Electronically delivered
December 7, 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 October 9, 2020, we notified you a remedy was imposed. On November 16, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 13, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 8, 2020 be discontinued as of November 13, 2020. (42 CFR 488.417 (b))

Also, as we notified you in our letter of On October 9, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 8, 2020. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

Electronically delivered

November 10, 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 November 4, 2020 we informed you that we were imposing enforcement remedies.

On October 26, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On October 26, 2020, the situation of immediate jeopardy to potential health and safety cited at F622 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

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

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

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

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

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of

an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 3, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

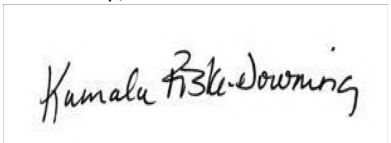
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
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 10/26/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/21/20 through 10/26/20 an abbreviated 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: H5544160C, with a deficiency cited at F622. The following complaints were found to be unsubstantiated: H5544161C and H5544162C. The survey resulted in an Immediate Jeopardy (IJ) at F622 when the facility failed to allow 1 of 1 residents (R1) to return to the facility after being sent to the hospital under suspicion of alcohol intake and behavioral issues. The facility refused to allow R1 back into the facility. This resulted in an immediate jeopardy (IJ) for R1 when she ran out of money by 10/22/20 and had no access to food or transportation. The IJ that began on 10/19/20, was removed on 10/26/20. 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/10/2020

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

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F 000	Continued From page 1 regulations has been attained in accordance with your verification.	F 000		
F 622 SS=J	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident	F 622		11/13/20

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F 622	Continued From page 2	F 622		

exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.

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F 622	Continued From page 3 (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to allow 1 of 1 residents (R1) to return to the facility after being sent to the hospital under suspicion of alcohol intake and behavioral issues. The facility refused to accept R1 back to the facility after they were discharged from the hospital on 10/19/20. When R1 returned to the facility, she was not allowed into the facility, was provided with a motel room, cab fare, and $50 for food until she could possibly get into housing in 7 days. This resulted in an immediate jeopardy (IJ) for R1 when she ran out of money by 10/22/20, housing was not secured, and had no access to food or transportation. The IJ began on 10/19/20, at 6:15 p.m. when the facility refused to allow R1 to reenter the facility following R1's discharge from the North Memorial Hospital emergency room, and identified on 10/22/20. The administrator, director of nursing (DON) were informed of the IJ on 10/22/20, at 5:20 p.m. The immediate jeopardy was removed on 10/26/20, but noncompliance remained at the lower scope and severity of a D-isolated scope and severity, which indicated no actual harm with potential for more than minimal harm, that is not	F 622	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 R6 has been discharged on 10/26/20 to community housing as scheduled. II. The Social Worker has reviewed residents who were discharged to the community from November 1st. The review included but was not limited to completion of the following documented discharge plan, care plan, community	

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F 622	Continued From page 4 immediate jeopardy. Findings include: R1's admission Minimum Data Set dated 9/2/20, included cognitively intact, with diagnoses including alcoholic cirrhosis of the liver, and hypertension. R1 exhibited behaviors directed towards others daily which did not put the resident or other residents at risk of physical injury, but did significantly disrupt cares or living environment. R1 was independent with most activities of daily living (ADL's). The MDS directed staff to assess the areas of: psychosocial wellbeing, mood state, and behavioral symptoms. R1's Psychosocial Well-being Care Area Assessment (CAA) dated 9/2/20, included, "Resident has conflicts with family, friends, roommate, other residents, or staff. Resident reports she has a fiance', however is unable to discharge to his house. Resident claims she is homeless. Resident is non compliant with COVID restrictions of not leaving the building and isolating in her room for 14 days. Resident has a history of substance abuse, including alcohol abuse. Resident on COVID restrictions for 14 days, however non compliant with restrictions. Resident in private room, however walks around the facility and leaves to go to 'medical appointment' that she schedules herself. Resident is currently homeless, however has a strong desire to discharge to the community. Working with relocation services." The CAA indicated R1 would be referred to house psychologist. The area would be addressed in the care plan to, "minimize risks."	F 622	coordinator, discharge planning meeting with resident and discharge summary reviewed and sent with resident. III. The Administrator and Director of Nursing have reviewed and revised the policy and procedure for discharge. Staff were educated on revised policy by Staff Development/designee. Social Worker maintains an active list of residents pending community discharge to verify compliance with facility policy and procedure. IV. The Administrator and Social Worker have developed an audit tool to assure compliance with facility policy and procedures for resident discharge. Audits will be completed for residents discharged starting 11/1/20. All findings will be reported to the QAPI monthly for follow-up recommendation.	

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F 622	Continued From page 5	F 622		

R1's Behavioral Symptoms CAA dated 9/2/20, Included, "Resident being verbally abusive, not in agreement with COVID restrictions. Resident does not understand the process of relocation and finding housing. Resident would like things instantly." "Resident swears, cries and yells when things do not go the way she wants them to. When redirected resident gets defensive and verbally abusive." R4's barriers were listed as poor rental history, lack of income, and alcohol and substance abuse. This area would be addressed in R1's care plan.

R1's care plan, revised 10/19/20, identified, "Focus; Discharge plan: [R1] is currently homeless. She would like to discharge to the community. Barriers to discharge lack of income, history of chemical and substance abuse. Working with Best Life Relocation Services. Goal; [R1] will be discharged to least restrictive environment. Interventions; Damage deposit assistance, Link to community resources, Working with Best Life Relocation Services." R1's care plan indicated a focus of hypertension and indicated the need to monitor blood pressure. R1's care plan dated 10/19/20, also included, "[R1] is a vulnerable adult due to her residing in a care center for short term rehab," and alcohol withdrawal, delirium, cirrhosis, and polysubstance abuse, as well as being verbally abusive to others. The goal was, "Resident will remain safe in this environment thru," with a target date of 12/31/20. Interventions included a behavior contract, Resident agreed to avoid dining room at these times to stay away from another resident: 9:30-10; 11-11:30; 6:30-7; and 8-8:15. followed by house psychologist and rule 25 assessment/referral (substance abuse assessment and referral). R1's adjustment

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F 622	Continued From page 6	F 622		

disorder care plan directed staff to, "Learn to recognize and identify stressors which may be early warning signs of problem behavior. Intervene and remove stressors where possible."

R1's care plan dated 10/19/20, also included, "[R1] potential to demonstrate verbally abusive behaviors r/t [related to] ineffective coping skills, poor impulse control. History of alcohol and substance abuse. yelling and swearing. Difficult to redirect." Staff were directed to, "Assess resident's coping skills and support system. Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation. Provide positive feedback for good behavior. Emphasize positive aspects of compliance." "[R1] has a behavior problem r/t leaving the facility whenever she wants. Not following COVID restrictions. Stating that she has a doctors appointment and being gone all day." Staff were directed to, "Explain all procedures to [R1] before starting and allow [R1] to voice her concerns related to adjust and changes. Praise any indication of compliance with facility rules progress/improvement in behavior."

R1's progress note dated 10/19/20, at 2:35 p.m. written by SW-A included, "SS [social worker] called residents primary care clinic. Put phone on speaker phone Physician gave order to DON send resident into North Memorial for 72 hour hold." R1's record lacked any other notes regarding transfer or discharge on 10/19/20.

R1's facility verbal order form, dated 10/19/20, included, "Per medical doctor [MD-I], ok to send resident to North Memorial Hospital for 72 hour hold r/t [related to] homocida [sic]/verbal

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	245544	A. BUILDING _____ B. WING _____	C 10/26/2020

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

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F 622	Continued From page 7	F 622		

aggression."

North Memorial ED (emergency department) Provider Note, dated 10/19/20, indicated R1 admitted to drinking alcohol on 10/19/20. R1 wished to go back to the facility because she had housing that would be available at the end of the week. The note identified the hospital had discussed returning R1 to the facility with, "nursing facility manager," who refused to accept R1 back secondary to, "recurrent and escalating agitated behavior." The note included, "She denies any suicidal or homicidal ideation."

R1's North Memorial Emergency Department Face Sheet, dated 10/19/20, identified she had left the hospital emergency room on 10/19/20, at 5:54 p.m.

When interviewed on 10/21/20, at 3:17 p.m. SW-A stated, R1 was supposed to have been discharged to an apartment on 10/19/20. On 10/19/20, R1 had packed up all of her belongings and was ready to go when they received notice the apartment would not be ready until 10/26/20, due to either the landlord was not available to sign the lease, didn't have the keys, or the apartment was not ready. When notified of this, R1 left the building indicating she had a doctor's appointment. SW-A stated often when R1 goes out to a doctor's appointment, this is not really where she had gone, she had gone out to drink. When she returns from these, "appointments," SW-A showed air quotes with her hands, R1 will exhibit behaviors. When R1 came back on 10/19/20, she had a, "meltdown," swearing, making lunging motions at staff, and was uncontrollable. SW-A stated the police were called and the ambulance came to take her on a

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F 622	Continued From page 8	F 622		

72 hour hold. SW-A was not aware of what happened with R1 after that, other than she was on a leave of absence (LOA).

When interviewed on 10/21/20, at 3:27 p.m. the administrator stated, R1 had been discharged from the hospital a couple hours after being sent there on a 72 hour hold on 10/19/20. When she returned, R1 did not provide any paperwork from the hospital. "She came back yelling, hollering, kicking at the door, the police were called." The administrator stated he knew staff did not allow R1 back into the building, he was busy, "getting her stuff together." The administrator stated, the facility was looking for an amicable, safe, defusing of the situation and sent her to the Super 8 motel. R1 had declined the Motel 6 they had offered, but was agreeable to the Super 8. "We prepaid for a cab, gave her money for food and they have a breakfast buffet." The administrator did not know if the hospital had called to say R1 was on her way back or not, "she just showed up." They had checked to ensure the motel had breakfast in the morning and had given her $70 for cab fare and food. In addition had paid for the motel room through 10/26/20. The administrator felt this was a safe discharge plan for R1.

When interviewed on 10/21/20, at 3:37 p.m. the DON stated, on 10/19/20, "She [R1] wanted to physically fight me, we were worried about her behavior towards other residents." R1's physician was contacted and gave an order to send R1 to the hospital on a 72 hour hold. However, the hospital discharged her, the DON did not know why R1 had not stayed the 72 hours. R1 said she did not want to come back to the nursing facility, but the, "landlord is holding it up [her discharge to

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F 622	Continued From page 9	F 622		

an apartment]." R1 came back a couple hours later as the hospital had discharged her. The DON stated, the hospital had not called them prior to discharging her and R1 had just shown up. The DON stated, she shad met R1 at the front door with her medications with printed instructions on the medication cards. She had reviewed medications with R1 and gave them to her to take to the motel. The DON stated earlier in the day on 10/19/20, R1 had requested her laundry be done by the facility and she had packed up all of her belongings as she had expected to discharge on that day. No written instructions for the medications or discharge instructions were sent with, because R1 was on, "LOA." DON stated the expectation is when a resident is discharged a resident is given a discharge summary that summarizes the resident's stay at the facility and medications instructions in a form the resident can understand.

When interviewed on 10/21/20, at 3:45 p.m. a Minneapolis precinct 4 officer stated, 2 calls from Victory Health and Rehab had been placed to the police department on 10/19/20, the first one included R1 was, "making gestures that was going to assault," and the second call was for, "an unwanted person on the premises, a female ordered a cab and left without incident, paid for by Victory."

When interviewed on 10/21/20, at 3:56 p.m. the financial director (FD)-A stated, he had instructed the front desk receptionist to contact him if the hospital called about R1. The hospital called and wanted to know why R1 was sent there, FD-A, "explained the situation." When the hospital called back later he told them he had grave

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	245544	A. BUILDING _____ B. WING _____	C 10/26/2020

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F 622	Continued From page 10	F 622		

concerns about the safety of other residents and requested the hospital find alternative placement for R1. The hospital had found her a, "new place," but R1, "showed up here kicking the door, she had attacked the receptionist once before." The door was locked, as normal, R1 was in the vestibule, the police came, she calmed down and was agreeable to going to a motel. R1 wanted to go to the Super 8, so they arranged for the motel, gave her money for food and transportation until Monday, the 10/26/20, when she could go to her apartment. The FD-A stated they had provided R1 with $70 cash and, "she has $50 in incidentals at the hotel." It was noted upon survey entrance R1's medical record was under the, "discharged residents," section. However, had been moved back to current resident section. FD-A stated, this was moved in error, R1 was only on LOA. FD-A stated all of R1's belongings were packed up and by the window in the conference room. Boxes of items were observed to be in the corner of the room by the window. FD-A verified, R1 was unable to take her things when she went to the hotel.

When interviewed on 10/21/20, at 4:11 p.m. R1's resident representative, (RR)-H stated she was the primary contact for R1. RR-H indicated facility did not contact her regarding R1's discharge. RR-H stated she found out about R1's discharge, when R1 appeared at her house a day later with her significant other.

When interviewed on 10/21/20, at 5:52 p.m. R1's county transition coordinator (TC)-B stated he was not informed by the facility that R1 had discharged to a motel arranged by the facility. TC-B indicated R1's apartment transfer was not finalized yet due to pending financing. TC-B

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	245544	A. BUILDING _____ B. WING _____	C 10/26/2020

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F 622	Continued From page 11	F 622		

stated he had been working with the facility to assist with securing funding assistance through Hennepin County nursing facility liaison (NFL)-C. TC-B indicated he did not feel it was safe for R1 to discharge to a motel without services being set up prior to discharge. TC-B indicated that support services including assistance with meals, chemical dependency treatment and PCA (personal care attendant) for R1 could not be initiated while she was in the motel and while the facility had listed R1 as on an LOA and not discharged. It was possible, but not probable, at this point that R1's apartment financing would be secured by 10/26/20.

When interviewed on 10/22/20, at 7:57 a.m. via telephone, R1 stated, she left the hospital emergency room by cab on 10/19/20, and went directly to the facility. R1 indicated she was met at the front door by the finance director (FD)-A and he refused her entrance to the facility. R1 stated she was given her medications by the DON and no discharge paperwork or discharge instructions, and did not know how to take her medications. R1 stated she did not understand the medication instructions on the back of the medication cards (envelope containing medications). R1 stated she had only the clothes she wore upon leaving for the hospital on 10/19/20, and really needed additional clothing and personal items. The facility had not allowed her to take any of her belongings. "They gave me $50 to eat, how am I going to survive on $50 until Monday?" "They helped me with nothing, what am it supposed to do after this?" "I have no money to eat or get a bus and I am hungry." R1 stated the facility had taken all of her belongings out of her room and put them in a room near the front door of the facility, but she had no access to

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F 622	Continued From page 12	F 622		

get them. The hotel did not have even a breakfast for guests.

When interviewed on 10/22/20, at 8:39 a.m. the Super 8 Motel front desk operator (FDO)-D stated the motel had not offered a breakfast bar or any meal service for over 3 months due to COVID-19 safety precautions. FDO-D stated each guest is given one bottle of water and one fruit bar (fruit roll up type) per day.

When interviewed on 10/22/20, at 9:35 a.m. North Memorial registered nurse (RN)-A indicated, R1 was seen in the hospital emergency room and not admitted to the hospital. The hospital contacted the administrator and director of nursing (DON) at facility, and the administrator and DON indicated the facility could not take R1 back. R1 had admitted to drinking alcohol and the hospital had assessed R1 was not a threat to self or others. RN-A stated, "[R1] was given 2 cab tokens and a list of homeless shelters she could go to and left the emergency room by cab."

When interviewed on 10/22/20, at 10:15 a.m. Broadway Family Medicine Clinic (primary physician for R1) nurse RN-B stated, the facility had notified primary physician, medical doctor (MD)-E, R1 had transferred from facility on 10/19/20. RN-B stated a transfer location was not known. RN-B stated the only communication from the facility was a faxed transfer notification with no further information on it. They were not aware R1 was at a motel. R1's Transfer/Discharge Report dated 10/19/20, identified R1's diagnoses and reason for transfer, but did not indicate where R1 was transferring to and did not include a discharge summary or list of medications.

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F 622	Continued From page 13	F 622		

When interviewed on 10/22/20, at 12:44 a.m. North Memorial social worker (SW)-B read the note from the emergency room social worker SW-C. SW-C worked with R1 on discharge and indicated, "Per conversation with [DON] and [administrator], patient is independent enough that she doesn't really need to be in a TCU [transitional care unit at facility] as they feel she can go to a shelter if it is medically unnecessary for her to come into the hospital. They will absolutely not accept her back under any circumstances. If she wants her stuff she can send someone because the patient herself is not allowed on the campus."

When interviewed on 10/22/20, at 1:20 p.m. SW-A stated, "With [R1's] LOA, she is not allowed to come back because she has threatened other residents and staff. Normally on an LOA they can come back and they have to go into isolation." There was a discharge summary in R1's medical record which had been created due to R1's plan to discharge to an apartment on 10/19/20, but was not give to her as she had not actually discharged, she was on LOA. The services listed on the discharge summary were not currently available to R1.

R1's Social Services Discharge Summary signed by RN-D on 10/19/20, included, initiation of services on discharge included PCA services, meals 7 days per week, rental assistance, rule 25 referral and furniture and household assistance through Hennepin County. Social Services Discharge Summary also indicated, "Medication and treatment instructions sent with resident/responsible party, copy of summary presented to attending physician, attending physician notified of summary available."

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F 622	Continued From page 14	F 622		

When interviewed on 10/22/20, at 2:18 p.m. TC-B called surveyor and stated TC-B had met with R1 at her motel as R1 had reached out to him, she had stated she had no food, no means of obtaining any food, nor means of transportation. TC-B stated R1 required assistance with her basic needs. The facility was not providing this. The county had no way of assisting R1 as she was still a resident of the nursing facility.

In an communication from the Ombudsman for Long Term Care (OOLTC)-E received 10/22/20, at 4:28 p.m. identified the Ombudsman's office had not received a required involuntary discharge notice from the facility, but the facility had refused to allow R1 to return to the facility. This was unsafe for R1.

Facility documentation including progress notes and provider orders, on and prior to 10/21/20, did not include documentation of R1's discharge location, communication with support services, communication with family, communication with primary physician or provider orders for discharge. Nor, was it documented R1 had returned from the hospital on 10/19/20, was not allowed entrance and was sent to motel. R1's progress notes since admission to facility, up until 10/19/20, included multiple uses of offensive language directed at staff and other resident, but did not include documentation of threatening language or physical altercations with other residents or staff. R1 had not been given a 30 day notice due to behaviors, nor was there any documentation of an involuntary discharge planned.

In an email from TC-B received 10/23/20, at 1:06

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	245544	A. BUILDING _____ B. WING _____	C 10/26/2020

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F 622	Continued From page 15	F 622		

p.m. included R1's apartment was not secured and was pending approval of financing through Hennepin County Economic Assistance office. R1 may or may not have housing on 10/26/20.

In an email from OOLTC-E received 10/23/20, at 3:48 p.m. indicated OOLTC-E had spoken with R1 and there was not a grocery store nearby where R1 can get food and R1 is, "overwhelmed" by her three times per day medications and was requesting assistance with medication set-up. R1 was also concerned as she has high blood pressure, which was not controlled, and no one was checking her blood pressure.

The immediate jeopardy which began on 10/19/20, was removed on 10/26/20, when the facility contacted R1 who refused to return to the facility, but agreed to an upgraded motel room with a refrigerator and a microwave, $50 a day for food and necessities to be delivered to her, a wellness check by a registered nurse daily with medication check, blood pressure and determination of her daily needs. The daily checks and money continued until R1 was able to secure independent living in an apartment on 10/26/20. The facility contacted the Ombudsman's office, R1's county case workers, R1's physician and adult protective services. The DON met with R1 to ensure appropriate discharge plans were in place along with county services including rent, damage deposit, daily meal delivery, and PCA care. Staff were provided with training on appropriate discharge planning. This was verified by observation, interview and document review by the surveyors on 10/26/20.

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F 622	Continued From page 16 A facility Transfer and Discharge Documentation policy, undated, included, "The reason for transfer or discharge will be documented in the medical record. Documentation from the Care Planning Team concerning all transfers or discharges must include, as a minimum, and as they apply: The reason(s) for transfer or discharge; That an appropriate notice was provided to the resident and/or representative (sponsor); The date and time of discharge; The new location of the resident; The mode of transportation; Should the resident be transferred or discharged because of health of individuals in the facility would otherwise be endangered, the basis for transfer or discharge must be documented in the resident's clinical record by a physician."	F 622		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 10, 2020

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

Re: Event ID: IRB511

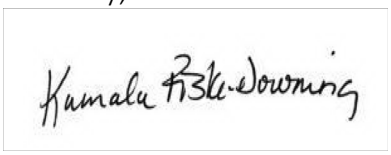
Dear Administrator:

The above facility survey was completed on October 26, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

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 10/21/20 through 10/26/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure. The following complaint was found to be UNSUBSTANTIATED: H5544161 and	2 000		

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2 000	Continued From page 1 H5544162C. The following complaint was found to be substantiated: H5544160C NO licensing orders were issued. 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		