Electronically delivered
September 22, 2020

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

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

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 September 3, 2020, a survey was completed at your facility by the Minnesota Department of Health, 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.
- 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" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140

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 December 3, 2020 (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 March 3, 2021 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's

informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 09/03/2020

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

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F 000	INITIAL COMMENTS On 9/1/20 to 9/3/20, an abbreviated standard survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5544145C The following complaints were found to be unsubstantiated: H5544144C H5544146C H5544147C H5544148C H5544149C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,	F 580		10/1/20

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

Electronically Signed | 09/23/2020

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F 580	Continued From page 1 consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in	F 580		

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F 580	Continued From page 2 §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident representatives were notified of a change in condition or treatment for 2 of 3 residents (R3, R1) who experienced a change in condition or whose medication therapy was changed. Findings include: R3 R3's admission Minimum Data Set (MDS) dated 7/9/20, identified R3 had moderate cognitive impairment and diagnoses which included cerebrovascular accident (stroke), hemiplegia or hemiparesis (weakness to complete paralysis on one side of the body), encounter for orthopedic aftercare following surgical amputation, acquired absence of right leg below knee, malnutrition and urinary incontinence. The MDS indicated R3 required set up help only with eating, was independent with locomotion off the unit and required extensive assistance with all other activities of daily living. R3's Care Plan dated 7/6/20, indicated R3 had a psychosocial well-being problem potential related to illness/disease process, diagnosis of sepsis, type two diabetes with right foot diabetic ulcer, anemia, lacunar stroke (type of ischemic stroke that occurs when blood flow to one of the small	F 580	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 dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. I. Resident R3 was permanently discharged from the facility on 8/31/20. Resident R1 was appointed a court appointed guardian on 9/1/20. A comprehensive care plan meeting is scheduled with court appointed guardian. II. Change of condition policy has been reviewed by the Administrator and DON. The DON/designee has reviewed the past 30 days progress notes/24-hour reports to identify change of resident change of condition. If documentation lacked family notification, the DON/designee notified the family member of change. III. The following measures have taken	

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F 580	Continued From page 3 arteries deep within the brain become blocked) and hyperlipidemia. R3's care plan listed various interventions which included staff to increase communication between R3, family and caregivers about care and living environment; explain all procedures and treatments, medications, results of labs/tests, condition, all changes, rules, and options. On 9/2/20, at 8:53 a.m. family member-(A) indicated she had concerns regarding the facility's lack of communication of changes in R3's condition. FM-A indicated R3 had experienced three infections within 2 weeks and had a urinalysis completed, however, she was unsure of the results of the laboratory tests. FM-A stated R3 had received antibiotics for all three infections and ultimately required hospitalization and surgery to drain an abscess. FM-A stated during this time, she had been in contact with R3 who on one occasion had been confused and reported to her he felt "delusional". FM-A indicated she had been "doing the footwork to contact them [the facility]" and "sometimes it felt like days" before she could get in contact with anyone. FM-A stated she would call the facility's main number, her call would be transferred and would "ring forever" and would then transfer back to reception. She would ask to leave a message and no one would return her call. FM-A indicated she had left messages for the nurses and social worker. However, the social worker's voicemail was full so she could not leave a voicemail. FM-A denied being notified when R3 was diagnosed with UTI or pneumonia and indicated she would have expected the facility to contact her as she was his primary emergency contact. FM-A indicated the facility had not even contacted her until "hours later" when R3 had been discharged	F 580	place to prevent reoccurrence. The Administrator and DON have reviewed the policy and updated accordingly. Transfers and residents' change status are reviewed during clinical meeting. If documentation is lacking notification of family/representative, the DON/designee will notify family/designated representative of said change. The facility has added a on call nurse to be notified of any transfers to hospital of change of status and verify family/designated representative has been notified. Licensed nursing staff have been educated on notification of change by staff development RN. New hire orientation will include change of resident condition/status notification by the Staff Development RN. IV. Compliance audits on notification of change shall be performed weekly for 60 days and results/findings reported immediately to the Administrator. Compliance audit findings and results will also be addressed monthly in QAPI for family/representative notification compliance. The Administrator or designee shall be responsible for ongoing compliance.	

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to the hospital and stated R3 had informed her of his admission to the hospital before the facility had done so.

Review of R3's Progress Notes dated 8/14/20 to 8/28/20 revealed the following:

-8/14/20, at 10:43 a.m. resident is running a temp (101.6, 99.6, 101.8 [degrees Fahrenheit]). NP (nurse practitioner) and nurse manager updated. Resident is alert and oriented x 3, no shortness of breath/weakness noted. Resident is incontinent of bowel and bladder, he at 30% of breakfast. Tylenol 650 [milligrams] administered, COVID-19 test was done by nurse manager, resident was put on airborne precaution. Resident vitals is every 4 hours, lab order sent to lab, still awaiting their arrival. Will continue to monitor.

-8/14/20 at 10:34 p.m. New order for cefadroxil (antibiotic) will start 8/15/20 for UTI [urinary tract infection].

-8/15/20 at 6:47 p.m. urinalysis and urine culture results faxed. Call placed to the on-call [provider], no new order but to continue with cefadroxil antibiotic medication until primary [physician] is updated.

-8/18/20 at 1:38 pm. Social Service Note: Care conference held today with R3, therapy, nurse manager, activities, social worker and family member (FM)-A via phone conference. Medications reviewed. Code status DNR [do not resuscitate]. R3 has case manager and spouse in the community. Weight is 240 pounds. Family would like R3 to return home, however, would need to walk in the bathroom. Therapy will continue to work with R3 toward goals. The care

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conference notes did not identity R3's family had been notified of the UTI and antibiotic use.

-8/22/20 at 12:39 a.m. Resident is on antibiotics, BP is within the limit but resident is running high fever. Temperature is within 99 and 100 [degrees Fahrenheit]. Need to follow up with the NP about the antibiotic medication because of no improvement.

-8/22/20 at 2:37 p.m. resident appears weak and refused getting up from bed. It is reported that resident was running a fever during the previous shift. NP notified and has stat lab order and chest X-ray. Lab drawn and pending result.

-8/22/20 at 6:16 p.m. Resident started on antibiotic cefuroxime and azithromycin medications for pneumonia.

R3's medical record lacked documentation R3's representative had been notified of the changes in condition and treatments related to UTI or pneumonia.

On 9/2/20, at 10:51 a.m. the director of nursing (DON) stated if there was a change in a resident's condition it should documented in a progress note right away and the physician or nurse practitioner and family were to be notified immediately or within 2 hours.

On 9/02/20, at 1:29 p.m. FM-B indicated he had heard of R3's change in condition from FM-A and even though he had told the facility to notify him of any changes, they had never done so. FM-B indicated he had called the facility and tried to talk to a nurse but would not get a reply or "they would say wait a minute and not get back to me." FM-B

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denied notification of R3's UTI, pneumonia or hospitalization and stated he was given "no kind of notification at all".

On 9/2/20, at 2:04 p.m. licensed practical nurse (LPN)-C stated for any resident change in condition, she contacted the supervisor, resident physician and then the resident family. LPN-C stated this should be documented in a progress note.

On 9/2/20, at 2:19 p.m. LPN-A stated if a resident experienced a change in condition she would first update the nurse manager and the nurse practitioner. LPN-A stated she would also call the family but the documentation depended on the type of change, and indicated something like a bruise would be documented in a progress note. LPN-A stated she had called FM-A when R3 had a fever. LPN-A confirmed the progress note she completed on dated 8/14/20, did not indicate she had called family but stated she remembered talking to FM-A on the phone.

On 9/2/20, at 3:14 p.m. LPN-D stated would notify the primary doctor, family and the DON as soon as a resident experienced a change in condition and document in the notification in the progress notes. LPN-D verified his note dated 8/22/20 at 6:16 p.m. did not include documentation family had been notified of R3's pneumonia, however indicated R3 had not been his assigned resident at the time; he had just been helping out to enter orders.

On 9/2/20, at 3:32 p.m. DON confirmed R3's record lacked documentation family had been notified of R3's UTI or pneumonia and indicated she would have expected family to have been

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notified when the NP was contacted.

R1

R1 Significant Change of Status Minimum Data Set (MDS) dated 8/19/20, indicated R1 had diagnoses which included traumatic brain dysfunction, schizophrenia, and post traumatic stress disorder. The MDS indicated R1 had severe cognitive impairment and identified R1's behaviors of care rejection or wandering which worsened compared to prior assessments.

R1's Cognitive Loss/Dementia CAA dated 8/19/20 indicated Cognitive loss has triggered by R1 experiencing long and short term memory impairment. Contributing factors include diagnosis of acute kidney disease, schizoaffective disorder, panic disorder, history of alcohol use, acute kidney failure, boarder line personality disorder. HIV. R1 was confused and required redirection. R1 had a wander guard and guardianship in progress as resident unable to make own decisions.

R1's progress noted dated 8/28/20, at 12.54 p.m. stated R1 was seen by the in-house psychiatrist on 8/25/2020 with the following orders: discontinue (D/C) risperidone (an antipsychotic medications), add Prozac (an antidepressant) 20 milligram (mg) every AM for three (3) weeks, then increase to 40 mg every AM DX: depression, and follow-up on 10/20/20.

On 9/2/2020, at 1:56 p.m. during telephone interview with R1's family member (FM)-C she stated the facility did not really keep in contact with her about changes with her R1. FM-C stated

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if anything happened it was usually her mother who calls her with updates. FM-C stated she had not been informed in the change on medications ordered on 8/28/20, and stated she would like to have known the changes due to the effect the changes could have on her mood and was concerned with the order to discontinue her risperidone. FM-C also stated she had been trying to contact the facility to check because she understood R1 needed a follow up with neurology due to recent tremors and an eye doctor due to changes in R1's eyes.

On 9/2/20, at 3:18 p.m. licensed practical nurse (LPN)-B stated if a resident had a change in health status, fall, accident, went to the hospital or changes in significant medications the resident representative should be notified as soon as possible.

On 9/2/20, at 3:14 p.m. registered nurse (RN)-A stated family should be informed whenever there is a change of condition of resident, if they go to the hospital, have a fall, injury or accident, and if there were any changes in residents' medications due to a provider visit. Upon review of R1's documentation, she could not verify if representative had been called and could not recall calling them. RN-A stated they should have been called.

An undated facility policy titled, Change in Resident's Condition or Status, indicated the facility would promptly notify the resident, his or her attending physician and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The policy directed unless

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F 580	Continued From page 9 otherwise instructed by the resident, the nurse supervisor/charge nurse would notify the resident's family or representative (sponsor) when: a. The resident is involved in any accident or incident that results in injury including injuries of an unknown source; b. There is a significant change in the resident's physical, mental, or psychosocial status; c. There is a need to change the resident's room assignment; d. A decision has been made to discharge the resident from the facility; and/or e. It is necessary to transfer the resident to a hospital/treatment center. The policy further indicated except in medical emergencies, notifications would be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.	F 580		

Electronically delivered
September 22, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: IO6V11

Dear Administrator:

The above facility was surveyed on September 1, 2020 through September 3, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

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

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

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

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

Gail Anderson, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	C 09/03/2020

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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 9/1/20 thru 9/3/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be not in compliance with the MN State Licensure. The following complaint was found to be SUBSTANTIATED with a licensing order issued.	2 000		

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2 000	Continued From page 1 H5544145C The following complaints were found to be UNSUBSTANTIATED: H5544144C H5544146C H5544147C H5544148C H5544149C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention;	2 265		10/1/20

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2 265	Continued From page 2 B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident representatives were notified of a change in condition or treatment for 2 of 3 residents (R3, R1) who experienced a change in condition or whose medication therapy was changed. Findings include: R3 R3's admission Minimum Data Set (MDS) dated 7/9/20, identified R3 had moderate cognitive impairment and diagnoses which included cerebrovascular accident (stroke), hemiplegia or hemiparesis (weakness to complete paralysis on one side of the body), encounter for orthopedic aftercare following surgical amputation, acquired absence of right leg below knee, malnutrition and urinary incontinence. The MDS indicated R3 required set up help only with eating, was	2 265	Corrected	

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2 265	Continued From page 3 independent with locomotion off the unit and required extensive assistance with all other activities of daily living. R3's Care Plan dated 7/6/20, indicated R3 had a psychosocial well-being problem potential related to illness/disease process, diagnosis of sepsis, type two diabetes with right foot diabetic ulcer, anemia, lacunar stroke (type of ischemic stroke that occurs when blood flow to one of the small arteries deep within the brain become blocked) and hyperlipidemia. R3's care plan listed various interventions which included staff to increase communication between R3, family and caregivers about care and living environment; explain all procedures and treatments, medications, results of labs/tests, condition, all changes, rules, and options. On 9/2/20, at 8:53 a.m. family member-(A) indicated she had concerns regarding the facility's lack of communication of changes in R3's condition. FM-A indicated R3 had experienced three infections within 2 weeks and had a urinalysis completed, however, she was unsure of the results of the laboratory tests. FM-A stated R3 had received antibiotics for all three infections and ultimately required hospitalization and surgery to drain an abscess. FM-A stated during this time, she had been in contact with R3 who on one occasion had been confused and reported to her he felt "delusional". FM-A indicated she had been "doing the footwork to contact them [the facility]" and "sometimes it felt like days" before she could get in contact with anyone. FM-A stated she would call the facility's main number, her call would be transferred and would "ring forever" and would then transfer back to reception. She would ask to leave a message and no one would return her call. FM-A indicated	2 265		

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2 265	Continued From page 4	2 265		

she had left messages for the nurses and social worker. However, the social worker's voicemail was full so she could not leave a voicemail. FM-A denied being notified when R3 was diagnosed with UTI or pneumonia and indicated she would have expected the facility to contact her as she was his primary emergency contact. FM-A indicated the facility had not even contacted her until "hours later" when R3 had been discharged to the hospital and stated R3 had informed her of his admission to the hospital before the facility had done so.

Review of R3's Progress Notes dated 8/14/20 to 8/28/20 revealed the following:

-8/14/20, at 10:43 a.m. resident is running a temp (101.6, 99.6, 101.8 [degrees Fahrenheit]). NP (nurse practitioner) and nurse manager updated. Resident is alert and oriented x 3, no shortness of breath/weakness noted. Resident is incontinent of bowel and bladder, he at 30% of breakfast. Tylenol 650 [milligrams] administered, COVID-19 test was done by nurse manager, resident was put on airborne precaution. Resident vitals is every 4 hours, lab order sent to lab, still awaiting their arrival. Will continue to monitor.

-8/14/20 at 10:34 p.m. New order for cefadroxil (antibiotic) will start 8/15/20 for UTI [urinary tract infection].

-8/15/20 at 6:47 p.m. urinalysis and urine culture results faxed. Call placed to the on-call [provider], no new order but to continue with cefadroxil antibiotic medication until primary [physician] is updated.

-8/18/20 at 1:38 pm. Social Service Note: Care conference held today with R3, therapy, nurse

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2 265	Continued From page 5	2 265		

manager, activities, social worker and family member (FM)-A via phone conference. Medications reviewed. Code status DNR [do not resuscitate]. R3 has case manager and spouse in the community. Weight is 240 pounds. Family would like R3 to return home, however, would need to walk in the bathroom. Therapy will continue to work with R3 toward goals. The care conference notes did not identity R3's family had been notified of the UTI and antibiotic use.

-8/22/20 at 12:39 a.m. Resident is on antibiotics, BP is within the limit but resident is running high fever. Temperature is within 99 and 100 [degrees Fahrenheit]. Need to follow up with the NP about the antibiotic medication because of no improvement.

-8/22/20 at 2:37 p.m. resident appears weak and refused getting up from bed. It is reported that resident was running a fever during the previous shift. NP notified and has stat lab order and chest X-ray. Lab drawn and pending result.

-8/22/20 at 6:16 p.m. Resident started on antibiotic cefuroxime and azithromycin medications for pneumonia.

R3's medical record lacked documentation R3's representative had been notified of the changes in condition and treatments related to UTI or pneumonia.

On 9/2/20, at 10:51 a.m. the director of nursing (DON) stated if there was a change in a resident's condition it should documented in a progress note right away and the physician or nurse practitioner and family were to be notified immediately or within 2 hours.

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2 265	Continued From page 6 On 9/02/20, at 1:29 p.m. FM-B indicated he had heard of R3's change in condition from FM-A and even though he had told the facility to notify him of any changes, they had never done so. FM-B indicated he had called the facility and tried to talk to a nurse but would not get a reply or "they would say wait a minute and not get back to me." FM-B denied notification of R3's UTI, pneumonia or hospitalization and stated he was given "no kind of notification at all". On 9/2/20, at 2:04 p.m. licensed practical nurse (LPN)-C stated for any resident change in condition, she contacted the supervisor, resident physician and then the resident family. LPN-C stated this should be documented in a progress note. On 9/2/20, at 2:19 p.m. LPN-A stated if a resident experienced a change in condition she would first update the nurse manager and the nurse practitioner. LPN-A stated she would also call the family but the documentation depended on the type of change, and indicated something like a bruise would be documented in a progress note. LPN-A stated she had called FM-A when R3 had a fever. LPN-A confirmed the progress note she completed on dated 8/14/20, did not indicate she had called family but stated she remembered talking to FM-A on the phone. On 9/2/20, at 3:14 p.m. LPN-D stated would notify the primary doctor, family and the DON as soon as a resident experienced a change in condition and document in the notification in the progress notes. LPN-D verified his note dated 8/22/20 at 6:16 p.m. did not include documentation family had been notified of R3's pneumonia, however indicated R3 had not been his assigned resident at the time; he had just been helping out to enter	2 265		

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2 265	Continued From page 7 orders. On 9/2/20, at 3:32 p.m. DON confirmed R3's record lacked documentation family had been notified of R3's UTI or pneumonia and indicated she would have expected family to have been notified when the NP was contacted. R1 R1 Significant Change of Status Minimum Data Set (MDS) dated 8/19/20, indicated R1 had diagnoses which included traumatic brain dysfunction, schizophrenia, and post traumatic stress disorder. The MDS indicated R1 had severe cognitive impairment and identified R1's behaviors of care rejection or wandering which worsened compared to prior assessments. R1's Cognitive Loss/Dementia CAA dated 8/19/20 indicated Cognitive loss has triggered by R1 experiencing long and short term memory impairment. Contributing factors include diagnosis of acute kidney disease, schizoaffective disorder, panic disorder, history of alcohol use, acute kidney failure, boarder line personality disorder. HIV. R1 was confused and required redirection. R1 had a wander guard and guardianship in progress as resident unable to make own decisions. R1's progress noted dated 8/28/20, at 12.54 p.m. stated R1 was seen by the in-house psychiatrist on 8/25/2020 with the following orders: discontinue (D/C) risperidone (an antipsychotic medications), add Prozac (an antidepressant) 20 milligram (mg) every AM for three (3) weeks, then increase to 40 mg every AM DX: depression, and follow-up on 10/20/20.	2 265		

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2 265	Continued From page 8 On 9/2/2020, at 1:56 p.m. during telephone interview with R1's family member (FM)-C she stated the facility did not really keep in contact with her about changes with her R1. FM-C stated if anything happened it was usually her mother who calls her with updates. FM-C stated she had not been informed in the change on medications ordered on 8/28/20, and stated she would like to have known the changes due to the effect the changes could have on her mood and was concerned with the order to discontinue her risperidone. FM-C also stated she had been trying to contact the facility to check because she understood R1 needed a follow up with neurology due to recent tremors and an eye doctor due to changes in R1's eyes. On 9/2/20, at 3:18 p.m. licensed practical nurse (LPN)-B stated if a resident had a change in health status, fall, accident, went to the hospital or changes in significant medications the resident representative should be notified as soon as possible. On 9/2/20, at 3:14 p.m. registered nurse (RN)-A stated family should be informed whenever there is a change of condition of resident, if they go to the hospital, have a fall, injury or accident, and if there were any changes in residents' medications due to a provider visit. Upon review of R1's documentation, she could not verify if representative had been called and could not recall calling them. RN-A stated they should have been called. An undated facility policy titled, Change in Resident's Condition or Status, indicated the facility would promptly notify the resident, his or her attending physician and representative (sponsor) of changes in the resident's	2 265		

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medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The policy directed unless otherwise instructed by the resident, the nurse supervisor/charge nurse would notify the resident's family or representative (sponsor) when:
a. The resident is involved in any accident or incident that results in injury including injuries of an unknown source;
b. There is a significant change in the resident's physical, mental, or psychosocial status;
c. There is a need to change the resident's room assignment;
d. A decision has been made to discharge the resident from the facility; and/or
e. It is necessary to transfer the resident to a hospital/treatment center.
The policy further indicated except in medical emergencies, notifications would be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing (DON) or designee could develop policies and procedures to ensure each resident's representative is promptly notified of all changes in condition and/or changes in treatments. The DON or designee could educate all appropriate staff on the policies/procedures, and monitor to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty One (21) Days.