Electronically delivered
January 5, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: F12K11

Dear Administrator:

The above facility was surveyed on December 23, 2021 through December 27, 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

"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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule 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: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	12/27/2021

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

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 12/22/21, through 12/24/21, and 12/27/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found 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

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2 000	Continued From page 1 when they will be completed. The following complaint was found to be SUBSTANTIATED: H5544285C (MN79524 & MN79533) with licensing orders issued at 1375. As a result of the investigation a licensing order was also issued at 1830. 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 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for 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	2 000		

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2 000	Continued From page 2 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		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R1) who was dependent on staff for meeting activities of daily living (ADLs) had trimmed toenails. Findings Include: R1's diagnoses included altered mental status, dementia with behavioral disturbance, transient alteration of awareness and convulsions obtained from the significant Minimum Data Set (MDS) dated 11/27/21. The MDS indicated R1 required extensive physical assistance with personal hygiene.	2 920	Corrected	1/22/22

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2 920	Continued From page 3 R1's care plan dated 11/21/21, identified resident had an ADL self-care performance deficit related to dependency on staff to complete ADL. The care plan directed staff for personal hygiene set up assistance and at times assist of one with personal hygiene and oral care. A Minnesota Adult Abuse Reporting Center (MAARC) report dated 12/19/21, indicated R1 was observed lying in bed without a incontinent brief on and there was dried urine on sheets. In addition, R1's toenails were long and curled over toes. During a review of hospital provided pictures dated 12/19/21, it was revealed R1 had long toenails which were approximately 2 inches long and curled over R1's toes and around the nail bed the skin was purple. During interview on 12/23/21, at 7:31 a.m. family member (FM)-A stated she had come to visit R1 as she had been told it was okay to visit R1. FM-A stated when she entered R1's room, R1 was lying in a fatal position and R1 had a single sheet covering her. FM-A then stated she observed the night gown had dried bowel movement smears and urine stains. FM-A also stated at the hospital the nurse had assisted her to look at R1's body and she had observed R1's toenails on both feet were long approximately 2 inches and the toenails were curled over the toes. During interview on 12/23/21, at 2:28 p.m. the director of nursing (DON) reviewed R1's medical record and verified for six weeks R1 had been at the facility Weekly Skin Checks had been completed three times on 11/21/21, 12/3/21 and 12/8/21. The DON reviewed the hospital provided	2 920		

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2 920	Continued From page 4 pictures dated 12/19/21, and the facility Weekly Skin Checks assessments completed on 12/3/21 and 12/8/21 and acknowledged although the toenails had been marked trimmed, the documentation was not accurate "they would have to have a podiatrist trim those they are at least 2 inches long and curled." . The DON stated both toenail and fingernail care should be done with showers and if the staff are not able to do it they were to let the nurse know. The DON also stated the staff was to attempt or re-approach the resident the next shift. On 12/27/21, at 10:44 a.m. during the exit conference with the interim administrator, and the infection control nurse (ICN), the interim administrator stated he would not have expected a nurse to trim R1's toenails but should be seen by a podiatrist, he further stated he was not sure about the contracted podiatrist schedule cycle. The interim administrator added, "[R1] had came to us with those toenails" but was not sure if R1 had been scheduled for podiatry as R1 had signed the consent for services at admission. The facility Activities of Daily Living (ADL's), Supporting policy reviewed 12/7/21, directed staff for resident who were unable to carry out ADL's independently the staff was to ensure they received the services necessary to main good nutrition, grooming, personal and oral hygiene. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently.	2 920		

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2 920	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Centers for Disease Control (CDC) guidelines were followed to prevent or minimize the transmission of COVID-19 for 1 of 5 residents (R4) who were placed on quarantine, though not enforced, following exposure to a COVID-19 positive roommate. This had the potential to affect 54 of 59 residents who had the potential to be exposed to R4 while accessing the communal areas of the facilities. The IJ began on 12/23/21, at 5:42 a.m. licensed practical nurse (LPN)-A wrote a progress note that she observed R4 in the hallway of the facility. LPN-A explained to R4 that she was on quarantine and should be in her room due to exposure to COVID-19 from a positive roommate. The progress note read; R4 told the nurse she was not going to stay in her room. The facility administrator and director of nursing (DON) were notified of the IJ on 12/23/21 at 4:57 p.m. The IJ was removed on 12/27/21, at 10:23 a.m. but remained at a lower scope and severity of F, no	21375	Corrected	1/22/22

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actual harm with potential for more than minimal harm that is not immediate jeopardy, widespread.

Findings include:

R4's quarterly Minimum Data Set (MDS) dated 11/4/21, noted R4 had intact cognition and was independent with most activities of daily living (ADL's). R4's face sheet accessed on 12/27/21, noted R4's diagnoses included: paranoid schizophrenia, anemia, hypokalemia, heart disease and tobacco use.

The facility provided a listing of COVID-19 positive residents during routine testing on 12/21/21.

During review of the infection control binder provided by the infection control preventionist, it was revealed the facility had been in outbreak status since 11/17/21, with a total of four positive staff members and 15 positive residents and one COVID-19 related death on 12/20/21, due to exposure to a positive roommate.

The facility documented that R4 refused the COVID-19 vaccination when offered under the immunization tab of R4's electronic health record (EHR).

During continuous observation on 12/23/21, beginning at 9:13 a.m. R4 approached this surveyor in the south hall without a mask on. R4 was concerned about housekeeping cleaning her room. At 9:22 a.m. R4 was seen outside smoking with several other unmasked residents, the smoking aide assisted R4 to the smoking area. At 9:31 a.m. R4 was in the dining room near the smoking area exit, unmasked and was within 6 feet of other unmasked residents. At 9:36 a.m.

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R4 was again observed outside smoking with other unmasked residents. At 10:03 a.m. R4 was near the nursing station and continued to self-propel her wheelchair to the north hall and approached a staff member. At 10:08 a.m. R4 was unmasked and in the dining room pouring coffee near other unmasked residents. At 10:21 a.m. R4 was still unmasked and in the dining room near the exit to the smoking area among other unmasked residents. At 10:24 a.m. the smoking aide placed a smoking apron on R4 and she went back outside to smoke. At 10:34 a.m. R4 re-entered the dining room, unmasked and within six feet of other unmasked residents.

When interviewed on 12/23/21, at 9:23 a.m. trained medication aide (TMA)-A stated she was unsure if quarantine residents had to remain in their room or if they are limited to certain areas of the facility.

When interviewed on 12/23/21 at 9:41 a.m. licensed practical nurse (LPN)-A stated a resident on quarantine should be observed for symptoms, they should limit their interaction with other residents however, they cannot stop the resident from going out to smoke when they want to.

When interviewed on 12/23/21, at 10:45 a.m. nursing assistant (NA)-A stated if a resident is on quarantine they should remain in their room. NA-A further stated she was not aware of any residents on quarantine.
When interviewed on 12/23/21, at 11:17 a.m. the infection preventionist (IP) stated R4 was put on quarantine status the evening of 12/22/21, after her roommate tested positive for COVID-19. Further, the IP stated residents that are on quarantine are required to stay in their rooms and if they are non-compliant with staying in their

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rooms, the interdisciplinary team will meet to come up with a solution. The IP stated R4 was not compliant with quarantining in her room, but there had not been an interdisciplinary meeting and one had not been scheduled at that time.

When interviewed on 12/23/21, at 11:17 a.m. the infection preventionist (IP) stated she was made aware of R4's roommate testing positive on the evening of 12/22/21. The IP stated she then called the facility and notified staff that R4's roommate tested positive for COVID-19 and was moved to the COVID-19 isolation wing in the facility and that R4 should be placed on quarantine.

When interviewed on 12/23/21, at 11:31 a.m. the acting administrator (AA) stated there were designated smoking times for residents that are on quarantine. The AA further stated they currently don't have any quarantined residents that go out to smoke.

On 12/23/21, at 12:18 p.m. social services (SS)-A and the IP stated they conducted a meeting and have developed interventions for keeping R4 in her room during her quarantine.

When interviewed on 12/23/21, at 2:01 p.m. an activities assistant (AA)-A stated R4 disliked wearing masks and would tell staff she would put mask on when she was "damn good and ready."

Resident refused interview on 12/23/21, at 2:06 p.m.

When interviewed on 12/23/21, at 2:18 p.m. the director of nursing (DON) stated quarantine residents must be in their rooms. The DON further stated she was unaware R4 was out of her

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room, self-propelling her wheelchair throughout the facility unmasked. The DON stated that should not have happened.

When interviewed on 12/23/21, at 3:58 p.m. the IC nurse stated R4 refused to be tested during the facility wide outbreak testing on 12/21/21. Further, the IC was not sure the last time R4 agreed to testing and referred to a three-ring binder for the information.

On 12/24/21, at 1:30 p.m. during the first attempted removal visit R4 was observed wearing a mask and was being wheeled down the hallway by the activities assistant (AA), they went past the nursing station and as they went past the employee break room, R4 asked AA to stop outside the employee breakroom. R4 then removed her mask and was observed talking to the staff who sat in the room. AA then redirected R4 to leave the mask on. R4 re-applied the mask and AA then wheeled R4 through the dining room to the entrance of the smoking area where R4 joined other residents in the smoking area.
-At 1:35 p.m. to 1:37 p.m. R4 was observed being assisted from the smoking area by staff and back into the dining room. At 1:38 p.m. R4 was observed return into the building from the smoking area and as she went past the door threshold AA cued her to wear her mask. At 1:40 p.m. R4 asked AA for a cup of coffee to drink in the dining room.
-At 1:41 p.m. AA approached R4 with a cup with coffee and was overheard telling R4 she was supposed to always have the mask on when out of the room except when eating, drinking or smoking. At 1:43 p.m. to 1:49 p.m. R4 was observed drinking coffee in the dining room. At 1:50 p.m. R4 was observed go over to the door again asked to go outside to smoke. As she

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approached the table with smoking supplies R4 was assisted by the staff to the smoking area however she did not have a mask on as she went past two residents who sat and stood by the door. At 1:57 p.m. R4 returned to the dining room and sat at the table by the wall as she continued to drink the coffee and not wearing a mask. At this same time AA and kitchen staff was observed setting up the dining room for the resident Christmas party and residents were independently coming into the dining room and being seated. At 2:06 p.m. to 2:29 p.m. R4 remained at the table seated not drinking or eating and was not wearing a mask. At 2:11 p.m. the DON came into the dining room and stood by R4 but never redirected R4 to go back to her room or wear a mask.
-At 2:13 p.m. the DON re-directed R4 to wear the mask and R4 asked how about the test results. R4 then asked the DON to stop standing by her and still did not put the mask on. The DON continued to stand by R4 and at this time the dining room had 15 residents seated waiting to be served food. At 2:29 p.m. as AA brought R4 food to eat in the dining room, the surveyor intervened, and the DON stated R4 was not supposed to be in the dining room because she was supposed to be quarantined in her room due to the exposure. The DON stated R4 was supposed to have been brought back to the room after smoking but AA was assisting with the Christmas party.
-At 2:31 p.m. DON wheeled R4 out of the dining room down the hallway to her room.

During interview on 12/24/21, at 2:39 p.m. the activities assistant stated she did not know that R4 was not supposed to participate in communal activities. The activities assistant stated she thought if R4 had her mask on and maintained 6 feet this was appropriate. AA stated she had told

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

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21375	Continued From page 11	21375		

R4 if she was not eating and drinking, she was supposed to have her mask on and she did not know why other staff did not re-direct R4 to put the mask on as she was busy assisting with the activity.

During interview on 12/24/21, at 3:04 p.m. the DON stated the facility was going to revised the training for the staff to include -unvaccinated residents can only go to smoke then back into their rooms and she of the infection control nurse would communicate to the staff the vaccination status of a residents when this situations came up and this would be implemented immediately in IJ the removal staff training.

An undated facility policy titled, COVID-19 Outbreak and Routine Testing Procedure was provided. The policy noted residents that refuse testing during an outbreak should be placed on transmission-based precautions (TBP) until the criteria for discontinuing the TBP have been met. Further, for these residents additional monitoring is necessary to ensure the resident maintains appropriate distancing, wears a face covering and practices hand hygiene. Additionally, the policy noted unvaccinated residents should generally be restricted to their rooms and not participate in group activities.

The CDC guidance for unvaccinated residents reads; unvaccinated residents that have close contact with someone with the SARS CoV-2 infection should be placed in quarantine for 14 days after their exposure, even if viral testing is negative.

The IJ was removed on 12/27/21, at 10:23 a.m. when it could be verified by observation, interview, and record review that the facility took

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21375	Continued From page 12 steps to educate staff on the process for vaccinated and unvaccinated residents on quarantine and additional procedures were implemented to direct quarantined residents to remain in their room or to other isolated areas of the facility. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program, including immediate implementation of droplet precautions and the enforcment of resident quarantine following an exposure to mitigate COVID-19 transmission. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a	21830		1/22/22

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family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.

(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known,

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whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

This MN Requirement is not met as evidenced by:

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21830	Continued From page 15 Based on interview and document review, the facility failed to ensure the physician and resident representative was notified of skin injury concerns for 1 of 3 residents (R1) reviewed for notification of change. Findings include: R1's diagnoses included altered mental status, dementia with behavioral disturbance, transient alteration of awareness and convulsions obtained from the significant Minimum Data Set (MDS) dated 11/27/21. The MDS indicated R1 required extensive physical assistance with bed mobility, transfers, toilet use and personal hygiene. In addition, the MDS indicated R1 had severely impaired cognition and it was important for family or significant other to be involved in R1's care discussions per the staff assessment completed. A Minnesota Adult Abuse Reporting Center (MAARC) report dated 12/19/21, indicated R1 was observed with multiple bruises on both legs, arms, old bruise on right cheek by the eye, and there was a bandage with a date of 12/19/21, on the left arm and under the bandage was a three and a half inch laceration. During review of R1's medical record the following was revealed: -Weekly Skin Check assessment dated 11/21/21, identified R1 had a skin tear the size of a nickel on the left lower leg. -Weekly Skin Check assessment dated 12/3/21, indicated R1 had a scab on the right medial wrist which measured 0.3 centimeter (cm) by 0.2 cm by 0.0 cm and a small scratch measuring 2.2 cm superior to the scab.	21830	Corrected	

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21830	Continued From page 16 -Weekly Skin Check assessment dated 12/8/21, indicated R1 did not have any skin concerns. -12/11/21, at 4:10 p.m. nursing note indicated R1 had crawled from the bed to the floor and had sustained injury to the arm. The writer indicated he had applied a dressing but R1 had removed the dressing. The note did not indicated which arm and did not indicated if the family representative and physician were notified of the change in skin condition. -12/17/21, at 12:15 p.m. an incident note indicated R1 had rolled out of her bed unto a mattress laid by her bed while trying to eat her lunch. In the process R1 had scraped her left arm against the bed frame thereby bruising the old scar which bleed slightly. The writer cleansed the area and apply bacitracin ointment over the affected area. The note did not indicated if the physician and resident representative had been notified of the injury. In addition, the note did not indicated the measurement and assessment of the injury. -12/18/21, at 6:57 a.m. an incident note indicated it was reported to writer that resident had an abrasion on the left forearm when she scraped her arm on the bed, as noted and assessed, the abrasion was about 7 inches long and 5 inches wide, was dry and no bleeding noted. The writer cleansed the area during the shift and had applied Vaseline gauze, bacitracin and wrapped the forearm with two staff assistance. The note did not indicated if the physician and resident representative had been notified of the injury. During interview on 12/23/21, at 7:31 a.m. family member (FM)-A stated after R1 was transferred	21830		

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21830	Continued From page 17 to the hospital the nurse had assisted her to look at R1's body and she had observed R1 had multiple bruises on both legs, arms, old bruise on right cheek by the eye, and there was a bandage with a date of 12/19/21, on the left arm and under the bandage was a three and a half inch skin tear which appeared infected. FM-A stated she was not aware of the bruises including the skin tear on the left arm. FM-A further stated she had reached out to the facility social service director recently and had asked for staff to send her pictures of R1's body which was after a staff had called her to inform her R1 had slipped out of bed and had bruised. FM-A stated the director of social service told her she needed to communicate with the director of nursing (DON) but was never assisted to facilitate that. During interview on 12/23/21, at 2:28 p.m. DON reviewed R1's medical record and verified R1 had sustained a skin tear on the left arm. The DON reviewed the hospital provided pictures dated 12/19/21, and verified multiple skin alterations were not all documented in R1's medical record and there was no documentation of the physician and family representative being notified. The DON stated when there was a skin alteration in any resident skin, the nurses were supposed to call the provider to see if there was a treatment for the wound, the family/responsible party was to be notified and the nurse was supposed to complete a risk management assessment. The DON further stated when R1 had sustained the skin tear to the left arm registered nurse (RN)-B night nurse had notified her. The facility Skin Tears--Abrasion, Bruising and Minor Breaks, Care of policy updated 4/13/21, directed the staff that notifying the responsible family member and physician were routine "(that	21830		

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21830	Continued From page 18 is, non-immediate) if the abrasion is uncomplicated or not associated with significant trauma..." The policy directed staff to assess skin alterations, complete in-house investigation of causation, generate non-pressure form, document the family and physician being notified in the medical record, if the resident refused treatament, if the explanation was provided for refusal and staff was to complete a Report of Incident/Accident with the measurements of the alterations and interventions put in place. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON, or designee, could review applicable policies and procedures and inservice staff on timely notification to resident representatives and/or guardians and physician. The DON will then audit resident charts to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		

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F 000	INITIAL COMMENTS Victory Health and Rehab is a Special Focus Facility (SFF). On 12/22/21, through 12/24/21, and 12/27/21, 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: H5544285C (MN79524 & MN79533). with deficiencies issued at F580, F677, F684 and F880. As a result of the investigation a deficiency was also issued at F558, F625. The survey resulted in an Immediate Jeopardy (IJ) at F880 when licensed practical nurse (LPN)-A wrote a progress note that she observed R4 in the hallway of the facility. LPN-A explained to R4 that she was on quarantine and should be in her room due to exposure to COVID-19 from a positive roommate. R4 told the nurse she was not going to stay in her room. The intrium facility administrator/owner, infection control nurse (ICN) and director of nursing (DON) were notified of the IJ on 12/23/21, at 4:57 p.m. The IJ was removed on 12/27/21, at 10:23 a.m. but remained at a lower scope and severity of F, no actual harm with potential for more than minimal harm that is not immediate jeopardy, widespread. 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	F 000		

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

Electronically Signed | 01/17/2022

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F 000	Continued From page 1 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a call light was within reach to enable calling for assistance for 1 of 2 residents (R2) reviewed for call light accessibility. Findings include: R2 diagnoses included unspecified dementia without behavioral disturbance, bilateral amputee above the knee, anxiety and osteoporosis obtained from the admission record dated 12/27/21. R2's quarterly Minimum Data Set (MDS) dated 10/27/21, identified R2 had intact cognition and required total dependence of one to two staff assistance with all activities of daily living.	F 558	R 2 was provided with the call light. R2 care plan was reviewed and updated to include keeping call light within reach. Existing resident call lights were checked and the call light was in reach of the resident. All other resident care plans were reviewed and updated as needed. Facility staff were in-serviced on the answering call light policy and procedure with focus on keeping the call light within reach of the resident. DON and/or designee will be responsible for compliance. Audits on call light placement will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure sustained compliance. Audits will be reviewed by the Administrator and audit results will be	1/22/22

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F 558	Continued From page 2 R2's care plan dated 12/15/21, identified resident was at a moderate risk for falls related to bilateral amputee, psychotropic medications, weakness and dementia. The care plan directed staff to "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." R2's falls Care Area Assessment dated 5/7/21, indicated staff was to anticipate and meet the resident's needs and they were to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. In addition, the staff was to respond to resident needs and requests for assistance promptly. On 12/22/21, at 3:35 p.m. during the facility tour the call lights in rooms 100, 103, 104 and 106 were observed to be on outside the room in the hallway and were audible at the nursing station. A resident was observed seated on the toilet calling "Help me I need help to get off the toilet." At the same time R2 who was this resident's roommate was observed lying on the bed calling out for assistance as surveyor went past the room. When approached R2 stated one of the nursing assistants (NA's) had been to her room and put the call light on top of the bedside table which she was not able to reach to call for assistance. R2's roommate stated she was not able to get assistance for R2 because she needed assistance to get off the toilet to do so. R2 stated she needed assistance to turn the fan on and clip her call light to her night gown. R2 further stated she had been calling out for an hour but nobody had come. -At 3:40 p.m. surveyor summoned NA-B to R2's room. NA-B then went to the bathroom and stated	F 558	brought to QAPI for review and recommendations.	

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F 558	Continued From page 3 to R2's roommate, "let me help you before you fall." NA-B then was observed assist the roommate with pericare then cued her to keep standing as she adjusted the roommates clothing and as she left the room, NA-B told R2 she was going to return to assist her. -At 3:44 p.m. NA-B came back to R2's room and was observed moving the soft touch call light which was on top of R2's bedside table and set it on R2's chest. NA-B acknowledged the call light was not at reach for R2. NA-B also stated R2 was not able to call for assistance using the call light and due to R2's limitations R2 was not able to reach for the call light where it was and staff was to ensure R2 had the call light on at all times. On 12/23/21, at 2:52 p.m. the director of nursing (DON) reviewed the care plan for R2 and stated the staff were supposed to make sure all resident's call lights were within reach and staff was supposed to answer call lights promptly at all times. The facility Answering the Call Light policy reviewed 8/5/21, directed staff to ensure the call light was at reach at all times, staff was to answer the call lights as soon as possible and for resident who were not able to use the call lights the staff was to check on them frequently.	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		1/22/22

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F 580	Continued From page 4	F 580		

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

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct

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

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F 580	Continued From page 5 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician and resident representative was notified of skin injury concerns for 1 of 3 residents (R1) reviewed for notification of change. Findings include: R1's diagnoses included altered mental status, dementia with behavioral disturbance, transient alteration of awareness and convulsions obtained from the significant Minimum Data Set (MDS) dated 11/27/21. The MDS indicated R1 required extensive physical assistance with bed mobility, transfers, toilet use and personal hygiene. In addition, the MDS indicated R1 had severely impaired cognition and it was important for family or significant other to be involved in R1's care discussions per the staff assessment completed. A Minnesota Adult Abuse Reporting Center (MAARC) report dated 12/19/21, indicated R1 was observed with multiple bruises on both legs, arms, old bruise on right cheek by the eye, and there was a bandage with a date of 12/19/21, on the left arm and under the bandage was a three and a half inch laceration. During review of R1's medical record the following was revealed: -Weekly Skin Check assessment dated 11/21/21, identified R1 had a skin tear the size of a nickel on the left lower leg.	F 580	R1 expired. Existing residents who are at high risk and had injuries from survey exit until present, these residents received a skin assessment and the MD was notified and the MD response was documented in the resident record. Future residents, the MD will be notified of incidents with injury and areas of concern will be documented. Nurses were in-serviced on the Skin Tears Minor Abrasion Policy and Reporting with focus on reporting skin alterations to the MD and documenting each area of concern separately until healed. Audits on MD notification for acute skin changes and skin documentation will begin 2x week for 2 weeks, weekly x4 weeks then monthly to ensure compliance. Director of Nursing and/or designee will be responsible for compliance. Audits will be reviewed by the Administrator and audit results will be brought to QAPI for review and recommendations.	

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-Weekly Skin Check assessment dated 12/3/21, indicated R1 had a scab on the right medial wrist which measured 0.3 centimeter (cm) by 0.2 cm by 0.0 cm and a small scratch measuring 2.2 cm superior to the scab.

-Weekly Skin Check assessment dated 12/8/21, indicated R1 did not have any skin concerns.

-12/11/21, at 4:10 p.m. nursing note indicated R1 had crawled from the bed to the floor and had sustained injury to the arm. The writer indicated he had applied a dressing but R1 had removed the dressing. The note did not indicated which arm and did not indicated if the family representative and physician were notified of the change in skin condition.

-12/17/21, at 12:15 p.m. an incident note indicated R1 had rolled out of her bed unto a mattress laid by her bed while trying to eat her lunch. In the process R1 had scraped her left arm against the bed frame thereby bruising the old scar which bleed slightly. The writer cleansed the area and apply bacitracin ointment over the affected area. The note did not indicated if the physician and resident representative had been notified of the injury. In addition, the note did not indicated the measurement and assessment of the injury.

-12/18/21, at 6:57 a.m. an incident note indicated it was reported to writer that resident had an abrasion on the left forearm when she scraped her arm on the bed, as noted and assessed, the abrasion was about 7 inches long and 5 inches wide, was dry and no bleeding noted. The writer cleansed the area during the shift and had

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F 580	Continued From page 7	F 580		

applied Vaseline gauze, bacitracin and wrapped the forearm with two staff assistance. The note did not indicated if the physician and resident representative had been notified of the injury.

During interview on 12/23/21, at 7:31 a.m. family member (FM)-A stated after R1 was transferred to the hospital the nurse had assisted her to look at R1's body and she had observed R1 had multiple bruises on both legs, arms, old bruise on right cheek by the eye, and there was a bandage with a date of 12/19/21, on the left arm and under the bandage was a three and a half inch skin tear which appeared infected. FM-A stated she was not aware of the bruises including the skin tear on the left arm. FM-A further stated she had reached out to the facility social service director recently and had asked for staff to send her pictures of R1's body which was after a staff had called her to inform her R1 had slipped out of bed and had bruised. FM-A stated the director of social service told her she needed to communicate with the director of nursing (DON) but was never assisted to facilitate that.

During interview on 12/23/21, at 2:28 p.m. DON reviewed R1's medical record and verified R1 had sustained a skin tear on the left arm. The DON reviewed the hospital provided pictures dated 12/19/21, and verified multiple skin alterations were not all documented in R1's medical record and there was no documentation of the physician and family representative being notified. The DON stated when there was a skin alteration in any resident skin, the nurses were supposed to call the provider to see if there was a treatment for the wound, the family/responsible party was to be notified and the nurse was supposed to complete a risk management assessment. The

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F 580	Continued From page 8 DON further stated when R1 had sustained the skin tear to the left arm registered nurse (RN)-B night nurse had notified her. The facility Skin Tears--Abrasion, Bruising and Minor Breaks, Care of policy updated 4/13/21, directed the staff that notifying the responsible family member and physician were routine "(that is, non-immediate) if the abrasion is uncomplicated or not associated with significant trauma..." The policy directed staff to assess skin alterations, complete in-house investigation of causation, generate non-pressure form, document the family and physician being notified in the medical record, if the resident refused treatament, if the explanation was provided for refusal and staff was to complete a Report of Incident/Accident with the measurements of the alterations and interventions put in place.	F 580		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with	F 625		1/22/22

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F 625	Continued From page 9 paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident or resident's representative was informed of the bed hold notice at the time of hospitalization for 1 of 3 residents (R1) reviewed for hospitalization. Findings include: R1's diagnoses included altered mental status, dementia with behavioral disturbance, transient alteration of awareness and convulsions obtained from the significant Minimum Data Set (MDS) dated 11/27/21. In addition, the MDS indicated R1 had severely impaired cognition and it was important for family or significant other to be involved in R1's care discussions per the staff assessment. During a review of the interdisciplinary notes, it was revealed on 12/19/21, at 4:08 p.m. the nurse had been called by family member (FM)-A to R1's room to evaluate R1. The nurse indicated R1 was non-verbal and could not respond to nurse or FM-A. The nurse then indicated he had decided to do a rapid Covid test which R1 tested positive	F 625	R 1 expired. Existing residents who transferred to the hospital from survey exit until present will have a bed hold completed, documented and stored in the resident electronic medical record. Future residents will have the bed hold presented verbally or completion of a signed bed hold form prior to leaving the facility. Nursing and IDT team will be in-serviced on the bed policy and procedure with emphasis of obtaining verbal or written consent prior to discharge, contacting the resident representative and/or following up with the hospital social worker for resident bed hold status. Social Service and/or designee will be responsible to ensure compliance. Audits on presenting the bed hold and documentation will begin on the bed hold procedure beginning weekly x 2 weeks then monthly. Audits will be reviewed by the Administrator and audit results will be brought to QAPI for review and	

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F 625	Continued From page 10 for Covid-19. As the nurse was in the process of evaluating the R1, FM-A called 911 and the ambulance with paramedics arrived within 10 minutes and R1 was transferred to the hospital. R1's medical record was reviewed, and lacked documentation that bed hold information was offered to R1, sent to the hospital for R1, given to FM-A at the time of transfer or attempts to contact FM-A to offer the bed hold policy. During interview on 12/27/21, at 8:55 a.m. registered nurse (RN)-A stated he was supposed to provide the bed hold when residents were sent to the hospital however he had not documented he had discussed the bed hold with the R1's family member (FM)-A at the time. On 12/27/21, at 10:44 a.m. during the exit conference with the interim administrator, and the infection control nurse (ICN), the interim administrator stated he expected the the staff sending the resident to the hospital to issue the bed hold at the time of the transfer to the hospital and for emergency transfers the staff should have made a call to the hospital to discuss the bed hold policy. The facility Transfer or Discharge Notice reviewed 12/22/21, directed the staff to provide a resident and/or the resident's representative (sponsor) with a thirty day written notice of the impending transfer or discharge. The policy lacked documentation on bed hold notices for residents when being transferred to a hospital/acute care setting.	F 625	recommendations.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		1/22/22

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F 677	Continued From page 11 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R1) who was dependent on staff for meeting activities of daily living (ADLs) had trimmed toenails. Findings Include: R1's diagnoses included altered mental status, dementia with behavioral disturbance, transient alteration of awareness and convulsions obtained from the significant Minimum Data Set (MDS) dated 11/27/21. The MDS indicated R1 required extensive physical assistance with personal hygiene. R1's care plan dated 11/21/21, identified resident had an ADL self-care performance deficit related to dependency on staff to complete ADL. The care plan directed staff for personal hygiene set up assistance and at times assist of one with personal hygiene and oral care. A Minnesota Adult Abuse Reporting Center (MAARC) report dated 12/19/21, indicated R1 was observed lying in bed without a incontinent brief on and there was dried urine on sheets. In addition, R1's toenails were long and curled over toes. During a review of hospital provided pictures dated 12/19/21, it was revealed R1 had long	F 677	R1 expired. Existing resident toenails were assessed and care was provided as needed. Resident refusals will be documented. Future residents will be provided with toe-nail care per plan of care. Licensed nurses and aides will be in-serviced on the Foot Care policy with emphasis on providing routine toe-nail care for residents per plan of care and residents who have foot disorders will be referred to qualified professional. Audits on toe-nail care for residents will begin weekly x 3 weeks then monthly to ensure compliance. DON and/or designee will be responsible for compliance. Audits will be reviewed by the Administrator and audit results will be brought to QAPI for review and recommendations.	

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F 677	Continued From page 12	F 677		

toenails which were approximately 2 inches long and curled over R1's toes and around the nail bed the skin was purple.

During interview on 12/23/21, at 7:31 a.m. family member (FM)-A stated she had come to visit R1 as she had been told it was okay to visit R1. FM-A stated when she entered R1's room, R1 was lying in a fatal position and R1 had a single sheet covering her. FM-A then stated she observed the night gown had dried bowel movement smears and urine stains. FM-A also stated at the hospital the nurse had assisted her to look at R1's body and she had observed R1's toenails on both feet were long approximately 2 inches and the toenails were curled over the toes.

During interview on 12/23/21, at 2:28 p.m. the director of nursing (DON) reviewed R1's medical record and verified for six weeks R1 had been at the facility Weekly Skin Checks had been completed three times on 11/21/21, 12/3/21 and 12/8/21. The DON reviewed the hospital provided pictures dated 12/19/21, and the facility Weekly Skin Checks assessments completed on 12/3/21 and 12/8/21 and acknowledged although the toenails had been marked trimmed, the documentation was not accurate "they would have to have a podiatrist trim those they are at least 2 inches long and curled." . The DON stated both toenail and fingernail care should be done with showers and if the staff are not able to do it they were to let the nurse know. The DON also stated the staff was to attempt or re-approach the resident the next shift.

On 12/27/21, at 10:44 a.m. during the exit conference with the interim administrator, and the infection control nurse (ICN), the interim

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F 677	Continued From page 13 administrator stated he would not have expected a nurse to trim R1's toenails but should be seen by a podiatrist, he further stated he was not sure about the contracted podiatrist schedule cycle. The interim administrator added, "[R1] had came to us with those toenails" but was not sure if R1 had been scheduled for podiatry as R1 had signed the consent for services at admission. The facility Activities of Daily Living (ADL's), Supporting policy reviewed 12/7/21, directed staff for resident who were unable to carry out ADL's independently the staff was to ensure they received the services necessary to main good nutrition, grooming, personal and oral hygiene.	F 677		
F 684 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 observation, interview and document review, the facility failed to investigate bruising for 1 of 1 residents (R1) reviewed for non-pressure related skin concerns. Findings include: R1's diagnoses included altered mental status, dementia with behavioral disturbance, transient	F 684	R1 expired. Existing residents noted with bruises, a risk management incident will be created and thoroughly investigated. Future incidents with bruises will have a risk management created and thoroughly investigated. Licensed staff was in-serviced on the updated Care of Skin Tears, Abrasion, Bruising and Minor Breaks policy and	1/22/22

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F 684	Continued From page 14 alteration of awareness and convulsions obtained from the significant Minimum Data Set (MDS) dated 11/27/21. The MDS indicated R1 required extensive physical assistance with bed mobility, transfers, toilet use and personal hygiene. A Minnesota Adult Abuse Reporting Center (MAARC) report dated 12/19/21, indicated R1 was observed with multiple bruises on both legs, arms, old bruise on right cheek by the eye, and there was a bandage with a date of 12/19/21, on the left arm and under the bandage was a three and a half inch laceration. During review of R1's medical record the following was revealed: -Weekly Skin Check assessment dated 11/21/21, identified R1 had a skin tear the size of a nickel on the left lower leg. -Weekly Skin Check assessment dated 12/3/21, indicated R1 had a scab on the right medial wrist which measured 0.3 centimeter (cm) by 0.2 cm by 0.0 cm and a small scratch measuring 2.2 cm superior to the scab. -Weekly Skin Check assessment dated 12/8/21, indicated R1 did not have any skin concerns. -12/11/21, at 4:10 p.m. nursing note indicated R1 had crawled from the bed to the floor and had sustained injury to the arm. The writer indicated he had applied a dressing but R1 had removed the dressing. The note did not indicated which arm. -12/17/21, at 12:15 p.m. an incident note indicated R1 had rolled out of her bed unto a	F 684	procedures with the focus on measuring the bruise and documentation daily until bruise is resolved. The DON and/or designee is responsible for compliance. Audits on risk management incidents with injuries and daily injury documentation will begin 2x week for 2 weeks, weekly x4 weeks then monthly to ensure ongoing compliance. Audit results will be reviewed by the Administrator and the Administrator will present the audit results at QAPI for review and recommendation.	

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F 684	Continued From page 15	F 684		

mattress laid by her bed while trying to eat her lunch. In the process R1 had scraped her left arm against the bed frame thereby bruising the old scar which bleed slightly. The writer cleansed the area and apply bacitracin ointment over the affected area. In addition, the note did not indicated the measurement and assessment of the injury.

-12/18/21, at 6:57 a.m. an incident note indicated it was reported to writer that resident had an abrasion on the left forearm when she scraped her arm on the bed, as noted and assessed, the abrasion was about 7 inches long and 5 inches wide, was dry and no bleeding noted. The writer cleansed the area during the shift and had applied Vaseline gauze, bacitracin and wrapped the forearm with two staff assistance.

During interview on 12/23/21, at 7:31 a.m. family member (FM)-A stated after R1 was transferred to the hospital the nurse had assisted her to look at R1's body and she had observed R1 had multiple bruises on both legs, arms, old bruise on right cheek by the eye, and there was a bandage with a date of 12/19/21, on the left arm and under the bandage was a three and a half inch skin tear which appeared infected. FM-A further stated she had reached out to the facility social service director recently and had asked for staff to send her pictures of R1's body which was after a staff had called her to inform her R1 had slipped out of bed and had bruised. FM-A stated the director of social service told her she needed to communicate with the director of nursing (DON) but was never assisted to facilitate that.

During interview on 12/23/21, at 2:28 p.m. DON reviewed the hospital provided pictures dated

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F 684	Continued From page 16 12/19/21, and verified multiple skin alterations were not all documented in R1's medical record. The DON stated the nurses were supposed to complete a risk management assessment and documentation for all skin alterations. The facility Skin Tears--Abrasion, Bruising and Minor Breaks, Care of policy updated 4/13/21, directed the staff that notifying the responsible family member and physician were routine "(that is, non-immediate) if the abrasion is uncomplicated or not associated with significant trauma..." The policy directed staff to assess skin alterations, complete in-house investigation of causation, generate non-pressure form, document the family and physician being notified in the medical record, if the resident refused treatament, if the explanation was provided for refusal and staff was to complete a Report of Incident/Accident with the measurements of the alterations and interventions put in place.	F 684		
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		1/22/22

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

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F 880	Continued From page 17 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 18 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Centers for Disease Control (CDC) guidelines were followed to prevent or minimize the transmission of COVID-19 for 1 of 5 residents (R4) who were placed on quarantine, though not enforced, following exposure to a COVID-19 positive roommate. This had the potential to affect 54 of 59 residents who had the potential to be exposed to R4 while accessing the communal areas of the facilities. The IJ began on 12/23/21, at 5:42 a.m. licensed practical nurse (LPN)-A wrote a progress note that she observed R4 in the hallway of the facility. LPN-A explained to R4 that she was on quarantine and should be in her room due to exposure to COVID-19 from a positive roommate. The progress note read; R4 told the nurse she was not going to stay in her room. The facility administrator and director of nursing (DON) were notified of the IJ on 12/23/21 at 4:57 p.m. The IJ was removed on 12/27/21, at 10:23 a.m. but remained at a lower scope and severity of F, no actual harm with potential for more than minimal harm that is not immediate jeopardy, widespread.	F 880	R 4 completed quarantine on 01/05/2022. R 4 was assessed and tested for COVID and as of current remains asymptomatic for COVID-19. R 4 will have a COVID care plan initiated and intervention will be implemented. All other residents were observed and experienced no adverse effect from the resident non-compliance to quarantine. The MD will be notified of this breech in infection control and their response will be recorded in the next QAPI meeting. Future residents who require quarantine will be educated, a COVID care plan initiated and appropriate interventions implemented and resident non-compliance documented. Facility staff will be in-serviced on the COVID-19 room assignment policy and procedure with emphasis on unvaccinated residents who are exposed to COVID will remain in quarantine for 14 days a respiratory care plan will be implemented, and interventions will be implemented that include resident hand hygiene and reminders to don face masks while in common areas. Future residents who	

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F 880	Continued From page 19 Findings include: R4's quarterly Minimum Data Set (MDS) dated 11/4/21, noted R4 had intact cognition and was independent with most activities of daily living (ADL's). R4's face sheet accessed on 12/27/21, noted R4's diagnoses included: paranoid schizophrenia, anemia, hypokalemia, heart disease and tobacco use. The facility provided a listing of COVID-19 positive residents during routine testing on 12/21/21. During review of the infection control binder provided by the infection control preventionist, it was revealed the facility had been in outbreak status since 11/17/21, with a total of four positive staff members and 15 positive residents and one COVID-19 related death on 12/20/21, due to exposure to a positive roommate. The facility documented that R4 refused the COVID-19 vaccination when offered under the immunization tab of R4's electronic health record (EHR). During continuous observation on 12/23/21, beginning at 9:13 a.m. R4 approached this surveyor in the south hall without a mask on. R4 was concerned about housekeeping cleaning her room. At 9:22 a.m. R4 was seen outside smoking with several other unmasked residents, the smoking aide assisted R4 to the smoking area. At 9:31 a.m. R4 was in the dining room near the smoking area exit, unmasked and was within 6 feet of other unmasked residents. At 9:36 a.m. R4 was again observed outside smoking with	F 880	require quarantine will be educated (to the degree possible) on hand hygiene and donning a mask if in common areas. The DON and IP will review the CDC Guideline for Isolation Precautions, MDH COVID-19 Infection Prevention and Control and Cohorting and the MDH: Interim Guidance for Hospital Discharge to Home or Admission to Congregate Living Settings and Discontinuing Transmission Based Precautions documents. A directed plan of correction root cause analysis will be conducted by the IDT team with review from the independent infection prevention consultant and the results of the root cause analysis will be implemented. The DON and Infection Preventionist and/or designee is responsible for compliance. Audits on resident placement of each new admission and resident location daily to ensure transmission based precautions are appropriately implement when cohorting residents. Audits will decrease when compliance for transmission based precautions are achieved. Audit results will be reviewed by the DON, IP and Administrator and the Administrator will present the audit results at QAPI for review and recommendation.	

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other unmasked residents. At 10:03 a.m. R4 was near the nursing station and continued to self-propel her wheelchair to the north hall and approached a staff member. At 10:08 a.m. R4 was unmasked and in the dining room pouring coffee near other unmasked residents. At 10:21 a.m. R4 was still unmasked and in the dining room near the exit to the smoking area among other unmasked residents. At 10:24 a.m. the smoking aide placed a smoking apron on R4 and she went back outside to smoke. At 10:34 a.m. R4 re-entered the dining room, unmasked and within six feet of other unmasked residents.

When interviewed on 12/23/21, at 9:23 a.m. trained medication aide (TMA)-A stated she was unsure if quarantine residents had to remain in their room or if they are limited to certain areas of the facility.

When interviewed on 12/23/21 at 9:41 a.m. licensed practical nurse (LPN)-A stated a resident on quarantine should be observed for symptoms, they should limit their interaction with other residents however, they cannot stop the resident from going out to smoke when they want to.

When interviewed on 12/23/21, at 10:45 a.m. nursing assistant (NA)-A stated if a resident is on quarantine they should remain in their room. NA-A further stated she was not aware of any residents on quarantine.
When interviewed on 12/23/21, at 11:17 a.m. the infection preventionist (IP) stated R4 was put on quarantine status the evening of 12/22/21, after her roommate tested positive for COVID-19. Further, the IP stated residents that are on quarantine are required to stay in their rooms and if they are non-compliant with staying in their

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rooms, the interdisciplinary team will meet to come up with a solution. The IP stated R4 was not compliant with quarantining in her room, but there had not been an interdisciplinary meeting and one had not been scheduled at that time.

When interviewed on 12/23/21, at 11:17 a.m. the infection preventionist (IP) stated she was made aware of R4's roommate testing positive on the evening of 12/22/21. The IP stated she then called the facility and notified staff that R4's roommate tested positive for COVID-19 and was moved to the COVID-19 isolation wing in the facility and that R4 should be placed on quarantine.

When interviewed on 12/23/21, at 11:31 a.m. the acting administrator (AA) stated there were designated smoking times for residents that are on quarantine. The AA further stated they currently don't have any quarantined residents that go out to smoke.

On 12/23/21, at 12:18 p.m. social services (SS)-A and the IP stated they conducted a meeting and have developed interventions for keeping R4 in her room during her quarantine.

When interviewed on 12/23/21, at 2:01 p.m. an activities assistant (AA)-A stated R4 disliked wearing masks and would tell staff she would put mask on when she was "damn good and ready."

Resident refused interview on 12/23/21, at 2:06 p.m.

When interviewed on 12/23/21, at 2:18 p.m. the director of nursing (DON) stated quarantine residents must be in their rooms. The DON

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further stated she was unaware R4 was out of her room, self-propelling her wheelchair throughout the facility unmasked. The DON stated that should not have happened.

When interviewed on 12/23/21, at 3:58 p.m. the IC nurse stated R4 refused to be tested during the facility wide outbreak testing on 12/21/21. Further, the IC was not sure the last time R4 agreed to testing and referred to a three-ring binder for the information.

On 12/24/21, at 1:30 p.m. during the first attempted removal visit R4 was observed wearing a mask and was being wheeled down the hallway by the activities assistant (AA), they went past the nursing station and as they went past the employee break room, R4 asked AA to stop outside the employee breakroom. R4 then removed her mask and was observed talking to the staff who sat in the room. AA then redirected R4 to leave the mask on. R4 re-applied the mask and AA then wheeled R4 through the dining room to the entrance of the smoking area where R4 joined other residents in the smoking area.
-At 1:35 p.m. to 1:37 p.m. R4 was observed being assisted from the smoking area by staff and back into the dining room. At 1:38 p.m. R4 was observed return into the building from the smoking area and as she went past the door threshold AA cued her to wear her mask. At 1:40 p.m. R4 asked AA for a cup of coffee to drink in the dining room.
-At 1:41 p.m. AA approached R4 with a cup with coffee and was overheard telling R4 she was supposed to always have the mask on when out of the room except when eating, drinking or smoking. At 1:43 p.m. to 1:49 p.m. R4 was observed drinking coffee in the dining room. At

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1:50 p.m. R4 was observed go over to the door again asked to go outside to smoke. As she approached the table with smoking supplies R4 was assisted by the staff to the smoking area however she did not have a mask on as she went past two residents who sat and stood by the door. At 1:57 p.m. R4 returned to the dining room and sat at the table by the wall as she continued to drink the coffee and not wearing a mask. At this same time AA and kitchen staff was observed setting up the dining room for the resident Christmas party and residents were independently coming into the dining room and being seated. At 2:06 p.m. to 2:29 p.m. R4 remained at the table seated not drinking or eating and was not wearing a mask. At 2:11 p.m. the DON came into the dining room and stood by R4 but never redirected R4 to go back to her room or wear a mask.
-At 2:13 p.m. the DON re-directed R4 to wear the mask and R4 asked how about the test results. R4 then asked the DON to stop standing by her and still did not put the mask on. The DON continued to stand by R4 and at this time the dining room had 15 residents seated waiting to be served food. At 2:29 p.m. as AA brought R4 food to eat in the dining room, the surveyor intervened, and the DON stated R4 was not supposed to be in the dining room because she was supposed to be quarantined in her room due to the exposure. The DON stated R4 was supposed to have been brought back to the room after smoking but AA was assisting with the Christmas party.
-At 2:31 p.m. DON wheeled R4 out of the dining room down the hallway to her room.

During interview on 12/24/21, at 2:39 p.m. the activities assistant stated she did not know that R4 was not supposed to participate in communal

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activities. The activities assistant stated she thought if R4 had her mask on and maintained 6 feet this was appropriate. AA stated she had told R4 if she was not eating and drinking, she was supposed to have her mask on and she did not know why other staff did not re-direct R4 to put the mask on as she was busy assisting with the activity.

During interview on 12/24/21, at 3:04 p.m. the DON stated the facility was going to revised the training for the staff to include -unvaccinated residents can only go to smoke then back into their rooms and she of the infection control nurse would communicate to the staff the vaccination status of a residents when this situations came up and this would be implemented immediately in IJ the removal staff training.

An undated facility policy titled, COVID-19 Outbreak and Routine Testing Procedure was provided. The policy noted residents that refuse testing during an outbreak should be placed on transmission-based precautions (TBP) until the criteria for discontinuing the TBP have been met. Further, for these residents additional monitoring is necessary to ensure the resident maintains appropriate distancing, wears a face covering and practices hand hygiene. Additionally, the policy noted unvaccinated residents should generally be restricted to their rooms and not participate in group activities.

The CDC guidance for unvaccinated residents reads; unvaccinated residents that have close contact with someone with the SARS CoV-2 infection should be placed in quarantine for 14 days after their exposure, even if viral testing is negative.

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F 880	Continued From page 25 The IJ was removed on 12/27/21, at 10:23 a.m. when it could be verified by observation, interview, and record review that the facility took steps to educate staff on the process for vaccinated and unvaccinated residents on quarantine and additional procedures were implemented to direct quarantined residents to remain in their room or to other isolated areas of the facility.	F 880		

Electronically delivered
January 5, 2022

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

RE: CCN: 245544
Cycle Start Date: December 2, 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 December 19, 2021, we informed you of imposed enforcement remedies.

On December 27, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be 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 widespread deficiencies that constituted immediate jeopardy (Level L), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On December 27, 2021, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of F.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 3, 2022.

- Directed plan of correction, Federal regulations at 42 CFR § 488.424 Please see electronically attached documents for the DPOC.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our

recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 3, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 3, 2022.

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.

As we notified you in our letter of December 19, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 3, 2022.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule 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: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 June 2, 2022 (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 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.

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/ 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 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
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