Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 23, 2026

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

RE: CCN: 245544
Cycle Start Date: June 2, 2026

Dear Administrator:

On July 21, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 16, 2026

Administrator
Victory Health & Rehabilitation Center
512 49TH AVENUE NORTH
MINNEAPOLIS, MN 55430

RE: CCN:245544
Cycle Start Date: June 2, 2026

Dear Administrator:

On June 2, 2026, 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor, Rapid Response
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nikki.Harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 September 2, 2026 (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 December 2, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social

Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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June 16, 2026

Administrator
Victory Health & Rehabilitation Center
512 49TH AVENUE NORTH
MINNEAPOLIS, MN 55430

Re: Event ID: 234212-H1

Dear Administrator:

The above facility survey was completed on June 2, 2026 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victory Health & Rehabilitation Center	**512 49TH AVENUE NORTH , MINNEAPOLIS, Minnesota, 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
F0000	INITIAL COMMENTS On 6/1/26 and 6/2/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55442638C (3024906) with a deficiency issued at F610. As a result of the investigation deficiencies were cited at F684. 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 that substantial compliance with the regulations has been attained.	F0000		06/17/2026
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F0610	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent informal dispute resolution session, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. 1. Immediate Actions and Assessments Staff immediately intervened to separate the	07/08/2026

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 reverse for further 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.

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

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F0610 SS = D	Continued from page 1 §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 perform complete and thorough investigations of allegations of abuse for 3 of 3 residents (R1, R2, R3) who were involved in resident-to-resident altercations. Findings include: A Nursing Home Incident Report (NHIR) dated 5/26/26 at 8:20 p.m., indicated at approximately 6:25 p.m., when R2 and R3 were both in the dining room, R2 struck R3 in the chest and face. Facility initiated 15-minute safety checks. The incident was witnessed by activity staff. A NHIR dated 5/26/26 at 10:30 p.m., indicated at 7:39 p.m., R2 and R1 were involved in a physical altercation in which R2 hit and scratched R1. Staff intervened and separated the residents, and staff performed monitoring and safety checks. Review of the investigative files on 6/1/26 of each of the two incidents revealed the investigations did not include interviews with other residents to ensure the other residents did not also have allegations of abuse by R2. During an interview on 6/2/26 at 12:09 p.m., the director of nursing (DON) stated during an investigation for abuse, other residents other than those involved in the incident, should be interviewed to determine if other residents had also been abused and acknowledged that had not occurred for either incident. A policy for abuse investigations was requested but not provided.	F0610	Continued from page 1 residents during both altercations. Following the incidents, a nurse assessed all involved residents, and Risk Management reports were completed. Social Workers conducted vulnerability assessments for R1, R2, and R3 on 5/27. Specific follow-up included: - R3: Evaluated by Advanced Clinical Psychology on 5/29; the resident showed no signs of distress or mood changes, had no memory of the incident, and expressed no ill will toward others. - R1: Met with the Substance Abuse Counselor on 5/27 and expressed a willingness to join group sessions. - R2: Permanently discharged from the facility on 6/3/2026. 2. Identifying Other Potential Issues To ensure no other residents were affected by R2, Social Workers will interview 10 residents from their respective caseloads. Any complaints identified during these interviews will be reported immediately to the Administrator for follow-up. 3. Systemic Changes and Staff Education An Ad Hoc resident council will be convened to review abuse reporting procedures. Additionally, administrative and licensed nursing staff will receive education on the facility's abuse investigation policy, with a specific focus on interviewing other residents who may be at risk. The Administrator and Director of Nursing (DON) have reviewed and updated the investigation policy to ensure ongoing compliance. 4. Monitoring and Quality Assurance The Administrator and DON have developed an audit tool to monitor compliance with abuse investigation protocols. Under the supervision of the Administrator, Social Workers will trigger and complete this audit following any reported resident-to-resident altercation. These audits will continue for every occurrence over	07/08/2026

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F0610 SS = D		F0610	Continued from page 2 the next three months. Any negative findings will be reported to the Administrator immediately, and overall results will be presented to the QAPI committee as scheduled.	07/08/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure a safe environment was maintained and monitoring was implemented as indicated in the medical record for 2 of 3 residents (R1, R3), and as ordered for 1 of 3 residents (R2) after resident-to-resident altercations. Additionally, the facility failed to ensure ongoing assessment and monitoring for 2 of 2 residents (R1, R3) after R1 was hit and scratched by R2, and R3 was hit in the torso and slapped by R2, which had the potential to result in unmonitored decline for R1 and R3. Findings include: A Nursing Home Incident Report (NHIR) dated 5/26/26 at 8:20 p.m., indicated at approximately 6:25 p.m., when R2 and R3 were both in the dining room, R2 struck R3 in the chest and face. Facility initiated 15-minute checks. The incident was witnessed by activity staff. A NHIR dated 5/26/26 at 10:30 p.m., indicated at 7:39 p.m., R2 and R1 were involved in a physical altercation in which R2 hit (did not indicate where) and scratched R1. Staff intervened and separated the residents, and staff performed monitoring and safety checks. R1 R1’s annual Minimum Data Set (MDS) dated 3/19/26,	F0684	Immediate Actions Taken - Resident Safety: Residents R1 and R2 were separated immediately following the altercation and placed on Q15-minute safety checks. R2 was permanently discharged from the facility on 6/3/26. - Care Plan Updates: Social Work updated care plans for R1 and R3. R1’s plan now includes specific target behaviors, while R3’s plan identifies a propensity for racist statements that may increase conflict risk. - Clinical Documentation: Following initial normal readings, subsequent vitals for R3 on June 6 were recorded as B/P 134/70, Temp 97.7, Pulse 72, Resp 18, and O2 sat 97%. A skin assessment for R2 on June 2 confirmed no alterations. - Record Review: On 6/2/26, the Administrator and Director of Nursing (DON) reviewed medical records for all residents assigned to Q15-minute safety checks. No other residents were on these checks at that time. Identification of Other At-Risk Residents - Care Plan Review: Social Workers and the Interdisciplinary Team (IDT) reviewed care plans for residents with known behavioral issues, specifically regarding racist statements, to ensure all target behaviors are addressed. - Documentation Audit: The Administrator and DON reviewed the last seven days of risk management reports and progress notes to ensure vital signs and skin checks are consistently documented in both records. Systemic Changes - Nursing Education: Licensed nursing staff were trained on obtaining MD orders for Q15-minute checks, ensuring each order includes a specific stop date. A licensed staff member will monitor flow sheets for signatures, with daily reviews conducted	07/08/2026

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F0684 SS = D	Continued from page 3 indicated intact cognition, no behaviors, and diagnoses that included anxiety, depression, and Post Traumatic Stress Disorder (PTSD). R1's care plan indicated the following: 5/19/25- safety- [R1] is at risk for potential abuse due to chemical dependency, mental illness, and intrusive thoughts. Intervention included to not have R1 near residents who disturb him and remove from potentially dangerous situations. 7/28/25- vulnerable adult due to mental health, cognition, physical impairment and nursing facility placement. The diagnoses list on the care plan indicated alcohol dependence and other stimulant use. R1's progress notes indicated the following: 5/26/26 at 10:25 a.m., R1's bath audit was completed with no skin concerns noted. 5/26/26 at 8:01 p.m., activity staff informed the licensed practical nurse (LPN)-B R1 was involved in a physical altercation with R2; R2 hit and scratched R1. R1 was noted to have scratches on the chest, abdominal area, and arm following the incident. Staff performed monitoring and safety checks. 5/27/26 at 7:19 a.m., 15-minute checks continued. The progress notes lacked a comprehensive assessment of the scratches, their length, depth, and width, description of the color, shape, and margins, and if there was any drainage from the wounds. Also, the progress note lacked mention of the treatment provided, a pain assessment, and indication of ongoing monitoring of R1's injuries. R1's Incident Audit Report dated 5/26/26 at 9:38 p.m., indicated the LPN-B was informed by activity staff, R1 and R2 were involved in a physical altercation, R2 hit and scratched R1 over a money conflict. Male resident [R1] noted with scratches to chest, abdominal area, and arm following the incident. The residents [R1 and R2] were separated, and safety checks were initiated. The director of nursing (DON), administrator, provider, police, and psychologist were notified. R1's care plan was reviewed and updated, first aid care was performed for R1's scratches, and a PTSD screen and Vulnerable Adult assessment were completed. Referrals were sent to R1's psychology clinic for onsite evaluation and to the onsite substance abuse counselor. Monitoring and safety checks continued.	F0684	Continued from page 3 by the DON or a designee. - Social Work Education: The Social Work team has been instructed to clearly identify target behaviors and risks related to racist statements within individual care plans. - Documentation Standards: Nursing staff are being educated on the requirement to record specific vital sign values and skin assessments in both progress notes and risk management reports. - Policy Review: The Administrator and DON have reviewed and modified the facility's abuse policy. Monitoring and Quality Assurance - Safety Check Audits: A new audit tool will track all residents on safety checks for three months. This daily audit, completed by the DON or a designee, will verify MD orders, stop dates, risk management documentation, and progress notes. - Care Plan Audits: Social Work will conduct a house-wide audit of existing care plans, followed by ongoing audits per the MDS schedule for three months. - Reporting: All audit findings and abnormal results will be reported to the Administrator immediately and presented to the QAPI committee for further recommendations	07/08/2026

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F0684 SS = D	Continued from page 4 R1's 15-Minute Check Sheet indicated 15-minute checks were implemented on 5/26/26 at 8:30 a.m., and continued through 5/28/26 at 7:00 a.m. The Check Sheet further indicated the 15-minute checks were omitted during the following time frames: 5/27/26 from 12:15 a.m., through 6:15 a.m. 5/28/26 from 8:15 a.m., through 2:15 p.m. 5/28/26 from 7:15 a.m., through the end of the 72-hour monitoring period R1's orders lacked mention of 15-minute checks. During an interview on 6/1/26 at 2:18 p.m., R1 stated he did not remember the incident with R2, but he had scratches on his arms and chest and was kicked by R2; staff told him about the incident. R1 stated he was not on safety checks, and the only time his VS were checked was twice daily when he had been drinking. R2 R2's quarterly MDS dated 3/12/26, indicated intact cognition, no behaviors, and diagnoses that included traumatic brain injury, depression, anxiety, and PTSD. R2's care plan indicated the following: 1/13/26- at risk for abuse due to being a vulnerable adult with an intervention dated 1/16/26 to not allow R2 to be near other residents who disturbed her. 3/19/26, updated 5/27/26- Impaired thought process related to substance abuse and dependence of alcohol dated, with an intervention dated 5/27/26 to initiate the facility alcohol and substance abuse policy. 5/27/26- potential to be physically aggressive after a resident to resident altercation with interventions to monitor and document for increase in behavior, specifically ( ), The care plan lacked indication of the behaviors the staff were supposed to monitor and was left blank.), and monitor, document, and report as needed (PRN) any signs and symptoms posing danger to self and others. The diagnoses list on the care plan indicated current alcohol use. R2's progress notes indicated the following:	F0684		07/08/2026

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F0684 SS = D	Continued from page 5 5/26/26 at 4:17 p.m., social worker (SW)-A went outside to schedule Care conference with another resident and R2 was passing a jug of liquor around to other residents. Staff asked to take the bottle, but R2 would not give up the bottle. Staff let nursing staff know the resident was drinking. 5/26/26 at 7:35 p.m., at approximately 6:30 p.m., activity staff informed LPN-A that R2 attempted to hit R3, and R2 initially stopped, but when activity staff turned to assist another resident R2 struck R3 in the chest and face. 15-minute safety checks were initiated. The police, DON, and administrator were notified. 5/26/26 at 9:04 p.m., R2 continued to exhibit signs of intoxication, including slurred speech and mood changes, medication on hold, and her medical provider was notified. The progress notes lacked mention of R2's second altercation, between R2 and R1, on 5/26/26 at 7:39 p.m. R2's 15-Minute Check Sheet indicated 15-minute checks were implemented on 5/26/26 at 6:30 p.m., and further indicated the 15-minute checks were omitted during the following time frames: 5/27/26 from 2:45 p.m., to 5/28/26 12:00 a.m. 5/28/26 from 6:30 a.m,. to 5/28/26 8:00 a.m. 5/28/26 from 1:15 p.m., through the 72-hour monitoring period R2's provider orders dated 5/27/26, indicated 15-minute safety checks every shift, fill out the paper form. The provider order did not have an end date and was not entered until the day after the safety checks were implemented. During an interview on 6/1/26 at 3:46 p.m., R2 stated R3 called her a racist name and, "a bitch." R2 told R3 to stop, but R3 didn't. R2 didn't recall the incident with R1, only that something happened. R2 stated she is able to hide from staff and staff couldn't keep up with her to check on her. During an interview on 6/1/26 at 3:00 p.m., the LPN-B stated both R1 and R2 were on 15-minute checks after the incident, which were completed on paper forms, usually for 72 hours after an altercation. The LPN-B stated she did not see R1's	F0684		07/08/2026

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F0684 SS = D	Continued from page 6 wounds up close but when R1 went outside, she saw them, and they were, "not gushing blood." R1 was angry and the LPN-B was afraid to approach him to assess the wounds more closely. The LPN-B stated staff should have continued to monitor and check on the wounds for signs of infection and was unsure is staff had. R3 R3's quarterly MDS dated 4/9/26, indicated severe cognitive impairment, no behaviors, and diagnoses that included malnutrition and visual problems. R3's care plan indicated the following: 10/10/24- no cultural preference. The care plan lacked interventions for known racism/racist comments. 5/13/25- impaired thought processes with an intervention dated 10/8/21, closely supervise activities and interactions with others. 11/5/25- safety- was at risk with a potential for abuse due to cognition and physical impairment with an intervention dated 10/24/25 to ensure safety around others who may take advantage of R3, and an intervention dated 3/7/23, do not allow R3 to be around others who disturbed her. The diagnoses list on the care plan indicated symptoms and signs involving cognitive functions and awareness, depression, and adjustment disorder with anxiety. R3's progress notes indicated: 5/26/26 at 7:24 p.m., indicated R3 was hit in the face by another resident, and the nurse conducted a head-to-toe assessment and found no swollen or open areas. VS were taken, and within normal range. Resident was placed in 15-minute checks. The progress note lacked values of the VS. 5/27/26 at 11:47 a.m., indicated the LPN-C was notified by other residents, R3 was slapped by R2. The LPN-C performed a head-to-toe assessment, VS were taken and were within normal range, the resident denied pain or discomfort, and R3 was placed on 15-minute checks. The provider and R3's FM were updated. 5/28/26 at 11:47 a.m., indicated the progress note created on 5/27/26 at 11:47 a.m., was not indicative	F0684		07/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0684 SS = D	Continued from page 7 of a new incident, but was instead a follow up note from the incident that was noted on 5/26/26. R3 remained stable and maintained on 15-minute checks. The progress notes lacked the VS values after the incident and lacked ongoing assessment after R3 was struck in the face by another resident. R3's Incident Report Audit dated 5/27/26 at 11:02 a.m., indicated an incident occurred 5/26/26 at 5:50 p.m., between R2 and R3. The Report indicated R2 slapped R3 in the face and a head-to-toe assessment was completed. Resident placed on 15-minute checks. The assessment lacked indication of VS values. R3's care plan was reviewed and updated, and a PTSD screen and VA assessment were completed. R3 was referred to on the onsite psychologist. R3's 15-Minute Check Sheet indicated 15-minute checks were implemented on 5/26/26 at 6:30 a.m., and continued through 5/30/26 at 8:00 a.m. The Check Sheet further indicated the 15-minute checks were omitted during the following time frames: 5/27/26 from 12:15 a.m., through 6:15 a.m. 5/28/26 from 8:15 a.m., through 2:15 p.m. R3's orders lacked mention of 15-minute checks. During an interview on 6/1/26 at 3:20 p.m., the activity aide (AA)-A stated she noticed on 5/26/26 after 6:00 p.m., R1 was shirtless, looked agitated, and had bloody scratches on his chest, a bloody handprint on his left arm, and the knuckles on both hands were bleeding. R1 walked towards his room but stopped where R2 was talking to another resident in front of R1's door and talked about how R1 went to the store for them, and came back with no money and no merchandise. R1 went into his room and walked out with a razor and threatened the other resident with it, and the AA-A hollered down the hallway for help. The AA-A asked R1 for the razor, but R1 walked outside instead. R2 picked up her walker and tried to hit R1 with it, but the AA-A redirected R2. The AA-A was discussing the incident with nursing staff (the AA-A didn't recall which nursing staff) and then walked outside to observe and saw R1 and R2 were hugging and appeared to be friendly again. Further, the AA-A stated she saw R2 hit R3 in the chest because R3 called R2 a racist name, and the AA-A hadn't heard the name-calling but the AA-A redirected R2 to keep her hands off R3. The AA-A	F0684		07/08/2026

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F0684 SS = D	Continued from page 8 stated she went to help someone else and came back and saw R2 had slapped R3's glasses off, and R3 said ow, that hurt. The AA-A stated she reported the incidents to a nurse, but didn't recall who, but the AA-A reported R2 first punched R3 in the chest and later slapped R3 on the face. During an interview on 8/2/26 at 8:56 a.m., the LPN-C stated 15-minute checks required an order, the checks were typically completed for 72 hours, and if the order did not have an end date, the checks should continue. The LPN-C acknowledged the 15-minute check order for R2 was still active, and the checks should have continued but did not and further acknowledged the 15-minute checks for R1, R2, and R3 were not completed fully. The LPN-C stated a change in condition could occur and if staff were not performing checks, staff would not know about the change in condition. During an interview on 6/2/26 at 9:34 a.m., the LPN-D stated R2 had two incidents on 5/26/26 when R2 was intoxicated with alcohol. The LPN-D stated she expected to see more of an assessment for R1's scratches, if they were old or new, if they required treatment, and if they were cleansed. The LPN-D stated she did not see any follow-up in the medical record about the scratches later but should have to ensure they were healing. The LPN-D acknowledged 15-minute checks were not completed fully for R1, R2, and R3., and if the checks were not completed, further incidents could occur. The checks were used to know the location of the residents, know they were safe, and to keep residents who had altercations away from each other while they are still upset. If the checks were not completed, staff would not know if the residents were in a safe situation. During an interview on 6/2/26 at 10:37 a.m., the nursing assistant (NA)-A stated staff were doing some15-minute checks on R3, but acknowledged staff did not do all the checks they were supposed to do, every 15 minutes for 72 hours. During an interview on 6/2/26 at 10:55 a.m., R3 did not recall the incident with R2. During an interview on 6/2/26 at 10:58 a.m., NA-B reviewed the 15-minute check sheets for R1, R2, and R3 and did not recognize the forms, and did not know their purpose. During an interview on 6/2/26 at 11:44 a.m., the family member (FM)-A stated R3 was racist, swore at staff and residents, and raised her middle finger often to them, and thought staff was protecting R3	F0684		07/08/2026

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F0684 SS = D	Continued from page 9 as best they could. During an interview on 6/2/26 at 1:20 p.m., the LPN-A stated she was aware of the incidents between R1 and R2, and R2 with R3. The LPN-A stated that when residents are assaulted, the nursing staff assessed each resident for injuries and implemented 15-minute checks to ensure the residents were not in the same place at the same time. The LPN-A stated a skin assessment was documented for each resident in the progress notes, and VS should be recorded. If a resident is injured, nursing staff would keep monitoring to ensure the resident's condition did not worsen. During an interview on 6/2/26 at 12:09 p.m., the DON stated she was notified of both incidents. Staff were expected to separate the residents after an altercation, start 15-minute checks, perform skin assessments and VS, and notify family, the DON, and administrator. The DON stated she saw the progress noted on 5/26/26 at 8:01 p.m., in which a skin assessment was noted with scratches, but the nurse did not describe the scratches, the treatment that was administered, record the VS, or perform a pain assessment, but should have. The DON further acknowledged R3's incident progress noted indicated VS were assessed, but the progress note lacked the VS values. Additionally, the DON acknowledged 15-minute checks were supposed to have been completed for 72 hours for R1 and R3, but were not completed as long as they should have been, and were not completed every 15 minutes as they should have been. Also, R2's order for 15-minute checks had no end date, so R2 should have remained on 15-minute checks until the order was discontinued. The DON stated the 15-minute checks were implemented for the safety of each resident, and if they were not completed, another incident could occur. The DON further stated 15-minute checks were in the facility's batch orders, and each resident on 15-minute checks should have an order for them, but R1 and R3 did not. The Resident-to-Resident Altercation policy dated December 2016 indicated if two residents were involved in an altercation staff would document in the resident's clinical record all interventions and their effectiveness and complete a Report of Incident/Accident form and document the incident, findings, and any corrective measures taken in the resident's medical/clinical record.	F0684		07/08/2026

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20000	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 6/1/26 and 6/2/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. The following complaints were reviewed during the survey: H55442638C (3024906). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.	20000		06/17/2026

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

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20000	Continued from page 1 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.	20000		06/17/2026