Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 30, 2025

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

RE: CCN: 245544
Cycle Start Date: December 2, 2025

Dear Administrator:

On December 3, 2025, we notified you a remedy was imposed. On December 23, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 19, 2025.

As authorized by CMS the remedy of:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective March 2, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 3, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 2, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 19, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

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December 30, 2025

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

Re: Reinspection Results
Event ID: 1D994B-H2 and 1DAC62-H2

Dear Administrator:

On December 23, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on December 2, 2025 and December 3, 2205. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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Electronically delivered
December 3, 2025

Administrator
Victory Health & Rehabilitation Center

512 49TH AVENUE NORTH
MINNEAPOLIS, MN 55430

RE: CCN:245544
Cycle Start Date: December 2, 2025

Dear Administrator:

On December 2, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by March 2, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 2, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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December 3, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 1D994B-H1

Dear Administrator:

The above facility survey was completed on December 2, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245544**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/02/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victory Health & Rehabilitation Center	**512 49TH AVENUE NORTH , MINNEAPOLIS, Minnesota, 55430**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 10/20/25 and 10/21/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H55443701C (2608219) with incidental findings at F554, F558, and F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		12/04/2025
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure a self-administration of medications assessment was completed for 1 of 1 resident (R2) observed with medication at their bedside. Findings include: R2's quarterly minimum data set (MDS) dated 8/21/25 indicated intact cognition with diagnoses included	F0554	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid Programs and constitute a credible allegation of compliance. The written plan of responses do not constitute an admission of noncompliance or agreement with any findings stated under F Tags. The facility reserves the right to dispute all findings and deficiencies in any appropriate forum, including in an independent informal dispute resolution session, or if appealable remedies are subsequently imposed by timely appeal to the Department Appeals Board. Resident R2 on 12/10/2025 as per assessment resident does not want self-administer medication. To identify other residents who may have been affected the Director of Nursing and or designee will complete an assessment on current residents. The Inter-disciplinary team (IDT) will review requests	12/19/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245544**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/02/2025**

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F0554 SS = D	Continued from page 1 morbid obesity and asthma. R2's self-administration of medications assessment dated 8/20/25 indicated R2 did not want to self-administer any medications R2's current provider orders on 10/21/25 included albuterol sulfate inhalation solution. 1 puff inhale orally every 4 hours as needed for shortness of breath due to asthma. R2's care plan dated 9/8/25 did not identify R2 did not identify a focus and/or interventions for self-administration of medication. During an observation and interview on 10/21/25 at 12:41 p.m., an inhaler was observed in a bowl on R2's bedside table. R2 stated he kept the inhaler next to his bed so he could use it as needed a couple of times a week. R2 did not tell staff when he used the inhaler. During an interview on 10/21/25 at 1:24 p.m., licensed practical nurse (LPN)-B confirmed R2 had an albuterol inhaler at his bedside. LPN-B stated when a nurse saw a medication in a resident room, the medication should be placed in the nurse's cart then an assessment needed to be completed. If the resident was deemed safe to self-administer the medication, an order needed to be obtained from the provider. LPN-B confirmed R2 had an order for an albuterol inhaler but did not have a self-administration order for the inhaler. During an interview on 10/21/25 at 11:29 a.m., the director of nursing (DON) stated if a resident asked to self-administer a medication the nurse needed to complete an assessment and if the resident was deemed safe, a provider order was obtained. The assessment was important to confirm the resident was capable and safe to self-administer the medication. During an interview on 10/21/25 at 12:13 p.m., the medical director stated if a resident requested to keep an inhaler at their bedside, the nurse should assess if the resident could use the inhaler properly, recognize when to use the inhaler, and how often they could use it. If the resident was deemed safe to self-administer, a provider order to keep the medication at the bedside should be obtained. The assessment was important to confirm the resident used the inhaler appropriately. The Self-administration of Medications policy dated 2/2021 instructed the interdisciplinary team to assess each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate. If the resident is	F0554	Continued from page 1 to self-administer medication. THE IDT will determine if resident is capable and competent to self-administer medication. If the resident is determined to be safe for self-administration an MD order will be obtained. The IDT will be re-educated as to the facilities Self Administration of Medication Policy and Procedure. by the Administrator and or designee. The Director of Nursing and or designee will re-educate the licensed nurses to the facilities Self Administration of Medication Policy and Procedure. The Director of Nurses and or designee will audit Self Administration of Medication assessments for compliance to the facilities policy and procedure once a week for four weeks. Followed by two times for a week and then one time month and then one time a month for two months. All negative findings will be reported to the Administrator when identified. Audit findings will be submitted tot the QAPI Committee for review and recommendations as per QAPI schedule.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245544**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/02/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victory Health & Rehabilitation Center	**512 49TH AVENUE NORTH , MINNEAPOLIS, Minnesota, 55430**

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F0554 SS = D	Continued from page 2 deemed safe and appropriate to self-administer medications, this would be documented in the medical record and the care plan.	F0554		
F0558 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 accommodate resident needs by ensuring call light buttons were within reach for 1 of 2 (R3) residents reviewed for call light usage. Findings include: R3 quarterly minimum date set (MDS) date 7/31/25 indicated severe cognitive impairment with diagnoses included schizoaffective disorder, bipolar type and catatonic schizophrenia. R3's care plan dated 9/8/25 instructed to be sure resident's call light is within reach and encourage resident to use it. During an observation and interview on 10/20/2025 at 2:41 p.m., R3 was lying in her bed. A cord was coming out of the wall near the head of the bed, but no call button was observed. R3 stated she did not have a call button. If she needed help, she would wave at staff as they walked by or would say "help me". During an observation and interview on 10/20/2025 at 2:51 p.m. licensed practical nurse (LPN)-A confirmed R3's call light was lying on the floor under her bed. LPN-A stated the call light should have been attached to R3's bed where she could reach it. Resident's call lights needed to be within reach so the resident could receive help when needed. During an interview on 10/20/2025 at 2:57 p.m. nursing assistant (NA)-A stated before leaving a resident room, a staff person should make sure the resident has their call light and other needed items within their reach.	F0558	The Director of Nurses upon notification secured resident R3 call light cord and positioned call light cord in reach of the resident. The Director of Nurses and or designee checked all remaining resident rooms to assure call light cords were secure and properly positioned in reach of the resident. The Director of Nurses and or designee have educated the Nursing and auxiliary staff regarding proper call light cord positioning. A call light cord audit for positioning will be conducted by the Director of Nurses and or designee every shift daily for two weeks. Followed by audit every two weeks for four weeks. Then every month for two months. All negative findings will be reported to the Administrator when identified. All findings will be reported to the QAPI Committee as scheduled for follow up recommendations.	12/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victory Health & Rehabilitation Center	**512 49TH AVENUE NORTH , MINNEAPOLIS, Minnesota, 55430**

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F0558 SS = D	Continued from page 3 During an interview 10/21/2025 at 11:29 a.m., director of nursing stated staff member need to be sure a resident has their call light within reach before leaving a resident's room. The call light is the resident's tool to communicate with staff. The Answering the Call Light policy dated 9/2022 instructed staff to ensure the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.	F0558		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to monitor temperature and intravenous access (IV) site for 1 of 1 resident (R3) following electroconvulsive therapy (ECT). Findings include: ECT is a procedure done under general anesthesia. During this procedure, small electric currents pass through the brain, intentionally causing a brief seizure. ECT seems to change brain chemistry, and these changes can quickly improve symptoms of certain mental health conditions. Electroconvulsive therapy (ECT) - Mayo Clinic R3 quarterly minimum date set (MDS) date 7/31/25 indicated severe cognitive impairment with diagnoses included schizoaffective disorder, bipolar type, and catatonic schizophrenia. R3's care plan dated 9/8/25 indicated R3 had ECT treatment 2 times a week on Tuesday and Thursday. Following treatment R3 should be monitored for extreme headache, nausea, vomiting, confusion, temperature	F0684	Resident R3 post ECT assessment was completed when identified. The assessment included Vital signs, temperature and monitoring for any severe headache, nausea, vomiting, confusion, temperature greater then 100.5, swelling/drainage at the IV site. There are no other residents at the facility receiving ECT. Licensed Nursing staff have been educated on the required post ECT monitoring by the Director of Nurses and or designee. Documentation for post ECT monitoring will be audited by the Director of Nursing and or designee twice a week, day of ECT Tuesdays and Friday for 30 days. Followed by two weeks for four weeks the monthly for 2 months. All negative findings will be reported to the Administrator when identified. All findings will be reported to the QAPI Committee as scheduled for follow up recommendations.	12/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245544**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/02/2025**

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F0684 SS = D	Continued from page 4 greater than 100.5, redness, swelling, and drainage or pain at the IV site lasting more than 24 hours. R3's ECT discharge orders and information dated 10/2/25, 10/7/25, 10/9/25, 10/14/25, and 10/16/2025 instructed what to report after ECT: Extreme headache, nausea, vomiting, confusion, Temperature greater than 100.5, Redness, swelling, and drainage or pain at the IV site lasting more than 24 hours, Major increase in depression or mania. R3's electronic physician orders included the aforementioned orders however did not include monitoring for temperature greater than 100.5 and redness, swelling, and drainage or pain at the IV site lasting more than 24 hours after ECT. The orders transcribed into the record included the following. -Physician order dated 5/14/24 instructed to monitor behaviors after ECT every shift on Tuesdays and Thursdays. -Physician order dated 7/31/25 instructed to monitor resident for extreme headache, nausea, vomiting, and confusion every shift on Tuesdays and Thursdays. -Physician order dated 7/16/24 instructed to complete vital signs every 4 weeks on Tuesday. R3's provider orders lack indication of R3's October treatment administration record (TAR) indicated R3 had ECT on 10/2, 10/7, 10/9, 10/14, and 10/16/2025. R3's temperature was checked on 10/7/25 and documented under the monthly vital sign check order. R3's TAR lacked temperature monitoring for 10/2, 10/9, 10/14, and 10/16/25. R3's nurse's notes for the month of October 2025 indicate R3's vital signs were checked one time on 10/14/25. R3's notes lack documentation of temperature monitoring on 10/2, 10/9 and 10/16. R3's notes lack documentation of IV site monitoring on 10/2, 10/7, 10/9, 10/14, and 10/16/2025. During an interview on 10/20/25 at 2:51 p.m., licensed practical nurse (LPN)-A stated if a resident needed additional monitoring an order would pop up in the TAR. Vital signs were supposed to be monitored as ordered in the TAR or if a resident was not feeling well. R3 had additional monitoring for behaviors, headache, and vomiting after ECT. Her vital signs were checked monthly.	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245544**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/02/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victory Health & Rehabilitation Center	**512 49TH AVENUE NORTH , MINNEAPOLIS, Minnesota, 55430**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0684 SS = D	Continued from page 5 During an interview on 10/21/25 LPN-B stated all special monitoring for a resident was documented on the TAR. Resident's vital signs were checked according to provider orders, usually once a month and as needed if a resident was not feeling well. LPN-B confirmed R3's monitoring following ECT included behaviors and extreme headache, nausea, vomiting, and confusion. LPN-B could not find an order to monitor for temperature greater than 100.5 and redness, swelling, and drainage or pain at the IV site lasting more than 24 hours after ECT. During an interview on 10/21/25 at 11:29 p.m., director of nursing (DON) stated the symptoms nurses should be monitoring would be placed in the TAR. DON confirmed R3 had ECT 5 times in October 2025. Her temperature was taken 1 time and there was no documentation of IV site monitoring. It is important to monitor a resident so if they start feeling unwell staff can intervene timely. During an interview on 10/21/25 at 12:13 p.m., the medical director (MD) stated nurses should follow the patient instructions for monitoring sent with the resident following ECT treatment. Staff need to be monitoring for increased temperature and headache. Temperature should be taken when the resident returns from ECT. Monitoring should be completed to catch any problems early. The Behavioral Assessment, Intervention and Monitoring policy dated 3/2019 instructed if the resident is being treated for altered behavior or mood, the interdisciplinary team (IDT) will see and document any improvements or worsening in the individual's behavior, mood, and function.	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/02/2025**

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/20/25 through 10/21/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		12/04/2025

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

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20000	Continued from page 1 The following complaints were reviewed: H55443701C (2608219) with a licensing order issued at 1565. 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 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.	20000		
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the	21565	This Plan of Correction and the responses too each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written plan of responses do not constitute an admission of noncompliance or agreement with any findings stated under F-Tags. The facility reserves the right to dispute all findings and deficiencies in any appropriate forum, including in an independent informal	12/19/2025

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21565	Continued from page 2 attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure a self-administration of medications assessment was completed for 1 of 1 resident (R2) observed with medication at their bedside. Findings include R2's quarterly minimum data set (MDS) dated 8/21/25 indicated intact cognition with diagnoses included morbid obesity and asthma. R2's self-administration of medications assessment dated 8/20/25 indicated R2 did not want to self-administer any medications R2's current provider orders on 10/21/25 included albuterol sulfate inhalation solution. 1 puff inhale orally every 4 hours as needed for shortness of breath due to asthma. R2's care plan dated 9/8/25 did not identify R2 did not identify a focus and/or interventions for self-administration of medication. During an observation and interview on 10/21/25 at 12:41 p.m., an inhaler was observed in a bowl on R2's bedside table. R2 stated he kept the inhaler next to his bed so he could use it as needed a couple of times a week. R2 did not tell staff when he used the inhaler. During an interview on 10/21/25 at 1:24 p.m., licensed practical nurse (LPN)-B confirmed R2 had an albuterol inhaler at his bedside. LPN-B stated when a nurse saw a medication in a resident room, the medication should be placed in the nurse's cart then an assessment needed to be completed. If the resident was deemed safe to self-administer the medication, an order needed to be obtained from the provider. LPN-B confirmed R2 had an order for an albuterol inhaler but did not have a self-administration order for the inhaler. During an interview on 10/21/25 at 11:29 a.m., the director of nursing (DON) stated if a resident asked to self-administer a medication the nurse needed to complete an assessment and if the resident was deemed safe, a provider order was obtained. The assessment was important to confirm the resident was capable and safe to self-administer the medication.	21565	Continued from page 2 dispute resolution session, or, if appealable remedies are subsequently imposed by timely appeal to the Department Appeals Board. Corrected	

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21565	Continued from page 3 During an interview on 10/21/25 at 12:13 p.m., the medical director stated if a resident requested to keep an inhaler at their bedside, the nurse should assess if the resident could use the inhaler properly, recognize when to use the inhaler, and how often they could use it. If the resident was deemed safe to self-administer, a provider order to keep the medication at the bedside should be obtained. The assessment was important to confirm the resident used the inhaler appropriately. The Self-administration of Medications policy dated 2/2021 instructed the interdisciplinary team to assess each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate. If the resident is deemed safe and appropriate to self-administer medications, this would be documented in the medical record and the care plan. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee should review and revise policies for self-administration of medication according to evidence-based practices/procedures. Nursing staff should be educated as necessary to the importance of ensuring the resident is deemed capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff should also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, should audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee should take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		