



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 29, 2025

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

RE: CCN: 245544
Cycle Start Date: December 19, 2024

Dear Administrator:

On January 24, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 29, 2025

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

Re: Reinspection Results
Event ID: GB3T12

Dear Administrator:

On January 21, 2025 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 December 19, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 3, 2025

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

RE: CCN: 245544
Cycle Start Date: December 19, 2024

Dear Administrator:

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

On December 19, 2024, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

An equal opportunity employer.

- 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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Renee McClellan, Regional Operations Supervisor
 Metro A District Office
 Health Regulation Division
 Minnesota Department of Health
 625 Robert Street N
 P.O. Box 64975
 Saint Paul, Minnesota 55164-0975
 Email: renee.mcclellan@state.mn.us
 Office: 651-201-4391 Mobile: 651-328-9282

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 19, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 19, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

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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Electronically delivered
January 3, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: GB3T11

Dear Administrator:

The above facility was surveyed on December 16, 2024 through December 19, 2024 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:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/19/2024
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments On 12/16/24-12/19/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 12/16/24-12/19/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H55441980C (MN00104072),H55441943C (MN00104942), H55441941C (MN00105894), H55441941C (MN00105912), H55441981C (MN00107348), H55441982C (MN00108253), H55441983C (MN00108393), H55441944C (MN00108363) and H55442441C (MN108940). 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.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/07/2025

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 000	Continued From page 1			F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal			F 550			1/13/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 550	Continued From page 2 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a dignified dining experience for 1 of 1 residents (R164) reviewed for dignity. Findings include: R164's admission Minimum Data Set (MDS) dated 12/6/24, indicated R164 had severe cognitive impairment, upper and lower extremity impairment of one side of the body, required substantial/maximal assistance with meals and a mechanically altered diet. R164's diagnoses included stroke, aphasia (condition limiting speech and understanding), dysphagia (condition affecting ability to swallow), and right-sided hemiplegia (paralysis affecting one side of the body). R164's care plan dated 12/5/24, indicated R164 had activities of daily living (ADL) self-care performance deficit related to stroke and was "able to eat independent after set up by staff using a divided plate." R164's physician order dated 12/4/24, indicated, "Resident is to be up in w/c for meals. Aides are to feed resident and check mouth for pocketing food."			F 550	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent informal dispute resolution session, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F 550 ☐ D Resident Rights R164 ADL care plan for eating was reviewed and updated as needed. There were no ill effects experienced during this deficient practice. All current residents who require ADL assistance for eating, their care plans will be reviewed and updated as needed. Future residents will be assessed upon admission, quarterly, significant changes and as needed, for ADL eating assistance and the care plan intervention will be implemented.		

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F 550	Continued From page 3 During observation on 12/17/24 at 8:47 a.m., R146 was in bed in room with breakfast tray on bedside table in front of him. R146 had ground sausage, cream of wheat, two whole waffles, and an unpeeled hard-boiled egg. R146 struggled to peel the egg and used his left hand fingers to eat the sausage. Further, R164 attempted to open a plastic water bottle with his teeth. No staff were present to assist. During observation on 12/17/24 at 8:50 a.m., nursing assistant (NA)-A entered R164's room to drop off a watcher pitcher for his roommate and exited the room without acknowledging R146 or offering to assist. During observation on 12/17/24 at 11:58 a.m., R164 was in the dining room in his wheelchair at a table by himself, and empty stationary chair sat next to him. Social services director (SSD) stood next to R164 while assisting him with his lunch. During interview on 12/17/24 at 12:05 p.m., SSD stated not being an NA and just helping staff out since they seemed short-handed. SSD stated never received any feeding assistance training and saw the empty chair next to R164 but assumed it was being saved for another resident. SSD stated R164 was "not a feeder" but had requested assistance so she wanted to help out. SSD was not aware that standing while assisting was considered undignified. During interview on 12/17/24 at 12:48 p.m., licensed practical nurse (LPN)-A stated staff should not stand over a resident while assisting with meals as it was not a dignified experience when they stood over them.			F 550	Licensed nurses and nurse aides will be in-serviced on the Assistance with Meals with emphasis on item #2 that directs the nursing team to serve trays and help/assist residents who require assistance with eating. The Director of Nursing and/or designee is responsible for compliance. Audits on resident eating care plan assistance review and visual audits on resident dining assistance given by nursing staff during meals will begin 2x week x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take the audit results to QAPI for review and recommendations.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 550	Continued From page 4 During interview on 12/17/24 at 12:51 p.m., director of nursing (DON) stated expectation staff would sit next to a resident when assisting with meals to provide a dignified dining experience. During interview on 12/19/24 at 9:56 a.m., speech therapist (ST)-A stated R164 was on a mechanical soft diet and required set up assistance and supervision with meals. ST-A stated staff were supposed to assist R164 with meals as needed with opening or arranging items until cleared by speech therapy. Facility policy Assisting the Impaired Resident with In-Room Meals dated 9/2013, instructed staff to check food for appropriate consistency prior to serving and to position a chair next to the resident where it would be convenient for staff and resident to assist with the meal. Facility policy Quality of Life-Dignity dated 2/2020, indicated, staff should not 'label' a resident or refer to them by their care needs. The policy indicated, "Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity an assist residents."	F 550			
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced	F 558			1/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/19/2024
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F 558	Continued From page 5 by: Based on observation, interview, and document review, the facility failed to ensure a call light was accessible for 1 of 3 residents (R164) reviewed for call lights. Findings include: R164's admission Minimum Data Set (MDS) dated 12/6/24, indicated R164 had severe cognitive impairment, upper and lower extremity impairment of one side of the body, required substantial/maximal assistance with most activities of daily living (ADL). R164's diagnoses included stroke, aphasia (condition limiting speech and understanding), and right-sided hemiplegia (paralysis affecting one side of the body). R164's care plan dated 12/5/24, indicated R164 was at risk for falls r/t (related to) CVA (cerebral vascular accident) affecting right dominant side of body. The care plan instructed staff to ensure resident's call light was within reach and to encourage him to use it. During observation on 12/16/24 at 1:20 p.m., R164 door was open and visible from the hallway. R164 was awake in bed with call light inside the top drawer of his nightstand out of his reach. During observation on 12/17/24 at 8:47 a.m., R146 was in bed in room with breakfast tray on bedside table in front of him. R146 had ground sausage, cream of wheat, two whole waffles, and an unpeeled hard-boiled egg. R146 struggled to peel the egg and used his left hand fingers to eat the sausage. Further, R164 attempted to open a plastic water bottle with his teeth. No staff were	F 558	F 558 ☐ D Reasonable Accommodation R164 call light was checked for functionality, call light clip was in position and the call light were placed in reach. All current resident call lights were checked for functionality and placement and any call light that was malfunctioning was replaced and/or repaired. Future resident admissions, the call light will be tested and will be placed in reach of the resident per facility policy. Nursing staff will be in-serviced on the call light policy with emphasis on ensuring that the call light is within reach of the resident before exiting the resident room. Unattended rooms, the call-light will be placed on the bed. Director of Nursing and/or designee is responsible for compliance. Audits on call light functionality and call light placement will begin 2x week for 3 weeks, weekly x 4 weeks then monthly to ensure compliance. Audits will be reviewed by the Executive Director and the Executive Director will take the audit results to QAPI for review and recommendation.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
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F 558	Continued From page 6 present to assist. R164's call light was inside the top drawer of his nightstand out of his reach. During observation on 12/17/24 at 10:08 a.m., R164's door was closed. R164 was in bed , awake, and call light in top drawer of his nightstand out of his reach. During observation on 12/18/24 at 8:13 a.m., R164 was in bed, sitting up with breakfast tray in front of him. No staff present and call light in top drawer of nightstand out of his reach. His meal consisted of a whole omelet. When asked if he needed assistance with his meal, he just grunted. During interview on 12/18/24 at 8:26 a.m., nursing assistant (NA)-C stated R164 was capable of using the call light. NA-C confirmed R164's call light was in his top drawer of his nightstand, out of reach. NA-C stated the call light should be close to the residents and within reach. During interview on 12/19/24 at 10:15 a.m., director of nursing (DON) stated expectation that R164 would have call light within reach at all times. Facility policy Answering the Call Light dated 9/2022, indicated, "Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor."	F 558			
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination	F 561			1/13/25

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F 561	Continued From page 7 through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food preferences of the resident were honored and implemented for 1 of 2 residents (R24) reviewed for choices. Findings include: R24's Medical Diagnosis form indicated the following diagnoses: multiple sclerosis (a disease in which the immune system eats away at the	F 561	F 561 ☐ D Self Determination R24☐s food preferences were reviewed by the resident and dietary supervisor on 1/7/2025. R24☐s dietary food preferences care plan and dietary slip will be reviewed and updated as needed. All current residents will have their dietary preferences reviewed and dietary slips updated as needed. Future residents will meet with the food service director to review resident preferences and		

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F 561	Continued From page 8 protective covering of the nerves), type II diabetes mellitus with hyperglycemia (high blood sugar), major depressive disorder and adjustment disorder. R24's Clinical Physician orders form indicated a diabetic diet encourage fluids, regular texture, and thin liquids consistency. R24's dietary slip on the breakfast tray on 12/18/24 indicated Diet- CCHO - Regular (Consistent Carbohydrate Diet), Liquids - Thin . Orange juice, grits and sausage link were crossed out. Observation on 12/18/24 at 8:00 a.m., the staff brought R24's breakfast tray, which consisted of 8 oz orange juice, 8 oz of milk, a bowl of frosted flakes, a piece of toast and an omelet. Interview on 12/18/24 at 8:05 a.m., R24 indicated that R24 had requested no orange juice. R24 indicated it comes on the breakfast tray every morning even though he/she requests no orange juice. Interview on 12/18/24 at 8:30 a.m., the Food Service Director(FSD) indicated the dietary aide is responsible for verifying the resident menu slip. The FSD indicated residents should get what they want as long as it is within the ordered diet. R24's care plan dated 12/18/24 indicated a nutritional problem or potential nutritional problem related to Multiple sclerosis, and diabetes mellitus. Goal was to maintain adequate status as evidenced by maintaining weight within 5% of 146#, no signs and symptom of malnutrition, and consuming at least 50% of meals. Interventions			F 561	implement meal care plan interventions per facility policy. Dietary staff along with nurse aides will be in-serviced on the Resident Food Preferences with emphasis on item #1 that nursing or dietary staff will meet to discuss/identify the resident preferences and will also be in-serviced on the Food and Nutrition Service policy with emphasis on items #7 that the food service staff will inspect the food that the correct meal is being served and if the meal is incorrect, the nurse aide will report this to the dietary manager and a new food tray will be served. The Food Service Director and/or designee is responsible for compliance. Audits on dietary meal tickets, dietary aide and nurse aide checking the meal ticket to ensure preferences are honored will begin 2x a week for 2 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take the audit results to QAPI for review and recommendations.		

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F 561	Continued From page 9 indicated to provide and serve diet as ordered	F 561			
F 689 SS=D	Review of the Resident Food Preferences policy dated 7/2017 indicated individual food preference will be assessed on admission, and when possible staff will interview the resident to determine food preferences. 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 ensure a resident was provided the appropriate therapeutic diet and meal supervision for 1 of 1 resident (R164) reviewed for nutrition. Further, the facility failed to ensure a resident was transferred from bed to wheelchair in a manner assessed safe for 1 of 2 residents (R164) observed during transfers. Findings include: R164's admission Minimum Data Set (MDS) dated 12/6/24, indicated R164 had severe cognitive impairment, upper and lower extremity impairment of one side of the body, required substantial/maximal assistance with most activities of daily living (ADL) including eating and transfers, and required a mechanically altered	F 689	F 689 ☐ D Free from Hazards ADL Assistance R164 ADL care plan for eating and set up assistance was reviewed and updated as needed. There were no ill effects experienced during this deficient practice. All current residents who require ADL assistance for eating, their care plans will be reviewed and updated as needed. Future residents will be assessed upon admission, quarterly, significant changes and as needed, for ADL eating assistance and the care plan intervention will be implemented. Licensed nurses and nurse aides will be		1/13/25

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F 689	Continued From page 10 diet. R164's diagnoses included stroke, aphasia (condition limiting speech and understanding), dysphagia (condition affecting ability to swallow), and right-sided hemiplegia (paralysis affecting one side of the body). R164's care plan dated 12/5/24, indicated R165 had an ADL self-care performance deficit related to stroke and required total assist by one staff to eat and was totally dependent on one staff for transferring. R164's care plan Special Instructions indicated, "Hoyer lift." R164's Nutrition Assessment dated 12/6/24, indicated R164 required mechanically altered diet. R164's Falls Assessment dated 12/6/24, indicated R164 was at moderate risk for falls. R164's physician orders included, Mechanical soft diet, Mechanical soft textures" dated 11/30/24 and "Aides are to feed resident and check mouth for pocketing for food" dated 12/4/24. R164's Therapy to Nursing Communication-Resident Status Update dated 12/2/24, indicated R164 required mechanical lift-Hoyer transfers. R164's occupational therapy notes dated 12/12/24, indicated OT (occupational therapist) reminded aides R164 required set up to eat meals. R164's physical therapy notes dated 12/17/24, indicated, "Nursing staff to continue to use Hoyer lift with pt [patient] for transfers."			F 689	in-serviced on the Assistance with Meals with emphasis on item #2 that directs the nursing team to serve trays and help/assist residents who require assistance with eating. The Director of Nursing and/or designee is responsible for compliance. Audits on resident eating care plan assistance accuracy, visual audits resident dining for appropriate nurse aide assistance will begin 2 x week x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take the audit results to QAPI for review and recommendations. Compliance: Resident Transfer R164 will have a new lift mobility assessment completed and R164 continues with therapy services per MD order. R164's care plan for transfer status was reviewed and updated as needed. R164 experienced no ill effects to this deficient practice. All current residents, their lift mobility assessment, transfer status was reviewed and the care plan updated as needed. Future residents will be assessed upon admission, quarterly and significant change for lift mobility and the care plan created and intervention implemented.		

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F 689	Continued From page 11 During interview on 12/16/24 at 2:48 p.m., family member (FM)-A stated R164 was receiving therapy to improve strength and independence but currently required assistance with transfers and meals. During observation on 12/17/24 at 8:47 a.m., R146 was in bed in room with breakfast tray on bedside table in front of him. R146 had ground sausage, cream of wheat, two whole waffles, and an unpeeled hard-boiled egg. R146 struggled to peel the egg with one hand and used his left hand fingers to eat the sausage. Further, R164 attempted to open a plastic water bottle with his teeth. No staff were present to assist. During observation on 12/17/24 at 8:50 a.m., nursing assistant (NA)-A entered R164's room to drop off a watcher pitcher for his roommate and exited the room without acknowledging R146 or offering to assist. During observation on 12/17/24 at 8:51 a.m., NA-A re-entered R164's room and asked if he was done with his meal, picked up the tray and left the room. NA-A did not check R164's mouth for pocketing food. During observation and interview on 12/17/24 at 12:20 p.m., NA-A and NA-B into R164's room to transfer R164 from bed to wheelchair so maintenance could swap out his bed. NA-A and NA-B assisted R164 to a sitting position on the edge of the bed. NA-A and NA-B were on either side of R164 and assisted him to a standing position by grabbing R164's pants and guided him to pivot and lower onto the wheelchair. NA-A stated R164 was a pivot transfer and did not require a lift.	F 689	The nursing facility staff was in-serviced on the Safe Lift Moving Resident Policy which instructs the staff to work in conjunction with the therapy department to assess the need for transfer on an ongoing basis and that manual lifting of residents shall be eliminated as feasible. Nurse aides will refer to the Kardex care item to perform correct resident transfers. The Director of Nursing and/or designee is responsible for compliance. Audits on resident care plan for transfer status and visual resident transfers for appropriate transfers will begin 2 x week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take the audit results to QAPI for review and recommendations.		

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F 689	Continued From page 12 During interview on 12/17/24 at 12:33 p.m., NA-B stated when they transferred R164 from bed to chair he did not require a lift or a transfer belt and only required a gait belt when actually walking. During interview on 12/17/24 at 12:33 p.m., director of rehabilitation services (PT)-A stated R164 had not been cleared for pivot transfers and still required a Hoyer lift for transfers. PT-A stated expectation that staff would be transferring R164 using a Hoyer lift. During interview on 12/17/24 at 12:38 p.m., NA-A reviewed R164's electronic health record (EHR) and confirmed R164's transfer status was Hoyer lift. During interview on 12/17/24 at 12:45 p.m., NA-D stated expectation for NAs to sit next to R164 and supervise during meals and transfer using a Hoyer lift. During interview on 12/17/24 at 12:48 p.m., licensed practical nurse (LPN)-A stated staff should be transferring him with a Hoyer lift until cleared by therapy for a pivot transfer. During interview on 12/17/24 at 1:06 p.m., LPN-A stated staff should be supervising R164 during meals since he was on a dysphagia diet. During observation on 12/18/24 at 8:13 a.m., R164 was in bed, sitting up with breakfast tray in front of him. No staff present and call light in top drawer of nightstand out of his reach. His meal consisted of a whole omelet. When asked if he needed assistance with his meal, he just grunted.	F 689			

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F 689	Continued From page 13 During interview on 12/18/24 at 8:26 a.m., NA-C stated R164 did not need any supervision during meals and can be left alone in his room with a tray. During observation on 12/19/24 at 8:32 a.m., R164 was in bed with breakfast tray in front of him. No staff present. His meal consisted of scrambled eggs - which he was eating with his left hand fingers and not utensils, ground sausage, 2 whole muffins, and cream of wheat. During interview on 12/19/24 at 9:56 a.m., speech therapist (ST)-A stated R164 required a mechanical soft diet, with set up assistance and supervision throughout the meal. During interview on 12/19/24 at 10:15 a.m., director of nursing (DON) stated expectation that R164 would have supervision with meals which meant staff would sit with him throughout the meal. DON stated R164's food should be ground or cut up and should not be served whole. An unpeeled hard boiled egg was inappropriate. DON further stated expectation for staff to use the appropriate transfer method for each resident. R164 should be transferred with a Hoyer lift until cleared by therapy for stand and pivot. During interview on 12/19/24 at 10:31 a.m., food service director (FSD) stated R164 should not have been served a whole hard-boiled egg. Facility policy, Assisting the Impaired Resident with in-Room Meals dated 9/2013, instructed staff to, "Review the resident's care plan and provide for any special needs of the resident" and "Check the tray before serving it to the resident to be sure that it is the correct diet ordered and that the food			F 689			

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F 689	Continued From page 14 consistency is appropriate to the resident's ability to chew and swallow."	F 689			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 692			1/13/25
			F 692 ☐ D Nutrition Hydration		

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F 692	Continued From page 15 review, the facility failed to comprehensively assess and implement interventions to prevent weight loss for 1 of 2 residents (R1). The facility failed to ensure that the resident was set up with assistance for meals and failed to provide a nutritional supplement that was needed to implement interventions to prevent further weight lost for 1 of 2 residents (R1) who had a significant unplanned weight loss. Further finding includes: R1's admission record indicated, R1 was admitted on 10/23/23 with the following diagnosis: Vascular Dementia with sever agitation, Cardiomyopathy (enlargement of the heart), Dysphagia (difficulty swallowing), Major Depressive Disorder, Delusional Disorders (disorganized thoughts and actions), Psychosis, Crohn's Disease, Type 2 Diabetes Mellitius (controlled), Anxiety disorder, History of Transient ischemic attacks (TIA's), Atherosclerosis heart disease, Hypertension, Insomnia, and adult failure to thrive. R1's quarterly Minimum Data Set (MDS): BIMS 11, Severe cognitive impairment due to medical diagnosis. Resident was unable to interview due to mental status and severe sleepiness during the day and evening. R1's physician orders: 1) Trazodone HCl Oral Tablet (Trazodone HCl) 75mg by mouth every day. 2) Abilify Oral Tablet 5 MG (Aripiprazole)by mouth in the morning 3) Sertraline HCl Oral Tablet (Sertraline HCl) 150mg by mouth every day 4) Lansoprazole Oral Suspension 3 MG/ML			F 692	R1 was reweighed on 1/7/2025 and this weight was recorded in the resident electronic medical record. R1 will have meal preference completed, intake reviewed by dietary manager and Director of Nursing and new dietary interventions will be created as needed. R1 MD will be made aware of the review and the MD's response will be recorded in the resident medical record. R1 dietary care plan focus interventions for meal intake and supplement use was reviewed and updated as needed. All existing resident care plans for nutritional interventions for meal intake, supplements and weight monitoring were reviewed and updated as needed. Future residents will have nutritional interventions created, meal intake monitoring recorded correctly, and supplement acceptance documented and implemented per facility policy. Facility nursing staff will be in-serviced on the Weight Assessment and Intervention Policy with emphasis on weighing the residents and recording the results in the resident record and that the care plan will have interventions to address weight loss or gain. Dietary manager/dietitian and/or designee is responsible or compliance. Audits on care plan interventions for meal intake monitoring, resident supplement orders and supplement intake and resident weight entry into the resident		

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F 692	Continued From page 16 (Lansoprazole)Give 10 ml by mouth two times a day for GERD (30mg) Before meals. 5) Losartan Potassium Oral Tablet 25 MG (Losartan Potassium) Give 3 tablet by mouth one time a day for HTN (75mg) Goal below 140/90 6) Memantine HCl Oral Tablet 10 MG (Memantine HCl) Give 1 tablet by mouth two times a day for Severe vascular dementia with agitation. 7) Donepezil HCl Oral Tablet 5 MG (Donepezil Hydrochloride) 1 tab PO at HS 8)Divalproex Sodium Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) Give 2 tabs capsules by mouth two times a day 9) Monthly weight Notify provider if 5 pounds difference in re weight. (active 7/12/2024) Estimated. 10) Nutritional Needs: Calories: 1375 -1925 kcal (25-35kcal/kg) Protein: 44 -66 g (0.8-1.2g/kg) Fluids: 1375 -1925 ml (1ml/kcal) 11) Monitor Behaviors 1. yelling/screaming, 2. delusions 3. excessive crying. Interventions: A. try to redirect with 1:1 conversation, B. Take care of needs. After interventions was there I=improvement, N= no change, W=worsened in behavior. Quarterly Care Plan: On 11/17/24 the care plan stated that R1 is usually in bed and needs encouragement to get up. The resident has little or no activity involvement r/t Disinterest, resident wishes not to participate. · The resident will express satisfaction with type of activities and level of activity involvement when asked through the review date. · Establish and record the resident's prior	F 692	electronic medical record will begin 2xweek for 3 weeks, weekly x 2 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take the audit results to QAPI for review and recommendations.		

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F 692	Continued From page 17 level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary. Invite/ assist to activities of their choice. ·Remind the resident that they may leave activities at any time and is not required to stay for entire activity R1 requires assistance with setup for all meals. R1's dietary note dated 10/4/2024 10:27 a.m., indicated R1 has no significant weight changes noted. Weight fluctuations are expected related to psychosis and vascular dementia. R1 would like to maintain or slightly gain some weight, but also states are not concerned about it. Dietary Lead (DL) offered education, but R1 was not interested. DL notified R1 that there has been weight loss and encouraged R1 to keep trying to eat as much as she could including meals/snacks. R1 was informed they could ask to speak with the dietitian with any questions or concerns. No complaints of chewing or swallowing difficulties noted. R1 exhibits adequate nutrition as evidenced by stable weight and good intake records. Skin is monitored regularly by nursing staff with intakes appropriate for routine healing as needed. Potential for altered nutrition related to dx/hx. RD to follow per MDS or PRN. Reviewed new order for adding a house nutritional supplement three times a day between meals was placed by the MD on 10/17/2024 per recommendation of DL. On 11/14/24 a dietary note stated: Nutrition/ Hydration. R1 has a nutritional problem or potential nutritional problem r/t dx/hx of cerebral	F 692			

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F 692	Continued From page 18 aneurysm (not ruptured), Crohn's disease, delusional disorders, dysphagia, HTN, hyponatremia, depression, DM2, psychosis, vascular dementia. R1 will maintain adequate nutritional status as evidenced by maintaining weight within 5% of 118# or gain 3-4#/month to 125#, no s/sx of malnutrition, and consuming at least 50% of meals. R1 will continue to take dietary supplements as ordered between meals. R1 has no significant weight changes noted. Weight fluctuations are expected related to psychosis and vascular dementia. R1 states she eats well at meals and does drink the supplement that is brought to her several times each day. R1 states that her clothes continue to fit the same as normal. R1 would like to maintain or slightly gain some weight, but also states she is not concerned about it. DL offered education, but R1 was not interested. DL notified R1 that she has lost some weight and encouraged her to keep trying to eat as much as she can at meals/snacks. Resident was informed she could ask to speak with the dietitian if she had any questions or concerns. No complaints of chewing or swallowing difficulties noted. Resident exhibits potentially inadequate nutrition as evidenced by continued weight loss with good intake records. Skin is monitored regularly by nursing staff with intakes appropriate for routine healing as needed. Potential for altered nutrition related to dx/hx. RD to follow per MDS or PRN. EATING: The resident requires set up assistance with eating. Monthly weight review: 12/5/2024 12:25113.6 Lbs. Wheelchair 11/11/2024 14:09 115.6 Lbs. Wheelchair 10/8/2024 10:01118.2 Lbs. Wheelchair	F 692			

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F 692	Continued From page 19 9/4/2024 12:59 120.8 Lbs. Standing 8/22/2024 11:38 123.2 Lbs. Wheelchair 7/30/2024 11:41 124.4 Lbs. Wheelchair 5/31/2024 12:48 122.8 Lbs. Standing 4/11/2024 09:13 125.4 Lbs. Standing 3/5/2024 12:23 127.8 Lbs. Standing Resident has had significant weight loss since 9/24 to 12/16/24 this has resulted in a -5/96 weight loss. During an observation on 12/16/24 at 02:03 p.m., R1 was in bed with the room lights off and blankets overhead. During an observation on 12/16/24 at 05:36 p.m., R1 was brought a dinner tray at approx. 5:25p.m. and it was sitting on side table. R1 was lying in bed with blanket over head. The nurse's aide (NA-C) brought the tray in and set it down on the side table. NA-C did not set up or encourage R1 other than stating "here is your supper." During an observation on 12/16/24 at 06:01 p.m., R1 was still in bed and the dinner tray was taken out of R1 room by dietary and R1 didn't eat any food on dinner tray. Direct observation of the dinner tray showed that R1 had eaten 0% of meal. During an observation on 12/17/24 at 08:42 a.m., R1 still in bed with lights off and blanket over head. During an observation on 12/17/24 at 12:12 p.m., R1 is still in bed and does have tray in room. R1 dinner tray is still in room with all lids on and looks like it has not been touched. During an observation on 12/17/24 at 02:17 p.m.,			F 692			

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F 692	Continued From page 20 R1 is still in bed and has blanket over head, at this same time an interview with NA-C was conducted. NA-C explained that R1 doesn't like to get up normally, so they let R1 sleep. NA-C explained that it is R1's choice to get out of bed. NA-C was also interviewed on the dietary supplement and if they have ever seen it in R1 room and NA-C verified what a nutritional supplement was and stated no. During an interview on 12/17/24 at 02:47 p.m., the social service aide (SSA) noted that as far as diet and other concerns it seems that this should be addressed more by dietary and reviewed in R1 care plan. SSA was asked if they work with R1 as far as eating, mobility, or ADL assessment and SSA stated that they should try to get R1 up and moving. SSA stated "that the few times that I spoke with R1 I think R1 understands but doesn't respond". During an observation on 12/18/24 at 08:22 a.m., R1 is again in bed currently with the light on and does have a breakfast tray in room and has eaten 20% of tray. During an observation on 12/18/24 at 09:58 p.m., R1 is still in bed with head covered in blanket. R1 food tray is still in room since breakfast and staff have not asked R1 about needing anything while constant observation from 8:22am till 10:00am. During an interview on 12/18/24 at 11:25 a.m., with NA-C they stated that they tried to go into R1 room early this am and get R1 to sit up and leave the room, but R1 refused. When interviewed about helping with setting up R1 tray specifically NA-C explained that they don't because R1 is independent. However, during this interview R1	F 692			

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F 692	Continued From page 21 breakfast tray is still in room from this am. NA-C did state that they usually get R1 up into a chair for lunch and bring R1 out to the table unless R1 refuses. When asked if they chart behaviors NA-C stated that they don't usually. During an interview on 12/18/24 at 11:37 a.m., SSA did state that a conversation had happened with R1 last night and staff are going to work on getting R1 more active and monitor R1 eating habits. Currently there is no current note addressing the concerns. During an interview on 12/18/24 at 12:36 p.m., a phone call placed to the Dietary Lead (DL) and message was left to return phone call. D.L. returned phone call and explained that they are familiar with R1 and R1 usually tells me what R1 wants and is fine with current weight. D.L explained that they have her care planned for three dietary supplements between meals. R1 usually has them between meals because that is how R1 chooses to have them. D.L. explained that there has not been anything new about R1 weight changes and would expect the DON or nursing staff to tell the D.L. if weight loss continued. During an observation on 12/19/24 at 08:59 a.m., R1 is in bed and has been sleeping since breakfast. There has been no observation of a supplement in R1 room. During an interview on 12/19/24 at 09:03 a.m., with the food services director (FSD) concluded that the D.L. will provide them with the information if a supplement needs to be ordered for a resident. D.L. stated that all supplements usually come from nursing. Supplements are	F 692			

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F 692	Continued From page 22 usually stored in the dry storage and nursing has some in their refrigerator for the residents that need them. When asked if she was familiar with R1 and being on a supplement she stated no, but FSD was able to name other residents that were currently on a supplement. During an interview on 12/19/24 at 09:07 AM, the licensed practical nurse (LPN-B) was asked if was aware if R1 was on a supplement and where they would chart this information. LPN-B is on explained that R1 was not on a nutritional supplement and was looking at the regular computer to see if it was given during med passed. LPN-B explained that is R1 is care planned for a supplement that nursing would provide it and chart it on the MAR/TAR. LPN-B did go to the director of nursing (DON) and came back and stated that R1 was on a house supplement, but he couldn't find it on the MAR/TAR where they would normally sign this off. LPN- B was asked if he can show me the MAR/TAR and see if R1 is scheduled for the supplement. LPN-B explained that he didn't have access to that part of the computer and did state that if it was placed as an order that the expectation is for staffing (nurse) to be provide the supplement (house supplement). During an interview on 12/19/24 at 09:21 a.m., the DON was asked about the house supplement order and how what is there process for monitoring weights. The DON stated that the supplements are in the MAR for the nursing staff to provide and sign off like an order. The DON noticed that the order for a house dietary supplement was placed on 10/23/2024 for three times a day between meals. When DON			F 692			

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F 692	Continued From page 23 reviewed the MAR/TAR it was not present on the last 3 months since October when the order was originally placed. The DON did state "I don't see it on there and I would expect that it would have been on the MAR/ TAR when the order was initiated". When the DON noticed that the order was not followed, DON did state that the nursing staff wouldn't have known that R1 was scheduled for the supplement. The DON did state that the purpose of providing a nutritional supplement was to prevent weight loss and provide a nutritional supplement. During a chart review on 12/19/24 at 09:31 a.m., it was verified that there was no order or documentation on the October, November, and December (up until 12/19/24) of a house nutritional supplement to be provided between meals. During chart review of the daily/ monthly weight book R1 was not even listed in the book for monitoring weights or flagged for observing for significant weight loss. According to a facility policy named Weight Assessment and Intervention (revised March 2022), resident's weights are monitored for undesirable or unintended weight loss or gain. The facility failed to follow the portions of the policy that included weights are to be recorded in weight chart and evaluation for weight gain or loss will be noted in the resident's care plan and interventions or orders will be carried out per dietician, nursing staff, and provider.	F 692			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758			1/13/25

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F 758	Continued From page 24 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their			F 758			

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F 758	Continued From page 25 rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a PRN (as needed) psychotropic medication order included an end date for 1 of 1 residents (R16) reviewed for PRN psychotropic medications. Findings include: R14's quarterly Minimum Data Set (MDS) dated 10/24/24, indicated R14 had moderate cognitive impairment and diagnoses of lung cancer and depression. Furthermore, R14's MDS indicated R14 received hospice care and had received psychotropic medications for anxiety. R14's provider order dated 12/13/24, indicated R14 required Lorazepam concentrate (psychotropic medication for anxiety) 0.25milliliters (ml) every 4 hours PRN for anxiety. The order did not include a stop date. R14's Medication administration record (MAR) dated 12/2024 showed R14 had received Lorazepam on 12/13/24. When interviewed on 12/18/24 at 11:16 a.m., licensed practical nurse (LPN)-C verified R14's Lorazepam order did not include a stop date. LPN-C stated the order should be used for 14	F 758	F 758 ☐ D Free from unnecessary medication R 19 medications were reviewed and any PRN psychotropic medication without physician review, a stop date will be implemented, or the order will be discontinued per physician standing orders and facility policy. All other residents with PRN psychotropic medications, their orders will be reviewed, and a stop date will be added to the current order. For future residents receiving PRN psychotropic medications, an automatic stop date will be added to the order unless the physician rational is documented. Licensed nurses and the facility Health Unit Clerk will be in-serviced on the Psychotropic Medication Use Policy that unless identified, an automatic 14-day stop date will be included into the physician order and PRN orders cannot be renewed unless the physician evaluates the resident for continued use. The Director of Nursing and/or designee is responsible for compliance.		

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F 758	Continued From page 26 days unless the provider gave a reason. LPN-C stated R14 was received hospice care and usually the orders were written for longer time frame and wasn't sure why that wasn't included when entering the order. When interviewed on 12/18/24. At 8:31 p.m., the Director of Nursing (DON) expected all PRN psychotropic medications to have a stop date of 14 days. DON further stated Lorazepam could be used for longer than 14 days with provider justification. DON verified R14's order did not have a stop date and the hospice providers usually wrote for 90 days. DON wasn't sure where why R14's order did not reflect this and stated it would need to be corrected. When interviewed on 12/19/24 at 10:19 p.m., the consultant pharmacist stated all PRN psychotropic medications should be ordered for no longer than 14 days. If the medication is not an antipsychotic medication, the provider can order longer than the 14 days with documentation. However, the order still must include an end date. A facility policy titled Antipsychotic Medication Use revised 7/2022, directed PRN psychotropic medications needed beyond the 14 day use must include a documented rationale and the duration of use will be indicated in the order.	F 758	Audits on PRN psychotropic medication stop date will begin 2x week for x 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audits will be reviewed by the Executive Director and brought by the Executive Director to QAPI for review and recommendation.		
F 811 SS=D	Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3) §483.60(h) Paid feeding assistants- §483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if-	F 811			1/13/25

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F 811	Continued From page 27 (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law. §483.60(h)(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help. §483.60(h)(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents with difficulty swallowing were assisted with meals only by qualified individuals. Findings include: R164's admission Minimum Data Set (MDS) dated 12/6/24, indicated R164 had severe cognitive impairment, upper and lower extremity impairment of one side of the body, required	F 811	F 811 ☐ D Feeding Assistance R164 ADL care plan for eating and set up assistance was reviewed and updated as needed. There were no ill effects experienced during this deficient practice. All current residents who require ADL assistance for eating, their care plans will be reviewed and updated as needed. Future residents will be assessed upon admission, quarterly, significant change		

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F 811	Continued From page 28 substantial/maximal assistance with meals and a mechanically altered diet. R146 had three days of speech therapy and four days of occupational therapy in the seven day lookback period. R164's diagnoses included stroke, aphasia (condition limiting speech and understanding), dysphagia (condition affecting ability to swallow), and right-sided hemiplegia (paralysis affecting one side of the body). R164's December Care Task sheet indicated, "ADL [activities of daily living]-Eating: dependent of 1 watch for pocketing food." R164's physician order dated 12/4/24, indicated, "Resident is to be up in w/c for meals. Aides are to feed resident and check mouth for pocketing food." During observation on 12/17/24 at 8:47 a.m., R146 was in bed in room with breakfast tray on bedside table in front of him. R146 had ground sausage, cream of wheat, two whole waffles, and an unpeeled hard-boiled egg. R146 struggled to peel the egg and used his left hand fingers to eat the sausage. Further, R164 attempted to open a plastic water bottle with his teeth. No staff were present to assist. During observation on 12/17/24 at 8:50 a.m., nursing assistant (NA)-A entered R164's room to drop off a watcher pitcher for his roommate and exited the room without acknowledging R146 or offering to assist. During observation on 12/17/24 at 11:58 a.m., R164 was in the dining room in his wheelchair at a table by himself. Social services director (SSD) stood next to R164 while assisting him with his			F 811	and as needed for ADL eating assistance and the care plan intervention will be implemented. Licensed nurses and nurse aides will be in-serviced on the Assistance with Meals with emphasis on item #2 that directs the nursing team to serve trays and help/assist residents who require assistance with eating. Facility Social Services Director received 1:1 in-service education that only licensed nurses and trained nurse aides are allowed to feed residents. The Director of Nursing and/or designee is responsible for compliance. Audits on resident eating care plan assistance accuracy, visual audits on resident dining for appropriate nurse assistance will begin 2x week x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take the audit results to QAPI for review and recommendations.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/19/2024
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F 811	Continued From page 29 lunch. R164's lunch included ground pork, mashed potatoes, diced squash and slice of bread. During interview on 12/17/24 at 12:05 p.m., SSD stated not being an NA and just helping staff out since they seemed shorthanded. SSD stated never received any feeding assistance training. SSD stated R164 was "not a feeder" but had requested assistance so she wanted to help out. During interview on 12/17/24 at 1:06 p.m., licensed practical nurse (LPN)-A stated staff must be trained to be qualified to assist residents with meals. LPN-A stated R164 was on a dysphagia diet and anyone assisting him must be trained since he was at risk for choking. During interview on 12/17/24 at 1:17 PM, director of nursing (DON) stated SSD was not a trained feeding assistant and was not qualified to assist R164 with his meal since he was on a dysphagia diet. During interview on 12/19/24 at 9:56 a.m., speech therapist (ST)-A stated R164 was on a mechanical soft diet and required set up assistance and supervision with meals. ST-A stated staff were supposed to encourage R164 to eat in the dining room where there would be supervision, assist as needed with opening or arranging items and to offer cues and reminders to chew and swallow. ST-A stated R164 was not to eat alone until cleared by speech therapy. During follow up interview on 12/19/24 at 10:15 a.m., DON stated R164 should have supervision throughout his meal, should be provided an appropriate diet with items cut in small pieces.	F 811			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2025
FORM APPROVED
OMB NO. 0938-0391

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F 811	Continued From page 30 DON stated expectation only qualified staff would assist residents with meals. Facility policy Assisting the Impaired Resident with In-Room Meals dated 9/2013, identified a procedure for staff to provide appropriate support for residents who needed assistance with eating, but did not identify the need for assistance to be provided by only qualified staff. Facility written statement regarding paid feeding assistants (PFA), undated, indicated, "If the facility employs PFA, provide the following information: a) Whether the PFA training was provided through a State-approved training program by qualified professionals as defined by State law, with a minimum of 8 hours of training; b) A list of staff [including agency staff] who have successfully completed training for PFA, and who are currently assisting selected residents with eating meals and/or snacks; c) A list of residents who are eligible for assistance and who are currently receiving assistance from PDA: NONE."	F 811			

Minnesota Department of Health

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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 12/16/24-12/19/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

01/07/25

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H55441980C (MN00104072),H55441943C (MN00104942), H55441941C (MN00105894), H55441941C (MN00105912), H55441981C (MN00107348), H55441982C (MN00108253), H55441983C (MN00108393), H55441944C (MN00108363), and H55442441C (MN108940). No licensing orders were issued. 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 surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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	2 000			

Minnesota Department of Health

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2 000	Continued From page 2 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. 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.	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident was provided the appropriate therapeutic diet and meal supervision for 1 of 1 resident (R164)	2 830	Corrected		1/13/25

Minnesota Department of Health

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2 830	Continued From page 3 reviewed for nutrition. Further, the facility failed to ensure a resident was transferred from bed to wheelchair in a manner assessed safe for 1 of 2 residents (R164) observed during transfers. Findings include: R164's admission Minimum Data Set (MDS) dated 12/6/24, indicated R164 had severe cognitive impairment, upper and lower extremity impairment of one side of the body, required substantial/maximal assistance with most activities of daily living (ADL) including eating and transfers, and required a mechanically altered diet. R164's diagnoses included stroke, aphasia (condition limiting speech and understanding), dysphagia (condition affecting ability to swallow), and right-sided hemiplegia (paralysis affecting one side of the body). R164's care plan dated 12/5/24, indicated R165 had an ADL self-care performance deficit related to stroke and required total assist by one staff to eat and was totally dependent on one staff for transferring. R164's care plan Special Instructions indicated, "Hoyer lift." R164's Nutrition Assessment dated 12/6/24, indicated R164 required mechanically altered diet. R164's Falls Assessment dated 12/6/24, indicated R164 was at moderate risk for falls. R164's physician orders included, Mechanical soft diet, Mechanical soft textures" dated 11/30/24 and "Aides are to feed resident and check mouth for pocketing for food" dated 12/4/24. R164's Therapy to Nursing	2 830			

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2 830	Continued From page 4 Communication-Resident Status Update dated 12/2/24, indicated R164 required mechanical lift-Hoyer transfers. R164's occupational therapy notes dated 12/12/24, indicated OT (occupational therapist) reminded aides R164 required set up to eat meals. R164's physical therapy notes dated 12/17/24, indicated, "Nursing staff to continue to use Hoyer lift with pt [patient] for transfers." During interview on 12/16/24 at 2:48 p.m., family member (FM)-A stated R164 was receiving therapy to improve strength and independence but currently required assistance with transfers and meals. During observation on 12/17/24 at 8:47 a.m., R146 was in bed in room with breakfast tray on bedside table in front of him. R146 had ground sausage, cream of wheat, two whole waffles, and an unpeeled hard-boiled egg. R146 struggled to peel the egg with one hand and used his left hand fingers to eat the sausage. Further, R164 attempted to open a plastic water bottle with his teeth. No staff were present to assist. During observation on 12/17/24 at 8:50 a.m., nursing assistant (NA)-A entered R164's room to drop off a watcher pitcher for his roommate and exited the room without acknowledging R146 or offering to assist. During observation on 12/17/24 at 8:51 a.m., NA-A re-entered R164's room and asked if he was done with his meal, picked up the tray and left the room. NA-A did not check R164's mouth for pocketing food.	2 830			

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2 830	Continued From page 5 During observation and interview on 12/17/24 at 12:20 p.m., NA-A and NA-B into R164's room to transfer R164 from bed to wheelchair so maintenance could swap out his bed. NA-A and NA-B assisted R164 to a sitting position on the edge of the bed. NA-A and NA-B were on either side of R164 and assisted him to a standing position by grabbing R164's pants and guided him to pivot and lower onto the wheelchair. NA-A stated R164 was a pivot transfer and did not require a lift. During interview on 12/17/24 at 12:33 p.m., NA-B stated when they transferred R164 from bed to chair he did not require a lift or a transfer belt and only required a gait belt when actually walking. During interview on 12/17/24 at 12:33 p.m., director of rehabilitation services (PT)-A stated R164 had not been cleared for pivot transfers and still required a Hoyer lift for transfers. PT-A stated expectation that staff would be transferring R164 using a Hoyer lift. During interview on 12/17/24 at 12:38 p.m., NA-A reviewed R164's electronic health record (EHR) and confirmed R164's transfer status was Hoyer lift. During interview on 12/17/24 at 12:45 p.m., NA-D stated expectation for NAs to sit next to R164 and supervise during meals and transfer using a Hoyer lift. During interview on 12/17/24 at 12:48 p.m., licensed practical nurse (LPN)-A stated staff should be transferring him with a Hoyer lift until cleared by therapy for a pivot transfer.	2 830			

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2 830	Continued From page 6 During interview on 12/17/24 at 1:06 p.m., LPN-A stated staff should be supervising R164 during meals since he was on a dysphagia diet. During observation on 12/18/24 at 8:13 a.m., R164 was in bed, sitting up with breakfast tray in front of him. No staff present and call light in top drawer of nightstand out of his reach. His meal consisted of a whole omelet. When asked if he needed assistance with his meal, he just grunted. During interview on 12/18/24 at 8:26 a.m., NA-C stated R164 did not need any supervision during meals and can be left alone in his room with a tray. During observation on 12/19/24 at 8:32 a.m., R164 was in bed with breakfast tray in front of him. No staff present. His meal consisted of scrambled eggs - which he was eating with his left hand fingers and not utensils, ground sausage, 2 whole muffins, and cream of wheat. During interview on 12/19/24 at 9:56 a.m., speech therapist (ST)-A stated R164 required a mechanical soft diet, with set up assistance and supervision throughout the meal. During interview on 12/19/24 at 10:15 a.m., director of nursing (DON) stated expectation that R164 would have supervision with meals which meant staff would sit with him throughout the meal. DON stated R164's food should be ground or cut up and should not be served whole. An unpeeled hard boiled egg was inappropriate. DON further stated expectation for staff to use the appropriate transfer method for each resident. R164 should be transferred with a Hoyer lift until cleared by therapy for stand and pivot.	2 830			

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2 830	Continued From page 7 During interview on 12/19/24 at 10:31 a.m., food service director (FSD) stated R164 should not have been served a whole hard-boiled egg. Facility policy, Assisting the Impaired Resident with in-Room Meals dated 9/2013, instructed staff to, "Review the resident's care plan and provide for any special needs of the resident" and "Check the tray before serving it to the resident to be sure that it is the correct diet ordered and that the food consistency is appropriate to the resident's ability to chew and swallow." Facility policy, Safe Lifting and Moving of Residents dated July, 2017, indicated the goal was "this facility uses appropriate techniques and devices to lift and move residents." The policy instructed nursing staff to work in conjunction with the rehabilitation staff to assess resident needs for transfer assistance. The care plan should reflect the resident transferring needs. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830			
2 950	MN Rule 4658.0530 Subp. 2 A-F Assistance with Eating - Volunteers	2 950			1/13/25

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2 950	Continued From page 8 Subp. 2. Volunteers. Volunteers may assist residents with eating if the following conditions are met: A. the nursing home has a policy allowing that assistance. The policy must specify whether family members are allowed to assist their immediate relatives with eating and, if allowed, what training is required for family members; B. the resident has been assessed and a determination made that the resident may be safely fed by a volunteer, and that is documented in the comprehensive plan of care; C. the resident has agreed, or an immediate family member, the legal guardian, or designated representative has agreed for the resident, to be fed by a volunteer; D. the volunteer has completed a training program on assisting residents with eating, which, at a minimum, meets the training and competency standards for eating assistance contained in the nursing assistant training curriculum; E. the director of nursing services must be responsible for the monitoring of all persons, including family members, performing this activity; and F. there are mechanisms in place to ensure appropriate reporting to nursing personnel of observations made by the volunteer during meal time. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents with difficulty swallowing were assisted with meals	2 950	Corrected		

Minnesota Department of Health

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2 950	Continued From page 9 only by qualified individuals. Findings include: R164's admission Minimum Data Set (MDS) dated 12/6/24, indicated R164 had severe cognitive impairment, upper and lower extremity impairment of one side of the body, required substantial/maximal assistance with meals and a mechanically altered diet. R146 had three days of speech therapy and four days of occupational therapy in the seven day lookback period. R164's diagnoses included stroke, aphasia (condition limiting speech and understanding), dysphagia (condition affecting ability to swallow), and right-sided hemiplegia (paralysis affecting one side of the body). R164's December Care Task sheet indicated, "ADL [activities of daily living]-Eating: dependent of 1 watch for pocketing food." R164's physician order dated 12/4/24, indicated, "Resident is to be up in w/c for meals. Aides are to feed resident and check mouth for pocketing food." During observation on 12/17/24 at 8:47 a.m., R146 was in bed in room with breakfast tray on bedside table in front of him. R146 had ground sausage, cream of wheat, two whole waffles, and an unpeeled hard-boiled egg. R146 struggled to peel the egg and used his left hand fingers to eat the sausage. Further, R164 attempted to open a plastic water bottle with his teeth. No staff were present to assist. During observation on 12/17/24 at 8:50 a.m., nursing assistant (NA)-A entered R164's room to drop off a watcher pitcher for his roommate and	2 950			

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2 950	Continued From page 10 exited the room without acknowledging R146 or offering to assist. During observation on 12/17/24 at 11:58 a.m., R164 was in the dining room in his wheelchair at a table by himself. Social services director (SSD) stood next to R164 while assisting him with his lunch. R164's lunch included ground pork, mashed potatoes, diced squash and slice of bread. During interview on 12/17/24 at 12:05 p.m., SSD stated not being an NA and just helping staff out since they seemed shorthanded. SSD stated never received any feeding assistance training. SSD stated R164 was "not a feeder" but had requested assistance so she wanted to help out. During interview on 12/17/24 at 1:06 p.m., licensed practical nurse (LPN)-A stated staff must be trained to be qualified to assist residents with meals. LPN-A stated R164 was on a dysphagia diet and anyone assisting him must be trained since he was at risk for choking. During interview on 12/17/24 at 1:17 PM, director of nursing (DON) stated SSD was not a trained feeding assistant and was not qualified to assist R164 with his meal since he was on a dysphagia diet. During interview on 12/19/24 at 9:56 a.m., speech therapist (ST)-A stated R164 was on a mechanical soft diet and required set up assistance and supervision with meals. ST-A stated staff were supposed to encourage R164 to eat in the dining room where there would be supervision, assist as needed with opening or arranging items and to offer cues and reminders to chew and swallow. ST-A stated R164 was not	2 950			

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2 950	Continued From page 11 to eat alone until cleared by speech therapy. During follow up interview on 12/19/24 at 10:15 a.m., DON stated R164 should have supervision throughout his meal, should be provided an appropriate diet with items cut in small pieces. DON stated expectation only qualified staff would assist residents with meals. Facility policy Assisting the Impaired Resident with In-Room Meals dated 9/2013, identified a procedure for staff to provide appropriate support for residents who needed assistance with eating, but did not identify the need for assistance to be provided by only qualified staff. Facility written statement regarding paid feeding assistants (PFA), undated, indicated, "If the facility employs PFA, provide the following information: a) Whether the PFA training was provided through a State-approved training program by qualified professionals as defined by State law, with a minimum of 8 hours of training; b) A list of staff [including agency staff] who have successfully completed training for PFA, and who are currently assisting selected residents with eating meals and/or snacks; c) A list of residents who are eligible for assistance and who are currently receiving assistance from PDA: NONE." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to appropriate use of non-nursing staff or paid feeding assistants. The DON or designee could re-educate all staff on policies and procedures, changes to care plans, and the results of assessments for those identified at risk for choking/swallowing issues. The DON or designee could develop a system for evaluating and	2 950			

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2 950	Continued From page 12 monitoring consistent implementation of policies and procedures and audits to ensure compliance. . The results of those measurable audits should be routinely brought to the facility's Quality Assurance Performance Improvement (QAPI) committee to determine ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 950			
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and implement interventions to prevent weight loss for 1 of 2 residents (R1). The facility failed to ensure that the resident was set up with assistance for meals and failed to provide a nutritional supplement that was needed to implement interventions to prevent further weight lost for 1 of 2 residents (R1) who had a significant unplanned weight loss. Further finding includes:	2 965	Corrected	1/13/25	

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2 965	Continued From page 13 R1's admission record indicated, R1 was admitted on 10/23/23 with the following diagnosis: Vascular Dementia with sever agitation, Cardiomyopathy (enlargement of the heart), Dysphagia (difficulty swallowing), Major Depressive Disorder, Delusional Disorders (disorganized thoughts and actions), Psychosis, Crohn's Disease, Type 2 Diabetes Mellitius (controlled), Anxiety disorder, History of Transient ischemic attacks (TIA's), Atherosclerosis heart disease, Hypertension, Insomnia, and adult failure to thrive. R1's quarterly Minimum Data Set (MDS): BIMS 11, Severe cognitive impairment due to medical diagnosis. Resident was unable to interview due to mental status and severe sleepiness during the day and evening. R1's physician orders: 1) Trazodone HCl Oral Tablet (Trazodone HCl) 75mg by mouth every day. 2) Abilify Oral Tablet 5 MG (Aripiprazole)by mouth in the morning 3) Sertraline HCl Oral Tablet (Sertraline HCl) 150mg by mouth every day 4) Lansoprazole Oral Suspension 3 MG/ML (Lansoprazole)Give 10 ml by mouth two times a day for GERD (30mg) Before meals. 5) Losartan Potassium Oral Tablet 25 MG (Losartan Potassium) Give 3 tablet by mouth one time a day for HTN (75mg) Goal below 140/90 6) Memantine HCl Oral Tablet 10 MG (Memantine HCl) Give 1 tablet by mouth two times a day for Severe vascular dementia with agitation. 7) Donepezil HCl Oral Tablet 5 MG (Donepezil Hydrochloride) 1 tab PO at HS 8)Divalproex Sodium Oral Capsule Delayed	2 965			

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2 965	Continued From page 14 Release Sprinkle 125 MG (Divalproex Sodium) Give 2 tabs capsules by mouth two times a day 9) Monthly weight Notify provider if 5 pounds difference in re weight. (active 7/12/2024) Estimated. 10) Nutritional Needs: Calories: 1375 -1925 kcal (25-35kcal/kg) Protein: 44 -66 g (0.8-1.2g/kg) Fluids: 1375 -1925 ml (1ml/kcal) 11) Monitor Behaviors 1. yelling/screaming, 2. delusions 3. excessive crying. Interventions: A. try to redirect with 1:1 conversation, B. Take care of needs. After interventions was there I=improvement, N= no change, W=worsened in behavior. Quarterly Care Plan: On 11/17/24 the care plan stated that R1 is usually in bed and needs encouragement to get up. The resident has little or no activity involvement r/t Disinterest, resident wishes not to participate. · The resident will express satisfaction with type of activities and level of activity involvement when asked through the review date. · Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary. Invite/ assist to activities of their choice. ·Remind the resident that they may leave activities at any time and is not required to stay for entire activity R1 requires assistance with setup for all meals. R1's dietary note dated 10/4/2024 10:27 a.m., indicated R1 has no significant weight changes noted. Weight fluctuations are expected related to psychosis and vascular dementia. R1 would like	2 965			

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2 965	Continued From page 15 to maintain or slightly gain some weight, but also states are not concerned about it. Dietary Lead (DL) offered education, but R1 was not interested. DL notified R1 that there has been weight loss and encouraged R1 to keep trying to eat as much as she could including meals/snacks. R1 was informed they could ask to speak with the dietitian with any questions or concerns. No complaints of chewing or swallowing difficulties noted. R1 exhibits adequate nutrition as evidenced by stable weight and good intake records. Skin is monitored regularly by nursing staff with intakes appropriate for routine healing as needed. Potential for altered nutrition related to dx/hx. RD to follow per MDS or PRN. Reviewed new order for adding a house nutritional supplement three times a day between meals was placed by the MD on 10/17/2024 per recommendation of DL. On 11/14/24 a dietary note stated: Nutrition/ Hydration. R1 has a nutritional problem or potential nutritional problem r/t dx/hx of cerebral aneurysm (not ruptured), Crohn's disease, delusional disorders, dysphagia, HTN, hyponatremia, depression, DM2, psychosis, vascular dementia. R1 will maintain adequate nutritional status as evidenced by maintaining weight within 5% of 118# or gain 3-4#/month to 125#, no s/sx of malnutrition, and consuming at least 50% of meals. R1 will continue to take dietary supplements as ordered between meals. R1 has no significant weight changes noted. Weight fluctuations are expected related to psychosis and vascular dementia. R1 states she eats well at meals and does drink the supplement that is brought to her several times each day. R1 states that her clothes continue to fit the same as	2 965			

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2 965	Continued From page 16 normal. R1 would like to maintain or slightly gain some weight, but also states she is not concerned about it. DL offered education, but R1 was not interested. DL notified R1 that she has lost some weight and encouraged her to keep trying to eat as much as she can at meals/snacks. Resident was informed she could ask to speak with the dietitian if she had any questions or concerns. No complaints of chewing or swallowing difficulties noted. Resident exhibits potentially inadequate nutrition as evidenced by continued weight loss with good intake records. Skin is monitored regularly by nursing staff with intakes appropriate for routine healing as needed. Potential for altered nutrition related to dx/hx. RD to follow per MDS or PRN. EATING: The resident requires set up assistance with eating. Monthly weight review: 12/5/2024 12:25113.6 Lbs. Wheelchair 11/11/2024 14:09 115.6 Lbs. Wheelchair 10/8/2024 10:01118.2 Lbs. Wheelchair 9/4/2024 12:59 120.8 Lbs. Standing 8/22/2024 11:38 123.2 Lbs. Wheelchair 7/30/2024 11:41 124.4 Lbs. Wheelchair 5/31/2024 12:48122.8 Lbs. Standing 4/11/2024 09:13 125.4 Lbs. Standing 3/5/2024 12:23 127.8 Lbs. Standing Resident has had significant weight loss since 9/24 to 12/16/24 this has resulted in a -5/96 weight loss. During an observation on 12/16/24 at 02:03 p.m., R1 was in bed with the room lights off and blankets overhead. During an observation on 12/16/24 at 05:36 p.m., R1 was brought a dinner tray at approx. 5:25p.m.	2 965			

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2 965	Continued From page 17 and it was sitting on side table. R1 was lying in bed with blanket over head. The nurse's aide (NA-C) brought the tray in and set it down on the side table. NA-C did not set up or encourage R1 other than stating "here is your supper." During an observation on 12/16/24 at 06:01 p.m., R1 was still in bed and the dinner tray was taken out of R1 room by dietary and R1 didn't eat any food on dinner tray. Direct observation of the dinner tray showed that R1 had eaten 0% of meal. During an observation on 12/17/24 at 08:42 a.m., R1 still in bed with lights off and blanket over head. During an observation on 12/17/24 at 12:12 p.m., R1 is still in bed and does have tray in room. R1 dinner tray is still in room with all lids on and looks like it has not been touched. During an observation on 12/17/24 at 02:17 p.m., R1 is still in bed and has blanket over head, at this same time an interview with NA-C was conducted. NA-C explained that R1 doesn't like to get up normally, so they let R1 sleep. NA-C explained that it is R1's choice to get out of bed. NA-C was also interviewed on the dietary supplement and if they have ever seen it in R1 room and NA-C verified what a nutritional supplement was and stated no. During an interview on 12/17/24 at 02:47 p.m., the social service aide (SSA) noted that as far as diet and other concerns it seems that this should be addressed more by dietary and reviewed in R1 care plan. SSA was asked if they work with R1 as far as eating, mobility, or ADL assessment and SSA stated that they should try to get R1 up and	2 965			

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2 965	Continued From page 18 moving. SSA stated "that the few times that I spoke with R1 I think R1 understands but doesn't respond". During an observation on 12/18/24 at 08:22 a.m., R1 is again in bed currently with the light on and does have a breakfast tray in room and has eaten 20% of tray. During an observation on 12/18/24 at 09:58 p.m., R1 is still in bed with head covered in blanket. R1 food tray is still in room since breakfast and staff have not asked R1 about needing anything while constant observation from 8:22am till 10:00am. During an interview on 12/18/24 at 11:25 a.m., with NA-C they stated that they tried to go into R1 room early this am and get R1 to sit up and leave the room, but R1 refused. When interviewed about helping with setting up R1 tray specifically NA-C explained that they don't because R1 is independent. However, during this interview R1 breakfast tray is still in room from this am. NA-C did state that they usually get R1 up into a chair for lunch and bring R1 out to the table unless R1 refuses. When asked if they chart behaviors NA-C stated that they don't usually. During an interview on 12/18/24 at 11:37 a.m., SSA did state that a conversation had happened with R1 last night and staff are going to work on getting R1 more active and monitor R1 eating habits. Currently there is no current note addressing the concerns. During an interview on 12/18/24 at 12:36 p.m., a phone call placed to the Dietary Lead (DL) and message was left to return phone call. D.L. returned phone call and explained that they are familiar with R1 and R1 usually tells me what R1	2 965			

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2 965	Continued From page 19 wants and is fine with current weight. D.L explained that they have her care planned for three dietary supplements between meals. R1 usually has them between meals because that is how R1 chooses to have them. D.L. explained that there has not been anything new about R1 weight changes and would expect the DON or nursing staff to tell the D.L. if weight loss continued. During an observation on 12/19/24 at 08:59 a.m., R1 is in bed and has been sleeping since breakfast. There has been no observation of a supplement in R1 room. During an interview on 12/19/24 at 09:03 a.m., with the food services director (FSD) concluded that the D.L. will provide them with the information if a supplement needs to be ordered for a resident. D.L. stated that all supplements usually come from nursing. Supplements are usually stored in the dry storage and nursing has some in their refrigerator for the residents that need them. When asked if she was familiar with R1 and being on a supplement she stated no, but FSD was able to name other residents that were currently on a supplement. During an interview on 12/19/24 at 09:07 AM, the licensed practical nurse (LPN-B) was asked if was aware if R1 was on a supplement and where they would chart this information. LPN-B is on explained that R1 was not on a nutritional supplement and was looking at the regular computer to see if it was given during med passed. LPN-B explained that is R1 is care planned for a supplement that nursing would provide it and chart it on the MAR/TAR. LPN-B did go to the director of nursing (DON) and came	2 965			

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2 965	Continued From page 20 back and stated that R1 was on a house supplement, but he couldn't find it on the MAR/TAR where they would normally sign this off. LPN- B was asked if he can show me the MAR/TAR and see if R1 is scheduled for the supplement. LPN-B explained that he didn't have access to that part of the computer and did state that if it was placed as an order that the expectation is for staffing (nurse) to be provide the supplement (house supplement). During an interview on 12/19/24 at 09:21 a.m., the DON was asked about the house supplement order and how what is there process for monitoring weights. The DON stated that the supplements are in the MAR for the nursing staff to provide and sign off like an order. The DON noticed that the order for a house dietary supplement was placed on 10/23/2024 for three times a day between meals. When DON reviewed the MAR/TAR it was not present on the last 3 months since October when the order was originally placed. The DON did state "I don't see it on there and I would expect that it would have been on the MAR/ TAR when the order was initated". When the DON noticed that the order was not followed, DON did state that the nursing staff wouldn't have known that R1 was scheduled for the supplement. The DON did state that the purpose of providing a nutritional supplement was to prevent weight loss and provide a nutritional supplement. During a chart review on 12/19/24 at 09:31 a.m., it was verified that there was no order or documentation on the October, November, and December (up until 12/19/24) of a house nutritional supplement to be provided between meals.	2 965			

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2 965	Continued From page 21 During chart review of the daily/ monthly weight book R1 was not even listed in the book for monitoring weights or flagged for observing for significant weight loss. According to a facility policy named Weight Assessment and Intervention (revised March 2022), resident's weights are monitored for undesirable or unintended weight loss or gain. The facility failed to follow the portions of the policy that included weights are to be recorded in weight chart and evaluation for weight gain or loss will be noted in the resident's care plan and interventions or orders will be carried out per dietician, nursing staff, and provider. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee should ensure dietary interventions are implemented in a timely manner. The facility should review and/or update or create policies and procedures, and educate staff on specific requirements or interventions related to weight and nutrition. The administrator, registered dietician, or designee should perform audits for a measurable amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items given, offered, or consumed by residents are implemented as identified or ordered. The facility should 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.	2 965			
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights	21805			1/13/25

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21805	Continued From page 22 Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a dignified dining experience for 1 of 1 residents (R164) reviewed for dignity. Findings include: R164's admission Minimum Data Set (MDS) dated 12/6/24, indicated R164 had severe cognitive impairment, upper and lower extremity impairment of one side of the body, required substantial/maximal assistance with meals and a mechanically altered diet. R164's diagnoses included stroke, aphasia (condition limiting speech and understanding), dysphagia (condition affecting ability to swallow), and right-sided hemiplegia (paralysis affecting one side of the body). R164's care plan dated 12/5/24, indicated R164 had activities of daily living (ADL) self-care performance deficit related to stroke and was "able to eat independent after set up by staff using a divided plate." R164's physician order dated 12/4/24, indicated, "Resident is to be up in w/c for meals. Aides are to feed resident and check mouth for pocketing food."	21805	Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/19/2024
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
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21805	Continued From page 23 During observation on 12/17/24 at 8:47 a.m., R146 was in bed in room with breakfast tray on bedside table in front of him. R146 had ground sausage, cream of wheat, two whole waffles, and an unpeeled hard-boiled egg. R146 struggled to peel the egg and used his left hand fingers to eat the sausage. Further, R164 attempted to open a plastic water bottle with his teeth. No staff were present to assist. During observation on 12/17/24 at 8:50 a.m., nursing assistant (NA)-A entered R164's room to drop off a watcher pitcher for his roommate and exited the room without acknowledging R146 or offering to assist. During observation on 12/17/24 at 11:58 a.m., R164 was in the dining room in his wheelchair at a table by himself, and empty stationary chair sat next to him. Social services director (SSD) stood next to R164 while assisting him with his lunch. During interview on 12/17/24 at 12:05 p.m., SSD stated not being an NA and just helping staff out since they seemed shorthanded. SSD stated never received any feeding assistance training and saw the empty chair next to R164 but assumed it was being saved for another resident. SSD stated R164 was "not a feeder" but had requested assistance so she wanted to help out. SSD was not aware that standing while assisting was considered undignified. During interview on 12/17/24 at 12:48 p.m., licensed practical nurse (LPN)-A stated staff should not stand over a resident while assisting with meals as it was not a dignified experience when they stood over them. During interview on 12/17/24 at 12:51 p.m.,	21805			

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21805	Continued From page 24 director of nursing (DON) stated expectation staff would sit next to a resident when assisting with meals to provide a dignified dining experience. During interview on 12/19/24 at 9:56 a.m., speech therapist (ST)-A stated R164 was on a mechanical soft diet and required set up assistance and supervision with meals. ST-A stated staff were supposed to assist R164 with meals as needed with opening or arranging items until cleared by speech therapy. Facility policy Assisting the Impaired Resident with In-Room Meals dated 9/2013, instructed staff to check food for appropriate consistency prior to serving and to position a chair next to the resident where it would be convenient for staff and resident to assist with the meal. Facility policy Quality of Life-Dignity dated 2/2020, indicated, staff should not 'label' a resident or refer to them by their care needs. The policy indicated, "Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity an assist residents." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805			

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21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a call light was accessible for 1 of 3 residents (R164) reviewed for call lights. Findings include: R164's admission Minimum Data Set (MDS) dated 12/6/24, indicated R164 had severe cognitive impairment, upper and lower extremity impairment of one side of the body, required substantial/maximal assistance with most activities of daily living (ADL). R164's diagnoses included stroke, aphasia (condition limiting speech and understanding), and right-sided hemiplegia (paralysis affecting one side of the body). R164's care plan dated 12/5/24, indicated R164 was at risk for falls r/t (related to) CVA (cerebral vascular accident) affecting right dominant side of body. The care plan instructed staff to ensure resident's call light was within reach and to encourage him to use it.	21810	Corrected		1/13/25

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21810	Continued From page 26 During observation on 12/16/24 at 1:20 p.m., R164 door was open and visible from the hallway. R164 was awake in bed with call light inside the top drawer of his nightstand out of his reach. During observation on 12/17/24 at 8:47 a.m., R146 was in bed in room with breakfast tray on bedside table in front of him. R146 had ground sausage, cream of wheat, two whole waffles, and an unpeeled hard-boiled egg. R146 struggled to peel the egg and used his left hand fingers to eat the sausage. Further, R164 attempted to open a plastic water bottle with his teeth. No staff were present to assist. R164's call light was inside the top drawer of his nightstand out of his reach. During observation on 12/17/24 at 10:08 a.m., R164's door was closed. R164 was in bed , awake, and call light in top drawer of his nightstand out of his reach. During observation on 12/18/24 at 8:13 a.m., R164 was in bed, sitting up with breakfast tray in front of him. No staff present and call light in top drawer of nightstand out of his reach. His meal consisted of a whole omelet. When asked if he needed assistance with his meal, he just grunted. During interview on 12/18/24 at 8:26 a.m., nursing assistant (NA)-C stated R164 was capable of using the call light. NA-C confirmed R164's call light was in his top drawer of his nightstand, out of reach. NA-C stated the call light should be close to the residents and within reach. During interview on 12/19/24 at 10:15 a.m., director of nursing (DON) stated expectation that R164 would have call light within reach at all times.	21810			

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21810	Continued From page 27 Facility policy Answering the Call Light dated 9/2022, indicated, "Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor." SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have their call lights within reach. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810			
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is	21830			1/13/25

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21830	Continued From page 28 unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that	21830			

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21830	Continued From page 29 the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food preferences of the resident were honored and implemented for 1 of 2 residents (R24) reviewed for choices.	21830	Corrected		

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21830	Continued From page 30 Findings include: R24's Medical Diagnosis form indicated the following diagnoses: multiple sclerosis (a disease in which the immune system eats away at the protective covering of the nerves), type II diabetes mellitus with hyperglycemia (high blood sugar), major depressive disorder and adjustment disorder. R24's Clinical Physician orders form indicated a diabetic diet encourage fluids, regular texture, and thin liquids consistency. R24's dietary slip on the breakfast tray on 12/18/24 indicated Diet- CCHO - Regular (Consistent Carbohydrate Diet), Liquids - Thin . Orange juice, grits and sausage link were crossed out. Observation on 12/18/24 at 8:00 a.m., the staff brought R24's breakfast tray, which consisted of 8 oz orange juice, 8 oz of milk, a bowl of frosted flakes, a piece of toast and an omelet. Interview on 12/18/24 at 8:05 a.m., R24 indicated that R24 had requested no orange juice. R24 indicated it comes on the breakfast tray every morning even though he/she requests no orange juice. Interview on 12/18/24 at 8:30 a.m., the Food Service Director(FSD) indicated the dietary aide is responsible for verifying the resident menu slip. The FSD indicated residents should get what they want as long as it is within the ordered diet. R24's care plan dated 12/18/24 indicated a nutritional problem or potential nutritional problem	21830			

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21830	Continued From page 31 related to Multiple sclerosis, and diabetes mellitus. Goal was to maintain adequate status as evidenced by maintaining weight within 5% of 146#, no signs and symptom of malnutrition, and consuming at least 50% of meals. Interventions indicated to provide and serve diet as ordered Review of the Resident Food Preferences policy dated 7/2017 indicated individual food preference will be assessed on admission, and when possible staff will interview the resident to determine food preferences. SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident choices and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then aduit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830			

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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 12/18/2024. 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

Electronically Signed

TITLE

(X6) DATE

01/07/2025

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	K 000			
K 232 SS=D	The facility has a capacity of 79 beds and had a census of 60 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation a review of available documentation and staff interview, the facility failed to maintain the corridor width per NFPA 101 (2012 edition), Life Safety Code, section 19.2.3.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/18/2024 at 10:30 AM, it was revealed by observation the corridor width in the service corridor was deminished to 40 inches and did not meet the required 48 inches due to laundry carts being stored in the corridor. An interview with the administrator verified this	K 232	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent informal dispute resolution session, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board.	1/13/25	

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K 232	Continued From page 3 deficient finding at the time of discovery.	K 232	The facility immediately corrected the practice of not maintaining corridor of 48 inches due to laundry cart storage. The carts have been relocated as not to obstruct the requirment of 48 inches in the corridor. Laundry staff and Maitainance has beed educated on requirements of maintaining 48 inches in the corridor. Monitoring will consist of audits twice weekly for 30 days. Results of audits will be reviewed by the Administrator and also QAPI Committee. The Administrator shall be responsible for the audits to ensure compliance.		
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K 353			1/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 4 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.4.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 12/18/2024 between 09:30 AM and 11:00 AM, it was revealed by a review of available documentation that the deficiency listed below was noted on the annual sprinkler inspection report dated 7/16/2024, and at the time of the survey the facility did not have documentation showing it had been repaired. -The piping from the fire department connection to the fire department check valve shall be hydrostatically tested at 150 PSI (10 Bar) for 2 hours at least once every 5 years. An interview with the Administrator verified this deficient finding at the time of discovery.	K 353	The facility has corrected the practice of having fire protection vendor: to have the fire department connection to the fire department check valve hydrostatically tested. Documentation of such test will be maintained by the Administrator for review. The facility will have the system hydrostatically tested once every 5 years as required. Documentation audits will occur weekly for 30 days to ensure documentation is present in the facility life safety binder. The Administrator is responsible for compliance and will conduct the audits and have them reviewed in the facilities QAPI meeting.		
K 711 SS=C	Evacuation and Relocation Plan 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.	K 711			1/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 711	Continued From page 5 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 a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/18/2024 between 09:30 AM and 11:00 AM, it was revealed by a review of available documentation that the fire safety plan that was provided at the time of the survey did not include the Transmission of the fire alarms to the fire department. An interview with the Administrator verified this deficient finding at the time of discovery.	K 711	The fire safety plan has been edited to include "Transmission of the fire alarms to the fire department". Staff have been educated that the fire alarms transmitt to the fire department. The policy revision which includes: "Transmission of the fire alarms to the fire department" has been included in the facilities Emergency Preparedness plan. The Administrator is responsible for compliance. The Administrator will audit the edited fire safety plan once a week for 30 days.		