



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 27, 2021

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

RE: CCN: 245544
Cycle Start Date: May 19, 2021

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 May 19, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- 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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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 August 19, 2021 (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 November 19, 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

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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,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

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

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

PRINTED: 06/15/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/19/2021	
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/19/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5544202C (MN00072851) However, no citations were issued due to action taken by the facility prior to entrance. However, another deficient practice was identified at F609 during the investigation. The following complaints were found to be SUBSTANTIATED: H5544203C (MN00066608), H5544204C (MN00066594), and H5544205C (MN00066125) with no deficiencies cited. The following complaint was found to be UNSUBSTANTIATED: H5544206C (MN00072022). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.			F 000			
F 609	Reporting of Alleged Violations			F 609			6/14/21

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

TITLE

(X6) DATE

Electronically Signed

06/04/2021

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 609 SS=D	Continued From page 1 CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure allegations of potential abuse were reported timely to the State agency (SA) for 2 of 5 residents (R1 and R4) who were reviewed for allegations of abuse. Findings include:	F 609	PTSD and Vulnerable Adult assessment completed for R1 and R4. Care plan has been updated to monitor both residents. Both R1 and R4 state they feel safe in the facility. The administrator and DON reviewed		

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F 609	Continued From page 2 R1's quarterly Minimum Data Set (MDS) dated 4/16/21, included cognitively intact, no behaviors identified in the reference period. R1's diagnosis included major depressive disorder. R1's care plan revised 2/18/21, included, "He instigates behaviors, acts as advocate for others and becomes verbally abusive and target[s] others." R1's care plan indicated a history of physical and verbal aggression toward staff and other residents. R4's quarterly MDS dated 2/20/21, included cognitively intact, no behaviors identified in the reference period. R4's diagnosis included alcohol use disorder and adjustment disorders with disturbance of conduct. R4's care plan revised on 3/29/21, included, "Verbally abusive toward staff by refusing cares. Swearing. Poor impulse control." When interviewed on 5/19/21, at 12:51 p.m. R1 stated about two weeks ago he got into an argument with R4, which led to R4 hitting him with a chair on his side. R1 stated multiple staff members witnessed the altercation but did nothing to intervene. R1 was unable to identify or describe any of the staff who witnessed the event. When interviewed on 5/19/21, at 1:52 p.m. the director of nursing (DON) stated he had been notified by the evening nurse supervisor, registered nurse (RN)-A, that activities assistant (AA)-A witnessed an argument between R1 and R4. DON added that he got, "mixed stories" on whether R4 hit R1 or not. DON said he instructed RN-A to complete a physical assessment of R1.	F 609	facility risk management and resident progress notes for last 30 days to identify any another resident to resident altercation/abuse. Staff will be reeducated on reporting abuse/neglect to administrator and DON, the SW/Designee will be responsible for education. Staff will be reeducated on appropriate time frames for reporting suspected abuse/neglect. The administrator and DON have developed an audit to monitor for any incidents but not limited to resident to resident altercation. The audit will include review of daily nurses notes, risk management review and any grievances received. The administrator designed will be responsible for completion of the audit. Audit will be completed daily x 14 days, weekly x 8 weeks then monthly ongoing. All negative findings will be reported to administrator immediately for follow up action. Audits will be review by QAPI committees as per schedule. Goal date of compliance June 14th, 2021.		

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F 609	Continued From page 3 RN-A informed him R1 denied pain and found no injury, bruising, or redness. DON stated due to being unsure if a physical altercation occurred and there was no injury, he did not think to report the incident to the state agency (SA). When interviewed on 5/19/21, at 2:52 p.m. RN-A stated AA-A reported to him that R4 hit R1 with a chair while the two were arguing. RN-A stated he separated the two residents, instructed staff to provide increased supervision for the remainder of the shift, notified the physician, the DON, and the administrator immediately. RN-A also passed the information to the next shift in nurse-to-nurse report. (AA)-A was unavailable for interview. An incident report completed on 4/5/21 included, that RN-A was notified by AA-A that R1 and R4 were fighting in the dining room. R4 was noted to be holding a chair in his hand. R1 stated R4 hit him with the chair on the left side of his abdomen. No bruising or redness noted. R1 and R4 were separated. The administrator, DON, physician and R4's representative were notified of the altercation. The policy Abuse, Neglect, Mistreatment and Misappropriation of Resident Property (undated) indicated, "Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the Nursing Home Administrator. The Nursing Home Administrator or designee will report "abuse" to the state agency per State and Federal requirements."	F 609			



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Electronically delivered
May 27, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: 8RVP11

Dear Administrator:

The above facility was surveyed on May 19, 2021 through May 19, 2021 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

Victory Health & Rehabilitation Center

May 27, 2021

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Victory Health & Rehabilitation Center

May 27, 2021

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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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/19/2021
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
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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 5/19/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.	2 000		

Minnesota Department of Health

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

TITLE

(X6) DATE

Electronically Signed

06/04/21

Minnesota Department of Health

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5544202C (MN00072851). However, no licensing orders were issued due to action taken by the facility prior to survey. However, a licensing order was identified at 1980 while investigating the complaint. The following complaints were found to be SUBSTANTIATED: H5544203C (MN00066608), H5544204C (MN00066594), and H5544205C (MN00066125) with no licensing order issued. The following complaint was found to be UNSUBSTANTIATED: H5544206C (MN00072022). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor 's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction	2 000		

Minnesota Department of Health

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2 000	Continued From page 2 is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined	21980		6/14/21

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21980	Continued From page 3 in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure allegations of potential abuse were reported timely to the State agency (SA) for 2 of 5 residents (R1 and R4) who were reviewed for allegations of abuse. Findings include:	21980	PTSD and Vulnerable Adult assessment completed for R1 and R4. Care plan has been updated to monitor both residents. Both R1 and R4 state they feel safe in the facility. The administrator and DON reviewed facility risk management and resident	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/19/2021
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
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21980	Continued From page 4 R1's quarterly Minimum Data Set (MDS) dated 4/16/21, included cognitively intact, no behaviors identified in the reference period. R1's diagnosis included major depressive disorder. R1's care plan revised 2/18/21, included, "He instigates behaviors, acts as advocate for others and becomes verbally abusive and target[s] others." R1's care plan indicated a history of physical and verbal aggression toward staff and other residents. R4's quarterly MDS dated 2/20/21, included cognitively intact, no behaviors identified in the reference period. R4's diagnosis included alcohol use disorder and adjustment disorders with disturbance of conduct. R4's care plan revised on 3/29/21, included, "Verbally abusive toward staff by refusing cares. Swearing. Poor impulse control." When interviewed on 5/19/21, at 12:51 p.m. R1 stated about two weeks ago he got into an argument with R4, which led to R4 hitting him with a chair on his side. R1 stated multiple staff members witnessed the altercation but did nothing to intervene. R1 was unable to identify or describe any of the staff who witnessed the event. When interviewed on 5/19/21, at 1:52 p.m. the director of nursing (DON) stated he had been notified by the evening nurse supervisor, registered nurse (RN)-A, that activities assistant (AA)-A witnessed an argument between R1 and R4. DON added that he got, "mixed stories" on whether R4 hit R1 or not. DON said he instructed RN-A to complete a physical assessment of R1. RN-A informed him R1 denied pain and found no injury, bruising, or redness. DON stated due to	21980	progress notes for last 30 days to identify any another resident to resident altercation/abuse. Staff will be reeducated on reporting abuse/neglect to administrator and DON, the SW/Designee will be responsible for education. Staff will be reeducated on appropriate time frames for reporting suspected abuse/neglect. The administrator and DON have developed an audit to monitor for any incidents but not limited to resident to resident altercation. The audit will include review of daily nurses notes, risk management review and any grievances received. The administrator designed will be responsible for completion of the audit. Audit will be completed daily x 14 days, weekly x 8 weeks then monthly ongoing. All negative findings will be reported to administrator immediately for follow up action. Audits will be review by QAPI committees as per schedule. Goal date of compliance June 14th, 2021.	

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21980	Continued From page 5 being unsure if a physical altercation occurred and there was no injury, he did not think to report the incident to the state agency (SA). When interviewed on 5/19/21, at 2:52 p.m. RN-A stated AA-A reported to him that R4 hit R1 with a chair while the two were arguing. RN-A stated he separated the two residents, instructed staff to provide increased supervision for the remainder of the shift, notified the physician, the DON, and the administrator immediately. RN-A also passed the information to the next shift in nurse-to-nurse report. (AA)-A was unavailable for interview. An incident report completed on 4/5/21 included, that RN-A was notified by AA-A that R1 and R4 were fighting in the dining room. R4 was noted to be holding a chair in his hand. R1 stated R4 hit him with the chair on the left side of his abdomen. No bruising or redness noted. R1 and R4 were separated. The administrator, DON, physician and R4's representative were notified of the altercation. The policy Abuse, Neglect, Mistreatment and Misappropriation of Resident Property (undated) indicated, "Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the Nursing Home Administrator. The Nursing Home Administrator or designee will report "abuse" to the state agency per State and Federal requirements." SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting	21980			

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21980	Continued From page 6 of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff identified in the citation to policies and procedures, and audit all complaints of alleged abuse or neglect for a set determined time. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21980			