 881	Continued From page 65 affect all 54 residents of the facility. Findings include: During interview on 1/12/23 at 1:10 p.m., the facility's infection preventionist (IP)-A indicated the nurses complete monitoring of symptoms if resident has a possible infection and report that information to the providers. The medical providers are required to use criteria per their own employer to identify potential infections, order testing and to review the cultures and results to ensure the resident is taking the proper antibiotic. IP-A stated the facility did not have a written protocol on antibiotic prescribing and was unaware of any infection assessment tools or management algorithms that are used for assessing or initiation of antibiotics. The IP-A stated she was the only one to fill out the facility spreadsheet titled MDH Infection Line Listing and the "only process I use [are] the policy and the spreadsheet". During interview on 1/12/23 at 1:10 p.m., the IP-A provided two documents to demonstrate facility antibiotic stewardship. One was a 3 page document with the months of Dec 2022, Nov 2022, Oct 2022 at the top of each page which had columns titled: Resident, Date, Illness, Treatment, Progress, Tracking/Trending and MD Order. The second document provided was a spreadsheet titled MDH Infection Line Listing which the IP-A stated she used to track antibiotic use. The IP-A stated the 3 page document labeled with the months of Dec 2022, Nov 2022, and Oct 2022 was "limited" and did not have "everything	F 881	effects noted for this deficient practice. The Loeb's criteria form will be completed for each resident infection to determine if the criteria was met. The Medical Director will be notified at the next QAPI meeting of these results. For all existing resident's infections a Loeb's criteria form will be completed, the line listing will be updated and 72 hour time out performed. Future residents who begin antibiotics will have a Loeb's criteria form completed first and this information will be reported to the MD before initiation of antibiotic therapy. The DON and IP will be in-serviced on the Antibiotic Stewardship policy with emphasis on reporting, surveillance, and documentation. DON, IP and/or designee is responsible for compliance. Audits on antibiotic orders, resident illness line listing entries and Loeb criteria documentation will begin 1x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 2/20/2023	

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 01/13/2023

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F 881	Continued From page 66 listed like the antibiotic". IP-A was unable to define what the "Progress" column indicated and determined there was no documentation on these forms of when symptoms started, when the antibiotic or medical treatment was initiated, or how long the antibiotic or medical treatment treatment was and follow up. Review of the logs included: --Oct 2022 with the same resident listed twice. The column labeled "Progress" had writing that the IP-A could not identify and blank entries for tracking and trending. --Nov 2022 with 4 residents listed. The progress column had a dash (-) placed for two entries and all of the tracking/trending columns had dashes also. --Dec 2022 with 4 residents listed. Date column with one blank entry, treatment column with one blank entry, progress column with a dash for one entry and blank entry for another, and one blank entry for tracking/trending and MD order. A monthly log titled MDH Infection Line Listing included columns for resident name, infection type, body system of infection, symptoms, onset date, antibiotic name, dose, antibiotic start date, antibiotic end date, date symptoms resolved. Review of the logs included: --October 2022 showed 8 residents. Column for infection type showed 2 entries as, "Other" with no indication of what that meant. Also the onset date was blank for these two entries. The column of antibiotic end date had one entry which was blank. --November 2022 with 9 entries (one resident was listed twice). Column for infection type showed 3 entries as, "Other" with no indication of	F 881		

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F 881	Continued From page 67 what that meant. Column for symptoms had one blank entry and onset date was empty for 5 entries. The column for symptoms resolved had 3 blank entries. --December 2022 with 12 residents. The column for infection type showed 9 entries as, "Other" with no indication of what that meant. The facilitys' pharmacist was called for interview on 1/12/23 but did not return call. During interview with the director of nursing (DON) on 1/13/23 at 2:10 p.m., the DON referred all questions about the facility's antibiotic stewardship and infection surveillance to the IP-A. Review of facility policy titled Surveillance for Infections reviewed 01/18/2022 indicated: 1. The infection prevenitoinsit or designated infection control personnel is responsible for gathering and interpreting surveillance data. 2. The surveillance should include a review of any or all of the following information to help identify possible indicatiors of infections: a. Laboratory records; b. Skin care sheets; c. Infection control rounds or interviews; d. Verbal reports from staff; e. Infection documentation records; f. Temperature logs; g. Pharmacy records; h. Antibiotic review; and i. Transfer log/summaries.	F 881		
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	F 886		2/20/23

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F 886	Continued From page 68 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 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	F 886		

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F 886	Continued From page 69 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 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 interview and document review the facility failed to ensure staff were properly trained to self administer a test for COVID-19 while the facility was in outbreak status. Additionally, the facility failed to ensure the procedure for rapid testing for COVID-19 for residents and staff was completed following manufacturer's instructions. These had the potential to affect all 54 residents residing in the facility. Findings include: SELF TESTING During interview with infection control preventionist (IP)-A on 1/9/23 at 6:54 p.m., IP-A provided a document titled "Positive Covid-19 resident "Dec 2022-Jan2023". It listed 27	F 886	Resident testing will continue to be performed by staff who have been educated on the COVID testing procedures. A designated area will be established for COVID testing for staff. Staff will be educated utilizing the manufacturer instruction and CDC antigen testing video. Competencies will be recorded by the IP. There were no resident ill effects from this deficient practice. Facility staff will be in-serviced on the COVID Antigen Testing policy with emphasis on maintaining distance during testing, education and following the manufacturer instructions on wait time to receive test results.	

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F 886	Continued From page 70 residents with dates of their positive test results. Outbreak testing was in place per IP-A. Interview with occupational therapist (OT)-A on 1/10/23 at 3:46 p.m., stated he was tested using the BinaxNow COVID-19 Ag Card (rapid test) for Covid-19 twice per week at the facility prior to their shift. OTA stated, "I test myself here" and stated he had not received any training on how to administer and conduct the rapid test. Interview with activities aide (AA)-A, staff on 1/10/23 at 3:47 p.m., stated she tested positive for Covid-19 on 12/31/22 after working at the facility. AA-A stated no competency or training was provided to self-test while at facility. During interview with licensed practical nurse (LPN)-A on 1/11/23 at 8:33 a.m., he stated that he did not receive training on how to self-administer a rapid test while at the facility. During interview with the director of nursing (DON) on 1/10/23 at 3:40 p.m. and on 1/11/23 at 8:01 a.m., the DON stated that facility did not have competencies or training for staff to demonstrate how to self-test for Covid-19 to ensure they were completing the test accurately. Facility staff and resident testing logs provided by IP-A on 1/10/23 at 8:30 a.m., indicated the facility performed the following rapid tests: 12/5/22 to 1/6/23 there were 97 tests performed on facility residents. All logs stated the results were negative. 1/8/23 to 1/10/12 there were 43 tests performed on facility staff. All logs stated the results were negative.	F 886	DON, IP and/or designee is responsible for compliance. Audits on employee covid testing, education and covid test wait times will begin 1x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 2/20/2023	

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F 886	Continued From page 71 PROCEDURE FOR TESTING According to IP-A on 1/9/23 at 6:54 p.m., the facility used BinaxNOW COVID-19 Ag Card for resident and staff testing. During observation on 1/12/23 at 2:55 p.m., LPN-B entered the testing room and self-tested with a BinaxNow COVID-19 Ag Card. IP-A was not in the testing room. LPN-B stated the IP-A or DON would read the results in, "about 5 minutes" and left the testing room to sit at the nursing station. No time was written on the testing card. LPN-B stated she would, "go out and work and they tell me what the results are". The observed testing was started at 3:00 p.m. At 3:04 p.m. the IP-A entered room and observed the control bar on the test and then wrote results of test (negative) at 3:07 p.m. on a piece of paper and placed the test in the trash. During interview with IP-A on 1/12/23 at 3:07 p.m., IP-A stated the test should take 15 minutes before confirming the result. IP-A verified it was not 15 minutes from the time the test was taken and reading it. At 3:22 p.m. the results was verified as negative. Per procedure card of the BinaxNow COVID-19 Ag Card, "In order to ensure proper test performance, it is important to read the result promptly at 15 minutes, and not before. " According to the Centers for Medicare and Medicaid Services QSO-20-38-NH Revised 09/23/2022 memo states, "Collecting and handling specimens correctly and safely is imperative to ensure the accuracy of test results	F 886		

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F 886	Continued From page 72 and prevent any unnecessary exposures. The specimen should be collected and, if necessary, stored in accordance with the manufacturer's instructions for use for the test and CDC guidelines."	F 886		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 355	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 6.1.3.4 and 6.1.3.8.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/10/2023 between 10:00 AM and 14:15 PM, it was revealed by observation that the fire extinguisher in the physical therapy office was not mounted and was sitting on the floor. An interview with the Maintenance Director verified these deficient findings at the time of discovery.

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

The above isolated deficiencies pose no actual harm to the residents

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/10/2023. At the time of this survey, Victory Health and Rehabilitation Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 02/10/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Victory Health & Rehab Center is a 2-story building with a partial basement that was built in 1990 and was determined to be of Type II(222) construction. This facility is divided into three separate smoke compartments. This facility is fully protected throughout by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is centrally monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 87 beds and had a census of 54 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a means of egress continuously maintained free of all obstructions per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 7.1.6.2, 7.1.6.4, and 7.1.10.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/10/2023 between 10:00 AM and 14:15 PM, it was revealed by observation that the sidewalk outside the West Hall exit door was covered with ice. 2. On 01/10/2023 between 10:00 AM and 14:15 PM, it was revealed by observation that the sidewalk outside the South Hall exit door was covered with ice.	K 211	The facility's west, south, east and north exit door walkways were cleared from any ice or means of obstruction on 1/14/2023 by the Director of Maintenance. The Director of Maintenance will do daily Egress rounds to monitor all four exit doors for obstruction or ice with an emphasis on snow or winter advisory days. On the weekend the housekeeper on duty will perform Egress rounds. The Administrator and Director of Maintenance will audit the exit doors biweekly to ensure corrective actions are being followed on a consistent basis . Compliance-2/20/2023	2/20/23

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K 211	Continued From page 3 3. On 01/10/2023 between 10:00 AM and 14:15 PM, it was revealed by observation that the sidewalk outside the East Hall exit door was covered with ice. 4. On 01/10/2023 between 10:00 AM and 14:15 PM, it was revealed by observation that the sidewalk outside the North Hall exit door was covered with ice. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 211		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321		2/20/23

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VICTORY HEALTH & REHABILITATION CENTER	**512 49TH AVENUE NORTH** **MINNEAPOLIS, MN 55430**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 4 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient findings could have an patterned impact on the residents within the facility. Findings include: 1. On 01/10/2023 between 10:00 AM and 14:15 PM, it was revealed by observation that resident room 106 was turned into a storage room and did not have a self-closing device on the door causing the door to not self-close. 2. On 01/10/2023 between 10:00 AM and 14:15 PM, it was revealed by observation that resident room 190 was turned into a storage room and did not have a self-closing device on the door causing the door to not self-close. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 321	The Director of Maintenance cleaned room 106 and 190 from all storage on 1/16/2023. All storage items will be stored in the basement by the Director of Maintenance. The Director of Maintenance and The Administrator will monitor empty rooms to ensure they are not being used for storage. Compliance-2/20/2023	
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service	K 346		2/20/23

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	245544	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/10/2023**

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K 346	Continued From page 5 Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire alarm out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/10/2023 between 10:00 AM and 14:15 PM, it was revealed by a review of available documentation that the fire alarm out-of-service policy that the facility provided was not site-specific. It appeared that they provided a template for a fire alarm out-of-service policy that was not filled out. An interview with the Administrator and the Maintenance Director verified these deficient findings at the time of discovery.	K 346	The fire alarm out of service policy is updated to include the local and state Fire Marshalls as well as the Department of Health agency for the State of Minnesota Fire Alarm system outage greater than 4 hours in a 24 hour period. The Administrator will maintain policies at least annually. The Administrator and or designee are responsible for compliance. Compliance-2/20/2023	
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined,	K 354		2/20/23

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K 354	Continued From page 6 recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire sprinkler out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.6, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/10/2023 between 10:00 AM and 14:15 PM, it was revealed by a review of available documentation that the fire sprinkler out-of-service policy that the facility provided was not site-specific. It appeared that they provided a template for a fire sprinkler out-of-service policy that was not filled out. An interview with the Administrator and the Maintenance Director verified these deficient findings at the time of discovery.	K 354	The sprinkler out of service policy has been updated to be site specific on 2/8/2023 by the Administrator. The updated facility out of service policy was provided for all staff. The Director of Maintenance and the Administrator will be responsible for maintaining compliance of the policy. Compliance-2/20/2023	
K 521 SS=F	HVAC CFR(s): NFPA 101	K 521		2/20/23

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K 521	Continued From page 7 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12 . This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/10/2023 between 10:00 AM and 14:15 PM, it was revealed by a review of available documentation the facility could not provide a damper inspection and testing report that includes the location of the damper, date of inspection, name of inspector, and deficiencies discovered, that was completed within the last four years. An interview with the Administrator and the Maintenance Director verified these deficient findings at the time of discovery.	K 521	The damper system was inspected on 2/13/2023 by a contracted vendor, Egan Company, 11611 Business Park Boulevard, Champlin, MN, 55316. The Director of Maintenance will be responsible for scheduling a repeat of the inspection at least every 4 years. The Director of Maintenance will keep documentation to show completion of this test in the life safety binder. The Administrator and Director of Maintenance will maintain compliance. Compliance-2/20/2023	
K 711 SS=F	Evacuation and Relocation Plan	K 711		2/20/23

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K 711	Continued From page 8 CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement an evacuation and relocation plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.1.1 and 19.7.1.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/10/2023 between 10:00 AM and 14:15 PM, it was revealed by a review of available documentation that the evacuation and relocation plan that the facility provided was not specific to the facility. It appeared that they provided a template for an evacuation and relocation plan that was not filled out. An interview with the Administrator and the Maintenance Director verified these deficient findings at the time of discovery.	K 711	The evacuation and relocation plan has been updated to be site specific by the Administrator on 2/8/2023. The Administrator will review the evacuation and relocation plan at least annually to ensure the policy is in accordance with evacuation and make updates as necessary. The Administrator will be responsible for compliance. Compliance-2/20/2023 K712 Fire Drills The Director of Maintenance will conduct fire drills in accordance with the requirements of NFPA 101-2012 edition. The Director of Maintenance will submit the fire drill schedule to the Administrator for review monthly. The Administrator will review the fire drill log to ensure requirements for fire drills are met during each month. The Administrator will report to the QAPI committee each month	

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K 711	Continued From page 9	K 711	regarding compliance. Compliance-2/20/2023	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, section 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/10/2023 between 10:00 AM and 14:15 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that a fire drill had been conducted during the second shift during the fourth quarter of 2022. An interview with the Administrator and the Maintenance Director verified these deficient findings at the time of discovery.	K 712	The Director of Maintenance will conduct fire drills in accordance with the requirements of NFPA 101-2012 edition. The Director of Maintenance will submit the fire drill schedule to the Administrator for review monthly. The Administrator will review the fire drill log to ensure requirements for fire drills are met during each month. The Administrator will report to the QAPI committee each month regarding compliance. Compliance-2/20/2023	2/20/23

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K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement smoking regulations per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. These deficient findings could have an isolated impact on the residents within the facility. Findings include:	K 741	The facility designated smoking areas have been cleared from all cigarette items by the Director of Maintenance on 2/9/2023. Staff received education on 1/17/2023 for redirecting residents to the designated smoking area during the observed smoking hours. On 1/10/2023, the Activities Director met with residents	2/20/23

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K 741	Continued From page 11 1. On 01/10/2023 between 10:00 AM and 14:15 PM, it was revealed by observation that the designated smoking area in the rear of the building was unkept, with discarded cigarettes on the ground. 2. On 01/10/2023 between 10:00 AM and 14:15 PM, it was revealed by observation that residents were smoking near the front doors, and that area is not a designated smoking area. 3. On 01/10/2023 between 10:00 AM and 14:15 PM, it was revealed by observation that there were discarded cigarettes on the ground and in planters near the front door. An interview with the Administrator and the Maintenance Director verified these deficient findings at the time of discovery.	K 741	who smoke to review the facility smoking policy with emphasis on location of the designated smoking area, not sharing cigarettes with others, always keeping all smoking material in drawers or on person. The receptionist will monitor the front area minimum of hourly for smoking paraphernalia. Residents are required to sign out at the receptionist desk to alert them as well as other staff of the resident's location. Facility employees have been notified that there is to be no smoking on facility grounds. Employees will be permitted to smoke in their car or off facility grounds. Areas identified as having cigarette butts were cleaned by the housekeeping staff and Director of Maintenance. Daily rounds of all smoking areas as well as the front will be completed by housekeeping and maintenance. Compliance-2/20/2023	

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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 1/9/23 - 1/13/23, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. The following licensing orders were issued. Please indicate in your electronic plan of correction that	2 000		

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2 000	Continued From page 1 you have reviewed these orders, and identify the date when they will be completed. The following complaint was found to be subtantiated: H55446642C (MN00089249), however no deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be unsubstantiated: H55447297C (MN00088893) and H55447298C (MN00088903). The following complaints were found to be unsubstantiated: H55447039C (MN00089595), however, a related licensing order was issued at 0830 (F689). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		2/20/23

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2 830	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess falls, identify causal factors, and implement interventions to decrease the risk of additional falls for 1 of 2 residents (R1) reviewed for falls. Findings include: R1's significant change Minimum Data Set (MDS) dated 12/19/22, indicated he was moderately cognitively impaired, required extensive two person assist for bed mobility, transfers, dressing, toilet use, and included diagnoses of fracture and malnutrition. R1's Resident Fall Risk dated 9/8/22, indicated R1 was at moderate risk for falls. A progress note dated 11/12/22, indicated the smoking aide reported to nurse R1 was unable to move at all. R1 told nurse he fell two days earlier and could not remember how. He stated he had not reported it previously but was having pain in both hips. Provider was contacted who ordered x-rays. A progress note dated 11/12/22, indicated R1 was sent to the hospital and admitted for a right broken hip. R1's Fall Incident/Accident Root Cause Analysis dated 11/12/22, included action taken to prevent further incidents of this kind as "Evaluate for pain" and current intervention of "Call light in use". The	2 830	Corrected	

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2 830	Continued From page 4 root cause analysis was identified as "resident not able to explain how the fall happened." R1's care plan initiated on 11/12/22, included R1 had an actual fall with serious injury due to poor balance, psychoactive drug use, and unsteady gait, and included interventions of continue previous interventions, monitor resident for 72 hours, pharmacy consult to evaluate medicates, PT consult for strength and mobility, and provide activities that promote exercise and strength building. A progress note dated 11/18/22, indicated R1 returned to the facility after treatment of right hip fracture. R1's Resident Fall Risk dated 11/29/22, indicated R1 was at moderate risk for falls. A progress note dated 12/2/22, 10:15 pm indicated R1 fell with no bleeding or injury noted. Resident was taken to bed and had an oxygen saturation (O2 sat) of 60% on room air (RA) with the O2 sat monitor on his right middle toe. The note identified he appeared unconscious and was placed on 2 liters of oxygen which brought O2 sat to 65% and 911 was called. R1 was sent to the hospital via ambulance at 8:35 pm. and the DON and provider were notified. Review of R1's progress notes, vital signs EMR (electronic medical record) dated 12/2/22,) lacked any information about the time of the fall, location, position R1 was found in or post-fall vital signs and monitoring from the fall to the arrival of emergency medical services. A progress note dated 12/5/22, indicated R1 returned to the facility at 1:15 p.m. with no noted	2 830		

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2 830	Continued From page 5 skin breaks or injury, and a post surgical incision on the right hip from un-witnessed fall on 11/16/22. A progress note dated 12/20/22, indicated R1 had an unwitnessed fall with no injuries and provider was notified. There was no assessment to determine what occurred, where they were found, or a root cause analysis to determine what interventions could be implemented to decease R1's risk of falling. Also, there was no indication of post-fall vital signs or any monitoring after the fall. R1's Resident Fall Risk dated 12/22/22, indicated R1 was at high risk for falls. R1's care plan lacked additional interventions after the falls on 12/2/22, and 12/20/22. R1's medical record lacked a root cause analysis for falls dated 12/2/22, and 12/20/22. During observation and interview on 1/9/23, at 2:55 p.m. R1 stated he broke his hip recently after a fall. R1 observed in bed and the bed was not in low position and there was not a mat on the floor. During interview on 1/12/23, at 11:15 a.m. nursing assistant (NA)-B stated she knew who was at risk for falls because the care plan told staff to watch them, or the resident would have their bed in low position or a mattress on the floor next to the bed. She stated R1 was at risk for falling. She stated staff watched him and assisted him to bed if requested to help avoid a fall. During interview on 1/12/23, at 12:51 p.m. NA-D stated if a resident was at risk for falls there	2 830		

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2 830	Continued From page 6 would be a mat on the floor, and it would be in the care plan, on the Kardex, and in the resident's closet in their room. During interview on 1/12/23, at 12:54 p.m. trained medication aide (TMA)-A stated a resident was at risk for falls if they were always in bed rolling toward the edge, attempting to stand up when they were unstable, or sometimes the nurses let her know. She stated she thought maybe R1 fractured his hip trying to self-transfer, but she was not sure. She stated she did not know if he had fallen again since then and did not know if there were additional interventions. During interview on 1/12/23, at 4:02 p.m. licensed practical nurse (LPN)-C stated when a resident fell, she informed the family, provider, and DON, wrote a progress note, completed an assessment, and obtained resident vital signs. She stated if the fall was unwitnessed, she tried to determine what happened and filled out a form which instructed staff to monitor the resident by completing vital signs and neurological status checks every 15 minutes for one hour, and additional checks as outlined on the form. She stated the completed form was either placed in the paper chart or uploaded into the electronic documentation system. She stated she also completed a post-fall note, a risk management electronic form, and a new falls risk assessment. She stated she did not add interventions to resident care plans, and only the MDS nurse did that. LPN-C stated R1 had a fall in November, but staff did not know about it until two days later when R1 told them he had hip pain. R1 was sent to the hospital, diagnosed with a hip fracture, had surgery, and returned to the facility. She stated R1 had another fall in early December. She stated R1 and some other residents were in the	2 830		

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2 830	Continued From page 7 dining room and another resident was heard calling out for staff. Staff returned and found R1 on the floor. He was taken to his room where they completed vital signs and he subsequently became unconscious. She stated another nurse ran in and he was placed on oxygen, an ambulance was called, and he was taken to the hospital. She was unable to locate documentation of neurological status for R1's unwitnessed falls. During interview on 1/12/23, at 1:10 p.m. registered nurse (RN)-A stated all residents had a falls risk assessment completed upon admission, quarterly, and after each fall. She stated the nurse on duty at the time of the fall completed the falls assessment which gave the resident a score, in addition to a post fall assessment and a root cause analysis for every fall. She stated any new falls interventions would depend on the circumstances around the fall. She stated all nurses can add interventions and it was the MDS nurse's job to update the care plan. RN-A confirmed there was no post fall assessment, root cause analysis, or interventions added to the care plan after either of the falls on 12/2/22, and 12/21/22. She confirmed R1 was at high risk for falls and stated she would "definitely" have added interventions. She stated resident falls were discussed in meetings every morning and falls risk was communicated to staff, including nursing assistants, during report and through the paper Kardex in the resident rooms. Upon review of the Kardex in R1's room, RN-A confirmed it was dated 6/18/2022 and was for a different resident, not R1. During interview on 1/13/23, at 8:33 a.m. RN-B stated he reviewed resident falls risk assessments and residents who were at risk wore a wrist band for identification. He stated if a	2 830		

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2 830	Continued From page 8 resident fell, he found out what led to the fall and added interventions appropriate to the situation. During interview on 1/13/22, at 10:43 a.m. director of nursing (DON) stated staff were made aware of resident fall risk through verbal report, the care plan, and the Kardex. DON stated if a resident fell, she expected staff to notify DON, family, and provider, complete a risk management report, write a progress note, and complete a falls assessment with each fall. She stated for any unwitnessed fall staff were expected to complete neurological checks and vital signs every 15 minutes for the first hour, every 30 minutes for the second hour, and as directed on the neuro check form, and one set of vital signs was not enough. Once completed the form was placed in the paper chart. She stated she expected a new fall risk assessment and a root cause analysis to be completed for each fall to identify the circumstances and determine appropriate interventions, and any interventions should be added to the care plan and the Kardex. She stated she heard R1 had a fall with a fracture and confirmed additional interventions should have been added to the care plan after the falls on 12/2/22, and 12/20/22 to help try to prevent further falls. The facility policy Falls and Fall Risk, Managing dated 12/27/22, indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. If falling occurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. The policy lacked instruction regarding post-fall assessment of	2 830		

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2 830	Continued From page 9 residents after unwitnessed falls. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents avoid falls, falls that occur are fully analyzed for root cause and appropriate interventions are put into place to avoid future falls. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures and develop audit systems to ensure ongoing compliance. The results of those audits could be shared with the facility's quality assessment and assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and	2 915		2/20/23

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2 915	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure activities of daily living (ADLs) including weekly baths or showers and nail care were provided for 1 of 1 residents (R38) who needed staff assistance with bathing and nail care. Findings include: R38's admission Minimum Data Set (MDS) dated 12/22/22, indicated R38 was cognitively intact, and required assist of one staff for bathing, personal hygiene, and dressing. The MDS included diagnoses of cancer, fracture, lung disease and indicated R38 exhibited no behaviors or rejection of cares. R38's care plan dated 12/18/22, indicated R38 had a self-care performance deficit and required staff assistance for showering/bathing and personal hygiene but lacked indication of level of assistance needed. The care plan lacked any evidence of refusal of showering/bathing and personal hygiene. During observation on 1/9/23, at 1:53 p.m. R38 was observed seated on the side of his bed with greasy-looking hair and fingernails approximately between 1/8 and 1/4 inch long, with dark brown matter under the nails approximately halfway up toward the tip. He stated staff did not help him cut or clean his nails and he did not like it.	2 915	Corrected	

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2 915	Continued From page 11 R38's Weekly Skin Check dated 12/19/22, indicated R38 had a bed bath but did not have his fingernails or toenails trimmed or filed. R38's orders printed 1/13/22, included an order for nursing to complete skin audit weekly on bath day, with R38 scheduled to receive bath/shower every Monday AM. The order included "please offer to trim nails and document". Review of R38's bathing documentation did not identify if he had a bath or his nails trimmed from 12/19/22, through 1/13/23. R38's Kardex for nursing assistants (NA) to follow to provide cares dated 1/13/22, indicated R38's preferred bath time was Monday mornings, but did not identify how much staff assistance was needed. The Kardex included R38's fingernails should be kept short to avoid scratching, and to monitor any behavior symptoms. During interview on 1/12/23, at 4:19 p.m. licensed practical nurse (LPN)-C stated nursing assistants trimmed residents' nails on bath days if needed, unless the resident was diabetic. During interview on 1/12/23, at 4:24 p.m. NA-A stated she looked at the Kardex and the assignment book to determine who needed a bath or shower on her shift. She stated if a resident refused, she told the nurse, reproached later, and if the resident continued to refuse, she documented it and a bath or shower would be offered another time. She stated R38 had not been in the facility very long but thought he might have taken a shower. During interview on 1/13/23, at 8:15 a.m. NA-C stated there was a shower schedule at the desk	2 915		

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2 915	Continued From page 12 and staff documented the showers in the electronic documentation system. She stated she trimmed residents' nails when she saw the need for it and most resident's wanted them trimmed. She stated the aides tried to clean the residents' hands with a washcloth, soap, and water and sometimes R38 refused, but the nurses knew about "the crud" under his fingernails. She thought R38 normally did not refuse showers. During interview on 1/13/23, at 10:03 a.m. RN-A stated nails should be checked weekly on bath days and trimmed as needed. She stated she had also noticed many residents needed their fingernails trimmed and cleaned, and ADL care of residents could be improved. She stated some of the residents refused, however the refusals should have been documented but she was not aware that R38 refused cares. On 1/13/23, at 10:17 RN-B observed R38's soiled fingernails and identified they should be cleaned and trimmed. During interview on 1/13/23, at 10:43 a.m. director of nursing (DON) stated residents had a scheduled weekly bath day and resident nail care was done when bathed. She stated bathing and nail care were important for infection control, and any refusals after re-approach were expected to be documented. The DON identified she was not aware if R38 refused cares. The facility policy Activities of Daily Living, Supporting (undated) indicated residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary	2 915		

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2 915	Continued From page 13 to maintain good nutrition, grooming, and personal and oral hygiene. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' requiring staff assistance, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of resident cares to ensure their personal hygiene needs are met consistently. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine personal grooming, bathing and cleanliness for 2 of 2 residents (R13 and R48) who were dependant on staff for their hygiene care. Findings include:	2 920	Corrected	2/20/23

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2 920	Continued From page 14 Resident #13 R13's admission minimum data set (MDS) dated 12/8/22, indicated he was cognitively intact, did not refuse cares, was totally dependent on two staff for bed mobility, transfers, grooming, and toilet use, and included diagnoses of arthritis. R13's diagnoses did not include diabetes. R13's care plan dated 12/6/22 included R13 had a self-care performance deficit and included R13 required total assistance with personal hygiene and instructed staff to check nail length and trim and clean on bath day and as necessary. The care plan did not address facial hair removal. On 1/9/23, at 1:33 p.m. R13 was observed lying in bed with a full beard of two to three inches and his moustache hanging over his top lip by approximately one inch. He had fingernails approximately 1/4 inch long with black matter underneath. He stated he could not clip them himself because he could not use his right hand due to neuropathy and the nursing assistants did not assist him in cleaning underneath his nails. He stated he did not like the beard and was normally clean shaven at home, but nobody had asked him if he wanted to shave despite mentioning it to several nursing staff. R13's physician orders, dated 12/19/22 included nursing to complete skin audit weekly on bath day, scheduled every Monday evening, and offer to trim nails and document starting 12/19/22. R13's Behavior Symptoms Task 30 day look back report dated from 12/14/23 through 1/12/23, indicated he did not refuse cares in the past 30 days.	2 920		

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2 920	Continued From page 15 During interview on 1/12/23, at 4:19 p.m. licensed practical nurse (LPN)-C stated R13 normally got a bed bath daily. LPN-C stated the aides trimmed fingernails for residents without diabetes, but nurses cut nails for diabetic residents. She stated she noticed R13's fingernails were long one day, but he refused to have them cut and when she reproached the next day he also declined. She stated she was unable to reproach again later because he was sleeping. She stated shaving was normally completed by one of the nursing assistants (NA's), and she did not think R13 generally refused shaving. During interview on 1/12/23, at 4:24 p.m. NA-A stated R13 was usually cooperative and well-liked and did not refuse cares. If a resident did refuse, she reproached, and if they still refused, she documented it in the electronic documentation record. She stated she had not shaved any residents at the facility but suggested some of the other aides might do it. She stated the NA's trimmed fingernails for residents who were not diabetic, but she had not clipped R13's nails. During interview on 1/12/23, at 4:49 p.m. NA-E stated he had spoken with R13, acknowledged the lengthy facial hair and nails, and would address them the following day. During interview on 1/13/23, at 8:15 a.m. NA-C stated the aides tried to clean the residents' hands with a washcloth, soap, and water, and trimmed residents' nails when she saw the need for it. She stated most resident wanted them trimmed. She stated most of the time one of the other aides did the shaving, and R13 had never refused shaving or nail care.	2 920		

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2 920	Continued From page 16 Resident #48 R48's admission MDS dated 12/17/22, indicated he was mildly cognitively impaired, required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene, totally dependent on one staff for bathing, and required partial/moderate assistance with oral hygiene. R48 was incontinent of bowel and used a urinary catheter. His diagnoses included stroke and seizure disorder, and he had no behaviors or rejection of cares. R48's care plan dated 12/17/22, indicated R48 had an activities of daily living (ADL) self-care deficit and included interventions of assist of one staff with showering, personal hygiene, and oral care. R48's Kardex printed 1/13/23, indicated R48's baths were scheduled for Tuesday evenings and R48 required assist of one staff for personal hygiene and oral care. The Kardex also instructed staff to monitor behaviors, there was no indicated R48 refused cares as a behavior. R48's physician order dated 12/20/22, included R48's bath day was scheduled every Tuesday evening. R48's task documentation indicated he had a bed bath on 12/14/22, and refused a shower on 12/20/22. R48's medical record lacked evidence of any bathing between 12/20/22, and 1/13/23. R48's behavior symptoms task documentation from 12/14/22, and 1/12/22 did not identify there was any rejection of cares. On 1/9/23, at 2:09 p.m. R48 was observed lying	2 920		

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2 920	Continued From page 17 in bed with blankets covering his body and wearing a hospital gown. His teeth were yellow in color and had facial hair approximately ¾ inch long was observed above his upper lip and below his lower lip across his jawline. His hair appeared disheveled, greasy, and approximately 4-6 inches long. R48 stated he was bedridden and had not had any showers or baths since his arrival (12/6/22) and would appreciate an opportunity to take a shower. He stated he had not had his hair washed and described it as a "horrible problem" and "disgusting". He stated his hair was way too long and he was way overdue for a haircut, and he would normally have a haircut by then. He reiterated, it needed shampooing "so badly". He further stated he "obviously" needed a shave and preferred to be clean shaven. R48 stated he had not been provided a toothbrush or tooth paste since he arrived at the facility. With permission from R48, his drawers, closet, and bathroom were searched for a toothbrush and toothpaste, but none were found. The bathroom contained one emesis basin with two dry razors sitting in it but no other hygiene supplies. The facility nursing schedule indicated NA-A and NA-B were scheduled on R48's wing on the evening of Tuesday, 1/10/22, R48's scheduled bath day. During interview on 1/12/23, at 11:15 a.m. NA-B stated she knew which residents needed a bath and what type by reviewing the Kardex in the resident's closet or looking at the assignment sheet at the nurse's desk. She stated the residents' hair can also be washed even if giving	2 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	C 01/13/2023

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

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2 920	Continued From page 18 a bed bath. She stated the aides were also responsible for shaving residents when requested, trimming fingernails on non-diabetic residents, and helping them brush their teeth. NA-B looked through R48's room and bathroom and verified R48 did not have a toothbrush or toothpaste. She stated she did not know if she forgot to help him brush his teeth, but everyone was supposed to have their teeth brushed in the morning. She stated she did not recall when R48 had a shower, but if he refused, she would chart it at the end of the shift. NA-B was unaware of when R48 had a bath/shower. During interview on 1/12/23 at 4:24 p.m. NA-A stated she looked at the Kardex and the assignment book to identify who needed a bath on her shifts and if they refused, they would be offered a shower again prior to the next bath day. She stated she had given R48 a shower in the past, but she did not remember washing his hair, nor helping him brush his teeth. NA-A looked throughout R48's room and bathroom and verified he did not have a toothbrush or toothpaste. R48's hair was observed to be greasy-looking and unkempt. R48 stated he had still not had his hair washed or teeth brushed. NA-A was unaware of when R48 had a bath/shower. During interview on 1/13/23, at 08:15 a.m. NA-C stated there was a shower list at the desk, and if a resident refused any care, she documented it. NA-C stated she had not helped R48 with his teeth, but if a resident refused, she documented that as well. NA-C was unaware of when R48 had a bath/shower. During interview on 1/13/23, at 8:26 a.m. R48 stated he still had not had a shower, and his hair was "so grubby". R48's was observed continued	2 920		

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2 920	Continued From page 19 to have facial hair approximately ¾ inch long above his upper lip and below his lower lip across his jawline. His hair appeared disheveled, greasy, and approximately 4-6 inches long and teeth remained yellow and unkept. During interview on 1/13/23, at 10:43 a.m. director of nursing (DON) stated her expectation was residents should be shaved if that was their preference, and one of the NA's usually did that. She stated residents had a scheduled weekly bath day and resident nail care was done when bathed, and bathing and nail care were important for infection control. Any refusals after re-approach were expected to be documented. The DON was unaware of when R48 had a bath/shower. The facility policy Activities of Daily Living, Supporting (undated) indicated residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to resident assistance activities of daily living. The DON or designee, could provide training for all nursing staff related assisting residents activities of daily living. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 920		

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2 920	Continued From page 20 (21) days.	2 920		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to store and label food to prevent potentially degraded food from being served to residents. This had the potential to affect all 54 residents as all residents received food from the kitchen. Findings included: On 1/9/23 at 11:58 a.m., an initial kitchen tour was conducated with Cook (C)-A. Dietary Manager, (DM) was not available during this time. The following was observed: Upright Cooler: - yellow sliced cheese aproximately 20 slices in plastic container with cracked lid - undated - mayonnaise gallon jar ¼ cup remaining - open date 12/26/22. - pan of red pasta sauce -covered and dated 12/27/22. - shredded yellow cheese, in plastic container, lid cracked - open date 12/19/22.	21100	Corrected	2/20/23

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21100	Continued From page 21 Dry storage: - large jug of picante sauce - unopened - expiration date 11/22/22 - 9 green peppers soft and wrinkled - packed on 12/22/22- undated - 2 bananas -visible brown discoloration, both were split open and available for resident consumption On 1/9/23 at 5:15 p.m., a kitchen tour was completed with the dietary manager (DM) and the previous undated items were now labeled. The bananas and green peppers were removed. When interviewed during the tour, DM stated when a food item has been opened or prepared, staff should clearly label it with the date. DM stated food borne illness may happen if expired food is served or a resident may get sick. DM stated she checks the food every 5 days. Although DM identified food was checked every five days, there was no indicaiton the facility had a system to ensure this was completed on an ongoing basis to prevent food born illness. Also, there was no indication they reviewed the dry storage area for expiration dates to ensure residents did not consume expired food products. The facility policy, "Food Receiving and Storage", revised July 2017, informed: "Food in designated dry storage areas shall be kept off the floor (at least 18 inches) and clear of sprinkler heads, sewage/waste disposal pipes and vents." "Dry foods that are stored in bins will be removed from original packaging, labeled, and dated. Such foods will be rotated using a 'first in-first out' system." "All foods in the refrigerator or freezer will be	21100		

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21100	Continued From page 22 covered, labeled, and dated." SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods are stored and labeled properly to prevent potential degraded food served to residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food storage and labeling. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items are stored and labeled appropriately. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 15, 2023

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

RE: CCN: 245544
Cycle Start Date: January 13, 2023

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 February 3, 2023, we notified you a remedy was imposed. On March 7, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 20, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 18, 2023 be discontinued as of February 20, 2023. (42 CFR 488.417 (b))

However, as we notified you in our letter of February 3, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 18, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 15, 2023

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

Re: Reinspection Results
Event ID: C5MK12

Dear Administrator:

On March 7, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 13, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us