Electronically delivered
May 24, 2022

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

RE: CCN: 245544
Cycle Start Date: May 6, 2022

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On May 6, 2022, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 8, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 8, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 8, 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.

This Department is also recommending that CMS impose:

• 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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 8, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Victory Health & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 8, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

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

DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 November 6, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program

Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Victory Health and Rehabilitation Center is a Special Focus Facility (SFF). On 5/2/22 to 5/6/22, an abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH) to conduct multiple complaint investigations. The facility was found to not be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H55441080C (MN83099) with non-compliance cited at F684. H5544310C (MN83028) with non-compliance cited at F684. The following complaint was found to be unsubstantiated: H5544309C (MN83030); however, incidental non-compliance was identified and cited at F580, F692. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		6/10/22

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

Electronically Signed

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 §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 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).	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 §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 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 an extended period of repeated refusals of insulin and medication were reported and addressed with the medical provider and responsible party to reduce the risk of complication or adverse event for 1 of 3 residents (R1) reviewed for notification of change. Findings include: R1's significant change Minimum Data Set (MDS), dated 11/27/21, identified R1 had severe cognitive impairment, required extensive assistance with most of her activities of daily living (ADLs), and had diabetes mellitus. R1's care plan, closed 12/20/21, identified R1 had behaviors which included yelling, hitting, biting staff, and refusing cares. Further, the care plan outlined R1 had diabetes mellitus and listed a goal which read, "The resident will have no complications related to diabetes ..." There was a single intervention listed to help R1 meet this goal which read, "Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness."	F 580	F 580 R1 has since passed away. Current resident progress notes were reviewed and any medication refusal documented, the MD will be contacted for further orders. Future residents who refuse medications and are experiencing acute change in condition, the MD will be called and the MD order obtained will be followed. Nursing staff will be in-serviced by the DON and or designee on the policy Refusal of Treatment with emphasis on notifying the MD time frame determined by the resident's condition and potential serious consequences of the refusal. In addition, the resident will be interviewed to determine the reason for refusal. Director of Nursing and/or designee is responsible for compliance. Audits will be completed by the Quality Improvement RN and or designee on documented resident refusals and MD response will begin 2x week for 2 weeks, weekly x 3 weeks then monthly to ensure compliance. Audit results will be reviewed by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 R1's nursing home History and Physical note, dated 11/9/21 (the day following R1's admission), identified R1 was being seen to establish care and listed R1 as admitting from the acute hospital for syncope and seizure secondary to a history of alcohol dependence. R1 was recorded as receiving glipizide, metformin, and insulin to help treat her diabetes, along with having Wernicke's encephalopathy [a disorder that primarily affects the memory system in the brain] with dictation reading, "+behaviors, verbal yelling and refusing cares." The report listed an, "Assessment and Plan," which reviewed R1's diabetes and directed, " ... Patient has documented noncompliance with meds and cares so unclear if no BG [blood glucose] checks cause she is refusing??? Too little info to continue scheduled short acting insulin at this time." R1's most recent Evaluation and Management note, dated 12/10/21, identified R1 was seen by a physician's assistant (PA) and recorded, "BG range: 128-182 over past 2 wks [weeks] (not being recorded daily)." R1 continued on glipizide, metformin, and insulin. However, after R1's NP visit on 12/10/21, R1's Medication Administration Record (MAR), dated 12/2021, identified several medications were refused and/or not provided for various reasons including: 1) Insulin Glargine (a long-acting insulin) with directions to administer 20 units subcutaneously every morning. This was recorded as being refused and/or not provided on 12/10/21, 12/11/21, 12/12/21, 12/13/21, 12/14/21, 12/15/21, 12/16/21, and 12/17/21; next being given on 12/18/21 with a recorded blood sugar of 143	F 580	Administrator and the Administrator will bring results to QAPI for review and recommendation. Compliance: 6/102022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4 mg/dl (a normal blood sugar reading is less than 140 mg/dl). 2) Omeprazole (used to treat heartburn or stomach ulcers) with directions to administer 20 milligrams (mg) once a day. This was recorded as being refused and/or not provided on 12/10/21, 12/11/21, 12/13/21, 12/14/21, 12/15/21, 12/16/21, and 12/17/21; next being given on 12/18/21. 3) Albuterol Sulfate HFA Inhaler with directions to administer 1 puff two times day. This was recorded as being refused and/or not provided on 12/10/21 (AM), 12/11/21 (AM), 12/12/21 (AM and PM), 12/13/21 (AM), 12/14/21 (AM), 12/15/21 (AM), 12/16/21 (AM), 12/17/21 (AM); next being given on 12/18/21. 4) Insulin Aspart (a short-acting insulin) with directions to administer 4 units subcutaneously three times a day. This was recorded as being refused and/or not provided on 12/10/21 (two of three doses), 12/11/21 (two of three doses), 12/12/21 (all three doses), 12/13/21, (two of three doses), 12/14/21 (two of three doses), 12/15/21 (all three doses), 12/16/21 (two of three doses), and 12/17/21 (two of three doses). On 5/2/22 at 8:09 a.m. R1's family member (FM)-B was interviewed. FM-B explained R1 admitted to the nursing home in November 2021, and she was R1's responsible party and helped R1 make decisions about her care due to her cognition. R1 was focused more on palliative (non-curative) care when she admitted, however, was not considered to be terminal or at the end of her life. FM-B expressed she visited R1 at the nursing home on 12/19/21, and found R1	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5	F 580		

appearing "severely dehydrated and malnourished" so R1 was subsequently transferred to the hospital where she passed away. FM-B expressed frustration with the lack of notification of R1's condition and stated she was never contacted or told by the nursing home R1 had declined or had been refusing medications for several days prior to her death at the hospital.

R1's medical record was reviewed and lacked evidence R1's medical provider (i.e., medical doctor and/or nurse practitioner) or their responsible party was updated with the repeated refusals of medications from 12/10/21 to 12/17/21, despite R1 having diabetes mellitus and severe cognitive impairment. There was no evidence the nursing home had contacted the medical provider or R1's responsible party with these refusals to help ensure a plan was developed to facilitate any potential increased monitoring as a result of the refusals or improve adherence to the medication regimen to reduce the risk of disease complication.

When interviewed on 5/2/22, at 2:15 p.m., registered nurse (RN)-B recalled R1 and had worked with her "once in awhile." RN-B described R1 as "feisty" and would reject cares "most of the time" when offered to her. RN-B explained if a resident refuses medications, then the medical provider should be updated and the notification should be documented in the medical record. RN-B reviewed R1's medical record and acknowledged there was no evidence the provider or family had been updated with R1's extended period of medication refusal (from 12/10/21 to 12/17/21) and explained the medical providers were onsite frequently and staff seem to "have a rapport" with them and could possibly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 6	F 580		

have just updated them verbally as staff "normally don't document" every single communication or discussion they have with the medical providers. RN-B stated the lack of documentation demonstrating R1's medical provider(s) were updated with the refusals was an example of the poor orientation process the nursing home had and added, "[It] falls back to what the expectations are." RN-B elaborated and explained several nurses likely would not even know to contact the provider with medication refusals, as demonstrated with R1, and added all refusals should be communicated to the medical provider as refusals, including extended periods of refusals, which could lead to negative outcomes. RN-B added, "It's really important," and the provider should be updated "as soon as possible."

On 5/2/22 at 4:37 p.m., nurse practitioner (NP)-B stated she recalled R1 but expressed she "hardly" knew her as only recalled seeing her one time during her admission to the nursing home. NP-B reviewed their electronic record system and voiced there was no dictation or evidence they had been updated with R1's repeated refusals and subsequent lack of insulin or medication administration on and after 12/10/21 adding, "We weren't made aware." NP-B stated the medical provider group should have been updated and explained, had they been notified, they would have likely involved family and discussed the refusals with R1 to potentially help better medication administration.

When interviewed on 5/3/22 at 10:26 a.m., the acting director of nursing (DON) stated he had reviewed R1's medical record and was unable to locate any evidence R1's physician team or the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 7 responsible party had been notified of the repeated medication refusals, including the refused insulin dosing from 12/10/21 to 12/17/21. The DON expressed staff should have "immediately" contacted the physician team and responsible party to help determine if new interventions were needed or warranted (i.e., increased monitoring), and to ensure the risk of not taking the medications was explained and communicated to the resident and responsible party. On 5/3/22 at 1:45 p.m., the chief executive officer (CEO) and administrator were interviewed. The CEO expressed the admission history and physical note completed for R1 on 11/9/21 (the day after she admitted), served as notification to the medical providers with regards to her refusal of medications. The CEO added, "They were aware." When discussing the lack of evidence supporting R1's responsible party had been notified of the multiple refused doses of medication, neither the CEO or administrator commented about it. A facility' policy on notification of change and/or medication refusals was requested and not provided.	F 580		
F 684 SS=G	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	F 684		6/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 8 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R2) reviewed for diabetic management were provided adequate care in accordance with current standards of practice and facility standing orders. This practice included lack of monitoring of low diabetic blood glucose (sugar) readings and interventions. This resulted in actual harm for R2 when he was found unresponsive due to low blood glucose and required emergency medical care at the hospital. Additionally, based on observation, interview and document review, the facility failed to implement interventions including completion of dressing changes as ordered with the administration order of Eucerin cream for 1 of 3 residents (R5) with non-pressure related wounds Findings include: R2's facility Admission Record, dated 10/14/21, indicated R2's diagnoses included insulin dependent diabetes mellitus (IDDM) (an autoimmune disorder in which the body destroys the cells that produce insulin) with foot ulcer, pancreatitis (inflammation of the pancreas), and osteomyelitis (inflammation of bone caused by infection). R2's quarterly Minimum Data Set (MDS), dated 2/5/22, identified R2 had intact cognition, exhibited no behaviors or rejection of care, and received insulin injections. R2's MDS further indicated R2 required supervision for eating and drinking during meals.	F 684	F 684 R 2 Insulin protocol and blood glucose documentation were reviewed by Primary Care Physician on 5/27. There was no change in current treatment plan. R2 and current residents with insulin orders were reviewed and their care plans updated as needed to include interventions for hypo/hyperglycemic episodes by the MDS coordinator. In addition, supplement and diet orders were reviewed and updated as needed by the Registered Dietician. Future residents will have insulin and meals delivered timely per policy and these residents will be observed for meal completion and for signs/symptoms of hypo/hyperglycemia after insulin administration. R 5 Wounds were assessed and orders were reviewed by MD. Euserin was discontinued and Remedy ointment was ordered. Current residents with wounds orders were reviewed and their skin/pressure care plan was also reviewed and updated as needed. Ointments, creams and treatment supplies were audited and stock replenished as needed. Future resident with wounds will have their treatment applied per physician orders. Nursing staff were in-serviced on the Management of Hypoglycemia by DON and or designee, with emphasis on recording/documenting the resident's level of consciousness before and after insulin	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 9 R2's care plan revised 5/2/22, indicated R2 had IDDM and directed staff to monitor and document side effects and effectiveness of medications. Additionally, R2's care plan lacked interventions to reduce the risk for hypoglycemic (low blood sugar related) events, monitor for signs and symptoms hypoglycemia (low blood sugar) which included slurred speech, loss of consciousness, confusion, increased lethargy, sweating, increased thirst and urination after R2 was sent to the emergency department on 3/3/22 following an episode of blood sugars becoming dagerously low. During interview on 5/4/22, at 12:06 p.m. R2 stated the staff at the facility had a difficult time managing his blood sugars from going to low and giving insulin as ordered. R2 further stated he recently required emergency medical services for the provision of emergency hypoglycemia care, was subsequently sent to the emergency room and received emergency treatment several times since admission to the facility for low blood glucose and going into a diabetic coma. He further stated his meals vary when they are delivered to the room anywhere from 7:30 a.m. to 8:30 a.m. R2 stated no staff had followed up with him on his episodes of hypoglycemia or developed a plan to help monitor for low blood sugars. R2 further stated he was aware when his blood sugars were low and attempted to notify the staff, but staff would take too long to respond. R2 stated he was tired of going to the hospital for his low blood sugars and it could be avoided if staff would monitor or provide better diabetes management. R2's physician progress note (PN) dated 3/7/22,	F 684	administration and on the Food and Nutrition Policy indicating that meals and supplements will be provided within 45 minutes of scheduled meal-time, and in accordance with the resident's medication requirements. In addition, the licensed nurses were in-serviced on the Administering Medications with emphasis on administering medications in accordance with prescriber orders, including any required time frame. Director of Nursing and/or designee is responsible for compliance. The Quality Improvement RN and or designee will complete Audits on insulin orders, supplements given, mealtime delivery and following physician wound orders will begin 3x week for 3 weeks, 1x week for 5 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will bring results to QAPI for review and recommendation. Compliance:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 10 indicated R2 was first hospitalized for hypoglycemia from 1/1/22 to 1/6/22, while at the facility . R2's medication order dated 3/1/22, directed staff to give Novolog (insulin) 100 unit/milliliter (ml) pen, inject 10 units subcutaneously (injection given under the skin) three times a day before meals. R2's Order Summary, dated 5/3/22, indicated R2 was ordered: - on 10/18/21, consistent carbohydrate (mild diabetic) diet. - on 4/26/22, check blood sugar before meals. - on 3/8/22, Basglar KwikPen (diabetes management medication) 100 unit/ml inject 48 units subcutaneously at bedtime. R2's Medication Administration Record (MAR), dated March 2022, indicated R2 received: - Insulin Glargine (long acting insulin) 48 units subcutaneously at bedtime for diabetes and was given on 3/1/22, 3/2/22, and 3/3/22 at bedtime. - Boost Glucose Control twice a day was to start on 3/26/22. R2's MAR lacked indication any Boost was given from 3/26/22 to 4/10/22. - Administer insulin with meals and indicated, "if you do not see the meal do not administer the insulin for risk for hypoglycemia." - Check blood glucose three times a day, only check prior to meals, and as needed if R2 became symptomatic. - Continue correction scale of 1:50 greater than 150 (one unit per 50 for a blood sugar of 150) every shift for diabetes. - Novolog Solution, (Insulin Aspart) inject 10 unit subcutaneously three times a day for diabetes. Give base dose 10 units if pre-meal blood sugar	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11 is greater than 70. - Novolog Solution injection at sliding scale subcutaneously (injection under the skin) before meals for DM and continue correction scale of 1:50 greater than 150 started on 3/3/22. - 70-150 give 10 units - 151-200 give 11 units - 201-250 give 12 units - 251-300 give 13 units - 301-350 give 14 units - 351-999 give 15 units - 351 and over give 13 units Review of R2's MAR administration times indicated on 3/3/22, R2 received scheduled Novolog 10 units given at 6:58 a.m. and sliding scale insulin 14 units given at 7:03 a.m. for a blood sugar of 344. R2's nurse PN dated 3/3/22, at 12:12 p.m. indicated R2 was sent to hospital after being unresponsive. R2's nurse PN dated 3/3/22, at 1:22 p.m. indicated R2 was found around 10:45 a.m. unresponsive with a blood sugar of 45 and R2's nurse gave glucagon injection and called 911. R2's nurse PN, dated 3/3/22, at 5:14 p.m. indicated "Resident BG check before breakfast was 344 around 8 am. As per orders this resident was given 14 units. Resident was given breakfast (scrambled eggs,oatmeal, milk and one piece of toast). Writer returned to check on the resident at 1045 AM and found him not responding. Resident was checked 45 minutes later BS was 45. Immediately help was requested, another nurse who gave Glucagon injection immediately. Writer noticed that the resident didn't eat any food item	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12 on his tray. After about 15 minutes the BG level was 103. Paramedics arrived checked his BP 156/105, P99 and he was taken for evaluation. Hospital called that he will be back today." Progress note did not include interventions or assessments were done between insulin administration and R2's unresponsiveness episode at 10:45 a.m. and the blood sugar check 45 minutes later. R2's hospital Discharge Summary (DS), dated 3/3/22, indicated on emergency medical services arrival (EMS) to the facility R2's blood sugar was 62 and EMS administered D10 (dextrose - emergency low blood surgar medication) 10 grams and R2 became more responsive enroute to the emergency department (ED). R2's DS indicated he was brought to the ED by EMS related to being hypoglycemic after administration of insulin. R2's DS further indicated R2 had a history of type one diabetes, chronic pancreatitis, and diabetic ketoacidosis (a serious complication of diabetes that can be life-threatening). Following hospitalization the following new sliding scale insulin orders were started: - Novolog Solution (Insulin Aspart) Inject as per sliding scale subcutaneously (injection under the skin) before meals for DM start date 3/8/22 indicated, if 151 - 200 = 2 units 201 - 250 = 4 units 251 - 300 = 6 units 301 - 350 = 8 units 351 - 400 = 10 units If greater than 400 units, give 10 units and call TCP	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 13 R2's MAR dated April 2022, indicated on 4/1/22, at 7:34 a.m. R2 received 10 units scheduled and 11 units per sliding scale for a blood sugar before breakfast of 182. R2's blood sugar reading at 11:00 a.m. indicated his blood sugar was 37. R2's nurse PN dated 4/1/22, at 11:59 a.m. indicated "Residents BS at 11 am is 37 mg/dl. Pt appears unresponsive, diaphoresis noticed and skin is clammy to touch. Nurse administered glucogon and alerted paramedics at 11:15 a.m. of Pt's current state. Resident's BS level at 11:15 a.m. is 49 mg/dl. Paramedics arrived at facility at 11:25 a.m. and attempted resuscitating resident via the use of IV glucagon. Resdient [sic] became responsive and was transported to the hospital via paramedics. Nursing alerted NP about patient's status. Will continue to monitor." R2's nurse PN dated 4/1/22, at 12:31 p.m. indicated R2 was returned to the facility without hospital admission on 4/1/22, after paramedics resuscitated R2 using glucogon. R2's provider PN dated 4/1/22, indicated R2 was unconscious on 4/1/22 due to a low blood sugar of 37 from not eating enough for breakfast after insulin was administered. R2's MAR dated April 2022, indicated on 4/4/22, at 7:30 a.m. R2 received Novolog 10 units scheduled and 14 units per sliding scale for a blood sugar before breakfast of 341. R2's nurse PN dated 4/4/22, at 2:49 p.m. indicated "Resident's finger stick glucose level at 11 am was 37 mg/dl. Resident had symptoms like tremors, cold clammy skin, diaphoresis, increased heart rate and respiratory rate and	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 14	F 684		

resident was not alert. Paramedics were notified and arrived at 11:25 a.m. IV dextrose was administered. Writer updated NP about the incident. Resident was later educated about safety measured, importance of eating regular meals and snacks, causes of hypoglycemia and importance of maintaining a normal blood glucose level. Nursing will continue to monitor.

R2's provider PN dated 4/8/22, indicated R2 was seen by nurse practitioner (NP) by request of staff for review of multiple orders for R2's blood sugar management. R2's PN indicated R2 had two episodes in the last week of unresponsiveness due to low blood sugars.

During interview on 5/2/22, at 8:18 a.m. family member (FM)-A stated she had concerns regarding the care provided by facility of the diabetes management of R2. FM-A further stated R2 had multiple hospital and emergency room visits due to hypoglycemia which could be avoided with proper management of insulin, meals, education, and follow up assessment to ensure R2 was eating his meals.

During interview on 5/3/22, at 11:45 a.m. family member (FM)-A stated R2 had been sent to the emergency room two to three times related to going into a diabetic coma and hypoglycemia. FM-A further stated the staff would administer R2 insulin, and not follow-up to make sure he had eaten, or he had side symptoms of hypoglycemia. FM-A stated she was concerned for R2 and the frequent hypoglycemic events.

During interview on 5/3/22, at 9:20 a.m. LPN-B when asked about the incident on 3/3/22, responded "what did my progress note state, that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 15 is what I did." LPN-B further stated, "I gave the medications when I documented." LPN-B further stated he got busy with providing blood sugar checks for other residents, and did not provide an explanation why there were no interventions for 45 minutes following first finding R2's unresponsiveness episode on 3/3/22 at 10:45 a.m.. During interview on 5/2/22, at 3:00 p.m. nurse practititioner (NP)-B stated R2 had "bottomed out twice." NP stated she was not aware R2 was not assessed by nursing staff for his blood sugar at 10:45 a.m. on 3/3/22, when he was first found unresponsive. During interview on 5/3/22, at 10:06 a.m. nurse practitioner (NP)-A stated R2 is a type one diabetic with history of hypoglycemia, and R2's insulin should be administered within 15 minutes before or 15 minutes after a meal. NP-A further stated she was also concerned regarding R2 was observed unresponsive at 10:45 a.m. and was not checked on again until 45 minutes later, when R2's blood sugar was taken. NP-A stated she expected staff to check R2's blood sugar at 10:45 a.m., administer glucagon, and continue to check a blood sugar every 15 minutes until R2's blood sugar was up to 80 or higher. During interview on 5/3/22, at 12:30 consulting pharmacist (CP) stated Novolog is a rapid acting insulin and becomes active within the bloodstream as soon as 15 minutes and peaks in one hour. CP stated nursing staff should have assessed and treated R2 for hypoglycemia when he was first found not responding and had a full uneaten meal tray on 3/3/22, at 10:45 a.m. and should not of waited. Additionally, CP stated	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 16 nursing staff need education on diabetes management, monitoring a resident who is diabetic and receives insulin, monitoring intake, blood sugars, and when to use glucagon. During interview on 5/2/22, at 3:15 p.m. acting director of nursing (DON) verified R2's blood sugar was 344 when checked on 3/3/22, 6:58 a.m. and R2 was given his scheduled 10 units of Novolog. DON further stated R2 was given 14 units of Novolog for his sliding scale insulin at 7:03 a.m. Additionally, DON stated R2 was sent to the emergency room on 3/3/22, when he was found unresponsive with a blood sugar of 45. DON stated R2 had multiple hypoglycemic events since the beginning of this year which required treatment. DON further stated the nurse should have assessed and treated R2 on 3/3/22 at 10:45 a.m. when R2 was found unresponsive and not waited to recheck R2 45 minutes later. DON stated all staff need education on diabetes, insulin, and diabetes management. . During interview on 5/3/22, at 1:58 p.m. acting DON stated he had provided education to nursing staff on hypoglycemia, where to locate the glucagon and when to administer. DON further stated he provided the education because of the incident with R2 who had a hypoglycemic event and nursing staff were not aware of where to find the glucagon which delayed the administration. A facility policy titled Management of Hypoglycemia, dated 9/30/21, indicated symptoms of hypoglycemia included weakness, restlessness, tachycardia, excessive perspiration, irritability, blurred vision, headaches, unconsciousness, or coma. Level three hypoglycemia was classified when altered mental	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 17	F 684		

and or physical status required assistance for treatment of hypoglycemia. The facility policy directed staff if a resident had a level three hypoglycemia and is unresponsive, to call 911, administer glucagon, notify the provider immediately, remain with the resident, place resident in a comfortable and safe position and monitor vital signs.

R5's quarterly Minimum Data Set (MDS) dated 4/27/22, indicated R5 was cognitively intact and had diagnoses of diabetes (diseases that result in too much sugar in the blood), hypertension (high blood pressure), and renal insufficiency (poor function of the kidneys). Further, the MDS identified R5 had moisture associated skin damage and required staff to provide application of nonsurgical dressings and ointments. R5's MDS lacked indication R5 had behaviors of refusing cares.

R5's care plan, revised date 3/14/22, identified R5 had skin alteration, a fluid filled blister on his right lower leg and fluid leakage from both legs. R5's care plan directed staff to administer treatments as ordered and monitor for effectiveness.

R5's Wound Evaluation and Management Summary dated 4/26/22, indicated R5 had four wounds which incorporated his right and left lower extremity and recommended for R5 to elevate his legs and wound care to be completed daily. R5's dressing treatment plan included applying Eucerin cream to intact skin, cover lower legs with xeroform gauze, absorbant pad, and wrap with secondary gauze dressings.

- Site one was described as a full thickness lymphedemic (tissue swelling caused by an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 18 accumulation of protein-rich fluid) wound of the right distal anterior leg which measured 1 centimeter (cm) x 1 cm x 0.1 cm with serous exudate (clear, thin, watery fluid). - Site two was described as a full thickness lymphedemic wound of the right distal medial (lower inside) leg which measured 1 cm x 1 cm x 0.1 cm with light serosanguinous exudate (composed of red blood cells and serous fluid, known as blood serum), 50 percent slough (dead tissue), 50 percent granulation (healing) tissue, and a fluid filled blister. R5's wound was described as in an inflammatory stage and unable to progress to a healing phase because of presence of a biofilm (can affect the healing). R5's wound was noted as unchanged and required surgical excisional debridement to establish viable tissue margins and remove necrotic tissue. - Site three was described as healed. - Site Four: lymphedemic wound of the left shin which was full thickness which measured 0.3 cm x 0.3 cm x 0.3 cm with light serosanguinous exudate, 50 percent slough and 50 percent granulation tissue. R5's wound was described as in an inflammatory stage and was unable to progress to a healing phase because of presence of a biofilm, had no change in healing status and required surgical excisional debridement to remove necrotic tissue and establish the margins viable tissue. R5's treatment administration record (TAR) dated 5/22, indicated R5's daily wound care orders for the right distal and anterior leg, left calf and shin included:	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 19 - Cleanse wounds with normal saline. - Apply Eucerin cream to intact skin on lower legs. - Apply xeroform gauze over lower legs, cover with absorbent dressing and wrap in gauze. On 5/2/22, at 11:30 p.m. R5 stated each nurse would complete the wound care differently or not at all. He further stated, some staff will not use all the supplies or apply the cream to my legs, and the wound care is not consistent. R5 stated his bandages fall off after a few hours and the nurses do not reapply them. He stated he had significant swelling in his legs and his legs would leak fluid out of them causing further skin irritation. During observation on 5/2/22, at 12:46 p.m. R5 was observed with no bandages on his lower extremities. R5's bilateral lower extremities from the knees down to toes were edematous, found to have areas of a thick build-up of skin scaling in areas, and slight red color to his lower legs. Additionally, R5's was found to have wounds located on his right anterior lower leg, right distal lower leg and at R5's left shin. During wound care registered nurse (RN)-B sprayed each leg with a wound cleanser and patted tehm dry. RN-B proceeded with applying xeroform directly onto the skin covering the wounds and non-affected skin. RN-B then covered R5's lower extremities with highly absorbent dressings and wrapped them with a secondary dressing of gauze rolls. During observation of R5's wound care, RN-B did not apply the ordered Eucerin cream. During interview on 5/2/22, at 1:10 p.m. RN-B stated R5 had wounds on both of his lower legs which required daily wound care. RN-B did not respond when asked why he did not apply	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 20 Eucerin cream to R5's legs prior to application of the xeroform gauze as directed by the R5's physician orders During interview on 5/3/22, at 2:30 p.m. acting director of nursing (DON) stated his expectation for nursing staff would be to follow the physician's order to provide wound care and any ointments as ordered for R5's wound care. Acting DON further stated if RN-B did not apply the Eucerin cream as ordered, he did not follow the wound care as ordered. A facility policy on wound care was requested but was not provided.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care	F 692		6/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 21 provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure assessed and care planned nutritional interventions for meal intake monitoring were completed to reduce the risk of complication for 1 of 1 resident (R1) reviewed who was subsequently hospitalized with a cachectic appearance (a loss of body weight and muscle mass). Findings include: R1's significant change Minimum Data Set (MDS), dated 11/27/21, identified R1 had severe cognitive impairment, was independent with eating after set-up, had diabetes mellitus, and admitted to the nursing home on 11/8/21. Further, the MDS identified R1 weighed 98.0 pounds (lbs) and had sustained no substantial weight loss or weight gain in the previous six months. On 5/2/22 at 8:09 a.m. R1's family member (FM)-B was interviewed. FM-B explained R1 admitted to the nursing home in November 2021, and while focused on palliative (non-curative) care was not considered to be terminal or at the end of her life. FM-B expressed she visited R1 at the nursing home on 12/19/21, and found R1 appearing "severely dehydrated and malnourished" so R1 was subsequently transferred to the hospital where she passed away. FM-B stated R1's usual body weight was typically between 102 to 105 pounds; however, the appearance and condition she found R1 to be in when she visited caused her significant concern as it appeared R1 had sustained a significant weight loss.	F 692	F 692 R1 has since passed away. All existing residents care plans for nutritional interventions for meal intake and weight monitoring were reviewed and updated as needed. Future residents will have nutritional interventions developed for meal intake monitoring and implemented per facility policy. Dietitian and dietary staff were in-serviced on the Comprehensive Care Plan policy with focus on choosing care plan interventions only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Dietary manager/dietitian and/or designee is responsible or compliance. Audits on care plan interventions for meal intake monitoring and resident weights will begin 2xweek for 3 weeks, weekly x 2 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will bring results to QAPI for review and recommendation. Compliance:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 22 R1's corresponding ED (Emergency Department) Provider Note, printed 1/7/22, identified R1 was seen in the acute hospital ED on 12/19/21, where she was non-verbal and had, "Cachectic appearance with extensive mottling." R1's Dietary / Nutrition Assessment, dated 11/12/21, identified R1 consumed a regular consistency, consistent carbohydrate diet, was 60 inches tall, and weighed 98.0 lbs at the time of the assessment. The assessment outlined, "Resident feels she has lost some wt. [weight] over the past few months but is uncertain just how much," and identified R1's ideal body weight (IBW) to be 100 lbs. with an estimated daily caloric intake needed of 1260-1575 calories. R1 demonstrated independence with eating and the assessment recorded R1 as having regular-sized portions for meals with, "Good (50-100%)," appetite. Further, the assessment determined R1 was at risk for impaired nutritional status and listed interventions to help ensure adequate nutrition was maintained including, " ... Encourage resident to eat 75% or more at meals. Monitor appetite and weights per facility policy." R1's care plan, closed 12/20/21, identified R1 was at risk for impaired nutrition due to a history of alcohol use, dementia, and medication non-compliance. R1 was recorded as being able to feed herself independently and several goals were listed for R1 including maintaining a stable weight of 90 - 100 lbs. and eating 75% or more at a majority of her meals. There were several interventions listed to help R1 meet these goals including, " ... Monitor appetite and weight per facility policy. Observe for any difficulty chewing or swallowing or for any change in eating habits."	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 23 R1's Weight Summary, dated 11/8/21 to 12/20/21, identified two weights were obtained on R1 during her admission to the nursing home. This included on 11/8/21 (98.0 lbs.) and on 12/3/21 (98.6 lbs.). When interviewed on 5/2/22 at 11:52 a.m., nursing assistant (NA)-A recalled R1 would repeatedly refuse cares and was "not a big eater" but could not recall much else about her due to R1 being discharged several months prior. NA-A explained meal intakes were supposed to be tracked for each meal and should be recorded in the computer by the NA staff who provide and pick-up the trays to rooms. R1's Follow Up Question Report NUTRITION - Amount Eaten, dated 11/8/21 to 12/19/21, identified R1's recorded meal intakes with a percentage (%) consumed. This report identified each date with one to three recorded entries supporting R1's meal intake. The recorded amounts identified R1 typically consumed 50% or more of the provided meals. However, the following date(s) had only one (out of three provided meals) recorded meal intakes: 11/13/21, 11/15/21, 11/20/21, 11/23/21, 11/24/21, 11/25/21, 11/26/21, 11/27/21, 11/28/21, 12/1/21, 12/2/21, 12/3/21, 12/6/21, 12/8/21, 12/12/21, 12/14/21, 12/17/21. Further, the following date(s) lacked any recorded meal intakes for the entire day: 11/12/21, 11/17/21, 11/18/21, 11/19/21, 11/22/21, 11/29/21, 12/5/21, 12/9/21, 12/20/21, 12/11/21, 12/13/21, 12/15/21, 12/16/21, 12/18/21. R1's medical record was reviewed and lacked any recorded evidence of R1's intakes for the remaining date(s), nor any evidence if she had	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 24 been offered and/or refused meals on those dates, despite having diabetes mellitus and being identified as "at risk" for impaired nutritional status through her assessment and care planning process. When interviewed on 5/2/22 at 2:15 p.m., registered nurse (RN)-B stated meal intakes were supposed to be recorded for each meal to his knowledge; however, expressed he did not think anyone was supposed to monitor or ensure these were being recorded for each shift or day. RN-B added, "Are we trained to go in [and check to ensure recorded], I don't think so." On 5/3/22 at 11:26 a.m., the registered dietitian (RD)-A was interviewed. RD-A stated the nursing home typically weighed people only on a monthly basis unless there existed a specific rationale or directions from the physician to implement more frequent monitoring. RD-A explained resident's appetites were monitored through the recorded meal intakes which were to be completed and documented for each meal. RD-A reviewed R1's medical record and stated while R1 seemed to maintain her weight, she did notice there were "some gaps" in the documentation. RD-A verified meal intakes should have been recorded and expressed she noticed the lack of recorded meal intakes continued to be noticed as of today. RD-A stated it was important to ensure meal intakes were recorded as the information helps them monitor the patient and help determine "what's going on[?]" if they decline. Further, RD-A stated she had not completed any education or inservice with nursing staff on meal intake recording, despite noticing they continued to not be recorded as they should, but was unsure if nursing had completed any such education or not.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 05/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 25 When interviewed on 5/3/22 at 1:56 p.m., the acting director of nursing (DON) stated meal intakes were to be monitored and recorded "on every shift" as "that was the expectation." This was important to do as the nutritional information and assessment process was used "for the well being of the resident," and it helped to quickly identify if someone was not eating enough. The DON stated there had only been some "very informal" education with staff on this issue in the past months he could recall despite it continuing to be a concern as identified by RD-A. During the onsite abbreviated survey, from 5/2/22 to 5/3/22, documentation or evidence was requested demonstrating what, if any, education was completed with direct care staff on meal intake recording. However, none was ever received. A provided Recording Percent of Meal Consumed policy, dated 2010, identified staff were to document the percentage of each meal consumed for each resident on a daily basis. The policy continued and outlined there were several ways this record could be completed and the RD would provide which method to be used.	F 692		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 24, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: O9HY11

Dear Administrator:

The above facility was surveyed on May 2, 2022 through May 6, 2022 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:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us