



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 7, 2020

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

RE: CCN: 245544
Cycle Start Date: September 3, 2020

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 October 9, 2020, we notified you a remedy was imposed. On November 16, 2020 the Minnesota Department(s) 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 November 13, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 8, 2020 be discontinued as of November 13, 2020. (42 CFR 488.417 (b))

Also, as we notified you in our letter of On October 9, 2020, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 8, 2020. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Victory Health & Rehabilitation Center

December 7, 2020

Page 2

A rectangular box containing a handwritten signature in black ink that reads "Kamala Fiske-Downing".

Kamala Fiske-Downing

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: kamala.fiske-downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 4, 2020

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

RE: CCN: 245544
Cycle Start Date: September 3, 2020

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 October 9, 2020, we informed you that we were imposing enforcement remedies.

On October 20, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby 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:

- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.
- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 8, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 8, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 8, 2020.

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 a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

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 \$11,160; 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 November 8, 2020, 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 November 8, 2020. 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" tag), i.e., the plan of correction should be directed to:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - 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 March 3, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 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**

Victory Health & Rehabilitation Center

November 4, 2020

Page 5

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

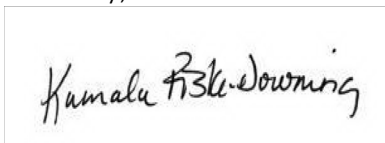
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/lrc_idr.cfm

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
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

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

PRINTED: 11/07/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS Victory Health and Rehabilitation Center is a Special Focus Facility (SFF) and received an abbreviated survey on 10/19/20 and 10/20/20, to conduct complaint investigations. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5544156C, H5544157C, H5544158C and H5544159C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		11/13/20	

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

TITLE

(X6) DATE
11/06/2020

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: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 610	<p>Continued From page 1</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure allegations of potential abuse resulting from resident to resident altercations were comprehensively investigated and corrective measures were taken to ensure safety and provide protection for 2 of 3 residents (R1 and R3) whose allegations were reviewed.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated 9/15/20, identified R1 had intact cognition.</p> <p>R2's quarterly Minimum Data Set (MDS) dated 9/24/20, identified R2 had intact cognition.</p> <p>A facility investigation file, dated 10/5/20, included, "Resident [R1] reported derogatory statements directed to him from [R2], time unknown, Allegation reported to MDH (Minnesota Department of Health) surveyor which reported to administrator. [R1] reported to MDH surveyor [R1] has not previously reported incident.' Residents reside in different neighborhoods. However, the verbal event is allegedated [sic] to have occurred in commons areas while '[R1] walks by [R2].' Both residents report felling safe. [R2] states '[R2] minds his own business here.' [R1] states 'he is a big boy and can take care of</p>	F 610	<p>This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board.</p> <p>F610 R 1 will have a risk management incident initiated and completed, their vulnerable adult care plan reviewed, and update as needed, and trauma informed care assessment initiated. Social Service Director will meet with R 1 2x a week as needed to ensure resident continues to feel safe while residing in the facility. R 2 will have a risk management incident completed, vulnerable adult care plan updated as needed and a trauma</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 610	<p>Continued From page 2</p> <p>self.' " In the investigation file under, Action take to prevent reoccurrence to the other resident, file indicated, "Residents scheduled to be seen by Associated Clinic Psychology [sic]. Behavior care planned updated by SW (social worker). LNHA (licensed nursing home administrator) spoke to all residents about communal living, conflict management techniques, respectful and courteous communication (the golden rule). Resident actively working with relocation services."</p> <p>When interviewed on 9/28/20, at 12:58 p.m. R1 stated, "R2 is terrorizing other residents. R2 is threatening me, R2 calls me a gay faggot ass and says I will kick you ass white boy, I will kill you white boy."</p> <p>When interviewed on 10/20/20, at 12:57 p.m. the administrator stated, as part of the investigation other resident statements regarding verbal abuse had been obtained and were indicated in the Resident Council meeting minutes from 9/30/20 under administrator comments.</p> <p>Resident council meeting minutes dated 9/30/20, indicated under administrator, "Administrator talked about communal living and how we all need to support each other in this difficult time. and how this will pass and slowly return to normalcy. Administrator spoke about quality care, life and challenges, how we al have some type of conflict in our life and how we try to overcome it." No further evidence of resident interviews were included in the meeting minutes.</p> <p>When interviewed on 10/19/20, at 4:13 p.m. the director of nursing (DON) stated care staff were aware of the incident of verbal abuse from R1 to</p>	F 610	<p>informed care history completed. Social Services will meet with R2 to discuss this incident and will provide education on resident rights and how verbal abuse causes fear and anxiety for others. Risk management incidents from survey exit will be reviewed and thoroughly investigated. Care Plans, group sheets and Kardex's will be updated for those incidents as needed. Existing residents will be interviewed to ensure no further verbal abuse has been experienced.</p> <p>Upon admission, residents will review the resident rights policy and procedure and will be educated on the facility grievance procedures.</p> <p>Facility staff will be in-serviced on the resident to resident altercation policy with emphasis on how to de-escalate resident confrontations and resident to resident incidents will be communicated during shift change and nurse aide group sheet and Kardex will be updated to reflect resident intervention changes. IDT team will be in-serviced on thoroughly investigating incidents and updating care plan interventions as needed.</p> <p>Social Services and/or designee is responsible for compliance.</p> <p>Audits on thoroughly investigating resident to resident incidents, care plan interventions after resident to resident altercations for appropriateness and timely implementation and shift to shift report will begin 3x week for 3 weeks, weekly x 4 weeks then monthly to ensure compliance.</p> <p>All audit results will be reviewed by the Administrator and the Administrator will</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 610	<p>Continued From page 3</p> <p>R2, and the expectation is that the incidents would be in the care plan and Kardex (resident individualized information sheet). An investigation should include interviews with other residents to ensure other residents were not be affected in the same manner, or if they had seen or overheard anything.</p> <p>R1's care plan dated 10/20/20, did not indicate R1 had verbal abuse directed at him from another resident. R1's Kardex (resident individualized information sheet) used by certified nursing assistants did not indicate R1 had verbal abuse directed at R1 from another resident.</p> <p>During interview on 10/20/20, at 8:35 p.m. licensed practical nurse (LPN)-B assigned to R1 indicated LPN-B was not aware of any resident who had directed verbal abuse against R1</p> <p>During interview on 10/20/20, at 8:54 a.m. nursing assistant (NA)-A assigned to R1 indicated NA-A was not aware of any resident who had directed verbal abuse against R1</p> <p>During interview on 10/20/20. at 12:34 p.m. R1's provider, nurse practitioner (NP)-D indicated they, as well as medical doctor (MD)-E had not been notified by the facility of the alleged abuse.</p> <p>Documentation of interviews with other residents and staff was requested but not provided by the facility. Investigation file contained an interview with the R1. Investigation file indicated R2 stated, "I will mind my own business here" but did not include an interview with R2.</p> <p>R3's admission MDS dated 8/29/20, identified R3</p>	F 610	take audits to monthly QAPI meetings x 3 months to ensure consistent implementation of the facility's policy with tracking and trending of policy compliance.		

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

PRINTED: 11/07/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	<p>Continued From page 4</p> <p>had intact cognition. R6's quarterly Minimum Data Set (MDS) dated 9/24/20, identified R6 had intact cognition. During interview on 10/19/20, at 9:46 a.m. stated, "It is not nice what [R6] does to me, my name is [R3] and [R6] calls me whatever. [R6] calls me bitch, dumb bitch and stupid bitch. It makes me anxious and I loose sleep."</p> <p>A provided facility investigation file under description of incident, dated 10/10/20, indicated " [R6] is acting wired [sic?] all shift. When [R3] was talking to [R3's] nurse and other staff, resident [R6] walked to [R3] standing over [R3's] head to accuse [R3] of gossiping with [R6's] name. Both residents stated [sic] shouting at each other using profanity. Writer hard [sic] the nose and came and removed R3 to North hallway, [R6] chased after [R3] threatening that [R6] will lead her a long way." [R3's] investigation file did not include interviews with other residents or other staff. Documentation of interviews with other residents and staff was requested but not provided by the facility.</p> <p>During interview on 10/19/20, at 4:04 p.m. director of nursing (DON) indicated care staff were aware of the incident of verbal abuse between R6 and R3 and staff were aware through the daily change of shift report. DON indicated that change of shift reports are shredded daily and there is no record from the change of shift reports regarding this communication. DON indicated the expectation is that the incidents would also be in the care plan and Kardex (resident individualized information sheet).</p> <p>A provided risk management report dated 10/10/20, indicated R1's provider and family was notified of the alleged abuse.</p>	F 610		

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

PRINTED: 11/07/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 610	Continued From page 5 R3's care plan dated 9/20/20, did not indicate R3 had verbal abuse directed at R3 from another resident. R3's Kardex did not indicate R3 had verbal abuse directed at R3 from another resident. During interview on 10/20/20, at 8:35 p.m. licensed practical nurse (LPN)-B assigned to R1 indicated LPN-B was not aware of any resident who had directed verbal abuse against R1 During interview on 10/20/20, at 8:54 a.m. nursing assistant (NA)-A assigned to R1 indicated NA-A was not aware of any resident who had directed verbal abuse against R1 During interview on 10/19/20, at 1:02 p.m. family member (FM)-F indicated the facility had not notified FM-F of the alleged abuse. During interview on 10/20/20, at 4:35 p.m. NP-G indicated NP-G as well as medical doctor (MD)-H had not been notified by the facility of the alleged abuse. An undated facility policy entitled, Neglect, Mistreatment and Misappropriation of Resident Property, identified a section labeled, "Investigation," which directed allegations of abuse would be promptly and thoroughly investigated. A procedure was listed which included identifying who was involved, resident' statements, roommate statements (if applicable), involved staff and witness statements of events, a description of resident' behavior and environment at the time of the allegation, observation of the resident and staff behaviors during the investigation and any environmental	F 610			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 610	Continued From page 6 considerations. The policy directed the results of the investigation would be attached to the completed report.	F 610			
F 684 SS=D	<p>Quality of Care CFR(s): 483.25</p> <p>§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess suspected alcohol abuse, hold medications as ordered, and provide interventions to assist in maintaining sobriety for 1 of 4 residents (R6) reviewed who had an alcohol abuse disorder.</p> <p>Findings include:</p> <p>R6's admission Minimum Data Set (MDS) dated 9/2/20, included cognitively intact, verbal behavior directed at others daily and had diagnoses including alcohol dependence with other alcohol induced disorder, cocaine use, and alcoholic cirrhosis of liver without ascites.</p> <p>R6's Psychosocial Care Area Assessment (CAA) dated 9/3/20, included, "Resident has a history of alcohol abuse in [sic] which required hospitalization. Resident refuses treatment."</p>	F 684		11/13/20	
			<p>F 684 R 6 was discharge from the facility on 10/27/20. All other residents identified with substance abuse, their care plans will be initiated and/or interventions updated as needed. Future residents noted with substance abuse history will be assessed by social services and the appropriate care plan focus and interventions will be initiated. Nursing staff will be in-serviced on the alcohol policy with emphasis on item #9 that indicates if a resident is found intoxicated, the nurse will notify the physician and request medication hold parameters. The resident will be monitored every 15 minutes until the provider responds with frequency order. In addition, the nursing staff will be in-serviced on the acute change in condition policy and document all adverse</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 7</p> <p>R6's care plan, initiated on 8/24/20, indicated, "Discharge plan: [R6] is currently homeless. She would like to discharge to the community. Barriers to discharge [sic] lack of income, history of evictions, history of chemical and substance use." Staff are instructed to, "Link resident to community resources as needed." The care plan also indicated, "[R6] has alcoholic cirrhosis of liver without ascites" with instruction for staff to, "encourage rest and probably a change in lifestyle (adequate, well-balanced diet and elimination of alcohol)." The care plan initiated on 8/26/20 indicated, "[R6] has a behavior problem r/t [related to] leaving the facility whenever she wants. Not following COVID restrictions. Stating that she has a doctors appointment and being gone all day." Staff are instructed to, "Praise any indication of compliance with facility rules progress/improvement in behavior." The care plan revised on 9/30/20, included a mood problem for R6 related to her overall, "disease process" and various diagnoses such as, "alcohol withdrawal delirium, cirrhosis, hypokalemia," and "history [sic] polysubstance abuse." Additionally, the care plan included, "Verbally abusive, yelling, outburst." The staff were instructed to: "Avoid being confrontational with resident when having behavior," "Report any outburst to charge nurse," and "when resident [sic] yelling attempt to redirect and re-approach." The care plan for R6 contained no information or interventions regarding risk of relapse, monitoring for relapse, or a sobriety maintenance plan.</p> <p>When interviewed on 10/19/20, at 10:56 a.m. administration clerical (AC)-G stated, R6 had been verbally abusive with other residents after she leaves the facility and returns. AC-G stated,</p>	F 684	<p>resident incidents in the medical record and will be relayed in the end of shift report. Social service director will be in-serviced on implementation of appropriate interventions for substance abuse and creating a resident contract with R6 to gain compliance with plan of care. Social Service director will also be in-serviced on the Guidelines for Behavioral Health Phase 2 Services regulation and compliance document. Social Services and/or designee will be responsible for compliance.</p> <p>Audits on acute changes in resident condition, substance abuse care plan initiation and change of shift reporting to oncoming nurse will begin 3x week for 3 weeks, weekly x 4 weeks then monthly to ensure compliance.</p> <p>All audit results will be reviewed by the Administrator and the Administrator will take audits to monthly QAPI meetings x 3 months to ensure consistent implementation of the facility's policy with tracking and trending of policy compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 8</p> <p>"It happens all the time." AC-G indicated R6 had just left the facility for a doctors appointment and stated, "You watch what happens when she get back."</p> <p>When interviewed on 10/19/20, at 1:42 p.m. after her return from the outing, R6 became tearful while talking about wanting to discharge to the community, but not feeling ready. "I don't feel safe, I don't feel prepared. They haven't set anything up." R6 added, "I don't have a bed. I don't have nothing. I don't want to leave if I don't have everything." R6 frequently slurred her words throughout the interview. While discussing her discharge plan, R6 got increasingly agitated and began belligerently yelling, including swearing and name calling, directed at staff members who walked by her in the hallway. R6 confirmed she left the facility earlier to, "walk to the store." She denied being under the influence of drugs or alcohol. Multiple staff unsuccessfully attempted to calm R6. R6 continued to yell profanity and insults at staff.</p> <p>When observed on 10/19/20, at 2:18 p.m. R6 was standing at the nurses' station holding on to the counter with her eyes closed gently swaying back and forth. R6's slurring was more pronounced. Facility staff called 911. At 3:03 p.m. a police officer arrived. After visiting with the police officer, R6 agreed to go to the hospital and left facility in an ambulance.</p> <p>R6's progress note dated 8/24/20, at 10:59 a.m. included, "Resident declined referral for Rule 25 Assessment [community chemical dependency assessment] for treatment stating that she has already been through treatment. Resident most interested in finding housing."</p>	F 684			

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

PRINTED: 11/07/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	Continued From page 9 R6's Family Medicine Office Visit progress note dated 8/25/20, included, "Alcohol abuse: Patient needs (and states that she wants) inpatient treatment. In the meantime, we discussed Acamprosate [alcoholism medication] TID [three times a day] for help with cravings. She is agreeable to this, but notes that she has not taken it despite leaving [hospital] with a short script for this. Gave Rule 25 [community chemical dependency assessment] information again so she can follow up." R6's progress note dated 8/29/20, at 9:52 a.m. included, "At about 1730 [5:30 p.m.], somebody whom [R4] called her son delivered a packet of what looks like cigarettes to resident and [R4] refused to let writer see what is in the pack. At 2000 [8:00 p.m.], resident took her HS [night] meds [medications]. At 2015 [8:15 p.m.]... Found resident in her room deeply sleeping also unusual. Searched resident room for the pack but could not find it and resident did not wake up with all the noise. Will continue to monitor resident for change in status." R4's medication record showed no evidence that vital signs were completed, no indication the doctor was updated, or if frequent checks were completed. On 10/20/20, at 10:50 a.m. the DON reviewed the progress note and stated her expectation for follow up for R6 would include, "vital signs being completed, the physician being notified, family notified, medication being held, a clear statement that the nurse suspected intoxication, and follow-up documentation on [R4]'s status." The DON confirmed there was no supplemental information in the medical record regarding this event. The next progress note for R6 dated 8/30/20, at 10:51 a.m. addressed medication	F 684			

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

PRINTED: 11/07/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 10</p> <p>administration being completed. During an interview on 10/20/20, at 11:30 a.m. the administrator reviewed the progress note and did not think additional action needed to be taken. "It doesn't say she is intoxicated. I can only go by what they write. I can't speculate."</p> <p>R6's progress note dated 9/3/20, at 9:48 p.m. included, "[R6] was reported to be intoxicated by the social worker but when assessed by 3 nurses, [R6] did not exhibit any sign of alcohol usage neither did resident breath has [sic] alcohol smell, no alcohol was physically found with her, she did not have slurred speech and the gait was steady. Writer called primary and call taken by triage nurse by [sic] [name] who said she paged on call doctor 3 times and no response received till 9 p.m. so I gave her medication." R6's progress note dated 9/4/20, at 7:10 p.m. included, "Received call back from Dr. [doctor] who gave order to hold all medication tonight." An order instructing, "Hold all medications tonight if resident exhibits signs of substance intoxication" was received on 9/4/20 at 7:30 p.m. No supplemental information found in the medical record. When interviewed on 10/20/20, at 10:50 a.m. the DON reviewed both progress notes but remained unsure why the medications were held. The DON stated the two progress notes were written on two different days, by two different nurses. The DON added, "I don't know if they are discussing different events or not." When interviewed on 10/20/20, at 11:30 a.m. the administrator reviewed both progress notes and stated, "I'm not sure. I think these are about the same event."</p> <p>R6's progress dated 9/9/20, at 1:08 p.m. summarized a care conference held for R6 which</p>	F 684			

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

PRINTED: 11/07/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 11</p> <p>social services (SS)-A and registered nurse (RN)-C attended. R6 had refused to attend. The progress note included, "Resident has been leaving the facility claiming that she has a doctors appointment than [sic] coming back smelling like alcohol. [R6] has been informed of facilities [sic] non alcohol policy." When interviewed on 10/20/20, at 10:50 a.m. the DON reviewed the progress note and stated she was not aware of this information. The DON added, "They should be calling me or [administrator]." No supplemental information or assessment found in the medical record.</p> <p>R6's Diagnostic Assessment completed by a licensed psychologist on 9/25/20, included, "The goal of the evaluation is to assess mood, strategies to reduce incidents of substance use, strategies to mitigate distress and improve quality of life." "[R6] denies ever having brought alcohol or other substances into the building which may be incongruent with staff experiences." "She denies any anger toward other residents and does not mention any particular incidents apart from her frustration with others suspecting she is using and bringing alcohol (which she denies)." The progress note also included, "[R6] stated she has had inpatient and outpatient treatment in the past, had "4-5 years" of sobriety and does not desire inpatient treatment currently. She is open to outpatient." "[R6] is a woman with history of significant substance abuse including primary alcohol withdraw and dependence that have affected her medical status and arguable are associated with homelessness." "While she is open to treatment she feels confident "I can stay sober" despite her history and legitimate concerns by medical teams at hospital and current facility re [regarding] her ongoing</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 12</p> <p>substance abuse potential." The licensed psychologist recommended, "[R6] remains at high risk for substance abuse relapse and was encouraged to remain open to treatment options available in the community." "Discussed harm reduction strategies and additional options such as 12-step programming."</p> <p>R6's progress note dated 10/2/20, at 10:21 p.m. explained why medication was being held indicated, "Resident has alcohol smell on breath." In an interview on 10/20/20, at 10:50 a.m. the DON reviewed the progress note and confirmed she was not aware of this information. The DON added, "They should be calling me or [administrator]." No supplemental information or assessment found in the medical record.</p> <p>R6's progress note completed by the licensed psychologist dated 10/9/20, included, "Nursing engaged in [sic] assist [R6] to consider options for treatment available in the community. This date, [R6] noted she is open to alcohol treatment."</p> <p>R6 did meet with the licensed psychologist on 10/16/20, but documentation from this visit did not address substance abuse.</p> <p>When interviewed on 10/19/20, at 9:10 a.m. R1 described R6 as, "being drunk 24/7 [all the time]."</p> <p>When interviewed on 10/19/20, at 10:10 am licenses practical nurse (LPN)-A stated staff have suspected R6 to be under the influence of illegal drugs or alcohol "two times," but added, "I haven't seen it myself, but I have asked [R6] if she was since she will get loud. But [R6] denies it." LPN-A stated if a resident is suspected to be under the influence of drugs or alcohol she would, "hold</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 13 meds [medications]."</p> <p>When interviewed 10/19/20, at 11:04 a.m. RN-C stated it was her opinion that R6 has been intoxicated many times while at the facility.</p> <p>When interviewed on 10/19/20, at 3:50 p.m. RN-A stated that he, "frequently" had had suspicions that R6 had returned to the facility under the influence of drugs or alcohol. When R6 appeared to be under the influence of drugs or alcohol RN-A expressed the need to, "hold meds [medications]" and "try and keep her in her room."</p> <p>When interviewed on 10/19/20, at 4:14 p.m. the director of nursing (DON) stated, "No one has come to me and said [R6] 'is drunk' or 'I think she was.' Except for today, I can't say she has been under the influence. I could smell it on her breath today. That is why we called 911." The DON stated if a resident is suspected to be under the influence of drugs or alcohol she would expect the nurse on duty to, "document in the progress notes, call the administrator or myself, call the doctor to get an order to hold medications, complete an assessment including checking vital signs and checking neurocognitive status, frequent checks to make sure they are not sick or vomiting, keep monitoring, and talk to the resident and ask 'why.'" The DON stated suspicions of a resident being under in influence of drugs or alcohol should also be documented in the resident's care plan. When interviewed on 10/20/20, at 10:28 a.m. the DON stated she had not been made aware of any instances of R6 being under the influence of drugs or alcohol since R6 admitted to the facility stating, "if they [staff] suspected they [staff] should contact me or the administrator. That is our policy." The DON</p>	F 684			

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

PRINTED: 11/07/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 14</p> <p>stated the substance abuse resources available for R6 included, "ACP [Associated Clinic of Psychology] visits, Rule 25 [community chemical dependency assessment], and just today I gave her a list of outpatient treatments."</p> <p>When interviewed on 10/20/20, at 11:30 a.m. while discussing the facility's substance abuse plan the administrator stated, "We follow our policy; assess the resident, and update the doctor, hold meds [medications] if ordered. There should be info [information] in the progress notes." The administrator added the care plan should also be updated if there is a situation that involves drugs or alcohol.</p> <p>The facility's Alcohol and Illegal Substance Abuse Policy (undated) indicated, "A resident who the facility suspects of being under the influence or believes has been using alcohol or illegal substances will experience the following: Part A: Nursing assessment, including but not limited to the following: 1. Assessment and document any visible injuries. 2. Obtain vital signs. 3. Assist residents to a safe position, lying on side in case of emesis. 4. Call 911 if resident is unable to be aroused. 5. Call 911 if resident is showing signs of difficulty breathing. 6. Contact 911 for uncontrolled, unsafe behaviors such as repetitive falls violence to self or others, belligerent threats. 7. Room search-removal and destruction will be removed from the room and destroyed. Part B: Contact the attending physician and request orders for the following: 1. Alcohol level or drug screening if indicated. 2. Evaluation in an emergency room, crisis center, or detox center if indicated. 3. Hold current medications if MD ordered."</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 740 F 740 SS=E	Continued From page 15 Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess and implement behavioral strategies for 5 of 6 residents (R1, R2, R3, R4, and R6) who displayed verbal and physical behaviors towards each other, which caused expressions of anxiety for each of these residents. Findings include: When interviewed on 10/19/20, at 9:10 a.m. R1 stated, "[R2] has been calling me names for months, last month he called me a, 'faggot,' and staff don't either know about it, nor do anything. The last time was yesterday, [R2] said, 'Hey you snitch ass faggot, I'll beat your ass.' He always comes up behind you and slams his fist on the table and says, 'achoo', to scare you. I have talked social worker (SW)-A about it and it still just happens." This behavior is causing increased feelings of fear and anxiety for R1. When interviewed on 10/19/20, at 9:12 a.m. R6	F 740 F 740	F 740 R 1, and R 3 will have a risk management incident initiated and completed, their vulnerable adult care plan reviewed, and update as needed, and trauma informed care assessment initiated. Social Service Director will meet with R 1 and R3 2x a week as needed to ensure resident continues to feel safe while residing in the facility. R 6 Discharged from facility on 10/27/20, R 2 and R 4 will have a risk management incident completed, vulnerable adult care plan updated as needed and a trauma informed care history completed. R 6 Discharged from facility on 10/27/20, Social Services will meet with R2 and R 4 to discuss this incident and will provide education on resident rights and how verbal abuse causes fear and anxiety for others. Risk management incidents from survey exit will be reviewed and thoroughly investigated. Care Plans, group sheets	11/13/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 740	<p>Continued From page 16</p> <p>stated, "[R4] she's calling me 'nigger bitches.' I don't know why she calls me names. When she goes out of her room we, [R6 and R2], are supposed to run to our rooms." R6 added, "They [staff] still don't do nothing. They act like they are scared of her. She [R4] does not abide by the rules. They [staff] will say something to us [R6 and R2] but nothing to her [R4]." "Yesterday [R4] said, "Get outta here bitch," and I was just in the hallway. She calls me a, 'black bitch,' every time she sees me." R6 stated this is, "abusive," and very upsetting to her.</p> <p>When interviewed on 10/19/20, at 9:38 a.m. R2 stated, "For about a month or a month and a half, she [R4] says mean things like, "Get that fucking Indian out of here. She verbally abuses us every day." R2 also said, "[R4] is so abusive they [staff] don't say nothing to her. It started when we were watching TV and [R6] came up behind me and asked for a cigarette. [R4] yelled, "Get your black ass off him, you nigger." R2 indicated he did not feel safe in his environment. The constant verbal attacks are causing increased anxiety.</p> <p>When interviewed on 10/19/20, at 9:46 a.m. R3 stated, "My name is [R3] and [R6] calls me whatever, [R6] calls me a bitch, dumb bitch and stupid bitch. It makes me feel bad." R3 stated the verbal abuse from [R6] causes her to lose sleep and feel anxious. This has negatively impacted her well-being.</p> <p>When interviewed on 10/19/20, at 10:55 a.m. R4 stated, R2 and R6 have been threatening to beat her up for the past month and a half. They call her, "crippled bitch," and, "bitch." This has caused increased anxiety, "I've had to increase my anxiety pills since all this started." She</p>	F 740	<p>and Kardex's will be updated for those incidents as needed. Existing residents will be interviewed to ensure no further verbal abuse has been experienced. Upon admission, residents will review the resident rights policy and procedure and will be educated on the facility grievance procedures. All future allegations of abuse will be reported per facility policy. Facility staff will be in-serviced on the resident to resident altercation policy with emphasis on how to de-escalate resident confrontations and resident to resident incidents will be communicated during shift change and nurse aide group sheet and Kardex will be updated to reflect resident intervention changes. IDT team will be in-serviced on reporting all resident allegations of abuse and updating care plan interventions as needed. Social Service director will also be in-serviced on the Guidelines for Behavioral Health Phase 2 Services regulation and compliance document. Social Services and/or designee is responsible for compliance. Audits on thoroughly investigating resident to resident incidents, abuse reporting, care plan interventions after resident to resident altercations for appropriateness and timely implementation and shift to shift report will begin 3x week for 3 weeks, weekly x 4 weeks then monthly to ensure compliance. All audit results will be reviewed by the Administrator and the Administrator will take audits to monthly QAPI meetings x 3 months to ensure consistent implementation of the facility's policy with</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 740	<p>Continued From page 17</p> <p>reported this to the social worker last week again, who told her not to report it to the State Agency because there was already an open case and they would get in trouble.</p> <p>When interviewed on 10/19/20, at 2:14 p.m. R7 stated, R2 comes up behind her and pretends to sneeze, he does this to scare her and it is effective. R7 stated, "I have seen [R2] do this to other residents." R7 stated she has seen R2 screaming and yelling at R1 for weeks. This is causing R1 to be anxious and upset.</p> <p>When interviewed on 10/19/20, at 2:31 p.m. R4 played an audio recording dated 10/11/20, that she identified as a recording of R2. A male voice on the recording can be heard addressing R1 by name and with a threatening voice, "You are a fucking white boy and a fucking snitch. I should treat you like the dumb dirty dog you are."</p> <p>When interviewed on 10/19/20, at 2:31 p.m. R6 stated, R2 calls R1 many, "foul," things and had threatened R1 with physical abuse. R6 stated, "[R2] comes up behind me and slams [R2's] fist on the table and says 'achoo.'" R6 stated this is meant to scare her, which it does. This causes continual anxiety. She has asked him to stop, but it continues. She has asked staff to make him stop, but they have not.</p> <p>R1's quarterly MDS dated 9/15/20, included cognitively intact, no behaviors noted and had diagnoses including bipolar disorder, schizophrenia, and post-traumatic stress disorder (PTSD).</p> <p>R1's care plan revised on 7/23/20, included, "Potential to demonstrate verbally abusive</p>	F 740	tracking and trending of policy compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 740	<p>Continued From page 18</p> <p>behaviors r/t [related to] ineffective coping skills, mental/emotional illness, poor impulse control. [R1] may yell scream and swear, strike out when he is scared or confused." Staff were instructed to, "Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; use de-escalation techniques. Logical reasoning does not work." Added to the care plan on 9/28/20, "Another resident called [R1] a fagot [sic]. Resident educated on calling names back and walking away."</p> <p>R2's quarterly MDS dated 9/24/20, included cognitively intact, verbal behavior directed at others 4-6 days during the reference period and had diagnoses including substance abuse and depression.</p> <p>R2's care plan revised 8/3/20, included, "4/20/20 resident got into an altercation with another resident." Staff were directed to, "Intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; remove resident from unsafe situations." Additionally, "House psychologist to follow resident to help de-escalate reduce conflict between other residents."</p> <p>R3's admission MDS dated 8/29/20, identified R3 had intact cognition. R3's face sheet, printed 10/20/20 indicated R3 had diagnoses including, dementia, depression, legal blindness, restlessness and agitation.</p> <p>R3's care plan printed 10/20/20 indicated under focus "[R3] is a vulnerable adult due to [R3's] dependency on others for care. [R3] resides in a skilled nursing facility 10-10 VA (vulnerable adult) report made resident to resident. Revision on</p>	F 740			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 740	<p>Continued From page 19</p> <p>10/19/20. Goal; [R3] will remain safe in [R3's] environment. Interventions; 10-10 Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response aggressive, staff to walk calmly away. and approach later: use de-escalation [sic] techniques. Logical reasoning does not work, Revision on 10/19/20.</p> <p>R4's quarterly MDS dated 9/22/20, included cognitively intact, physical behavior directed at others 1-3 days during the reference period, verbal behavior directed at others daily during the reference period, and other behavior symptoms not directed at others 1-3 days during the reference period and had diagnoses including schizophrenia, borderline personality disorder, and PTSD [post-traumatic stress disorder].</p> <p>R4's Behavior Care Area Assessment (CAA) dated 6/23/20, indicated, "Resident's behaviors put resident and others as risk of injury. Resident has been yelling and swearing at others."</p> <p>R4's care plan revised on 10/15/20, included, "History of other resident altercations. 9-21 VA [vulnerable adult] report of physical and emotional abuse. 9-29 VA report of verbal abuse with another resident. 10-9 VA report of Resident to resident altercation. 10-10 report resident to resident." Care plan also included, "10-10 Resident directed to her room. 9-21 All staff educated on abuse and neglect training. 10-5 refused referral to new SNF [skilled nursing facility]. 10-6 De-escalation techniques." Additionally the care plan indicated, "Potential to demonstrate verbally abusive behaviors r/t [related to] ineffective coping skills, mental/emotional illness, poor impulse control.</p>	F 740			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 740	<p>Continued From page 20</p> <p>[R4] often yells, screams and swears when she does not get her way."</p> <p>R6's Minimum Data Set (MDS) dated 9/2/20, included cognitively intact, verbal behavior directed at others daily and had diagnoses including alcohol dependence with other alcohol induced disorder, cocaine use, and alcoholic cirrhosis of liver without ascites.</p> <p>R6's care plan revised 10/19/20, included, "[R6] has potential to demonstrate verbally abusive behaviors r/t ineffective coping skills. Poor impulse control. New admission to center. History of alcohol and substance abuse. Yelling and swearing. Difficult to redirect. Goal; [R6] will verbalize understanding of need to control verbally abusive behavior through the review date. Staff were directed to, "Assess resident's coping skills and support system. Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation."</p> <p>R4's progress note dated 9/12/20, at 10:47 p.m. included, "[R4] was agitated during the shift, she continue [sic] yelling at staff and other resident's in the hallway. Resident was using abusive words toward other residents, writer tried to redirect her but she refused to be redirected or calm."</p> <p>R4's progress note dated 9/13/2020, at 9:14 p.m. included, "[R4] was agitated, she was yelling in the hall and swearing at both staff and residents. Writer tried to redirect her to her room.</p> <p>R2's licensed psychologist visit report dated 9/25/20, included, "Staff report and [R2] concurred a verbal altercation between he and</p>	F 740			

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

PRINTED: 11/07/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 740	<p>Continued From page 21 another resident occurred."</p> <p>R2's investigative report dated 9/28/20, at 3:55 p.m. included, R2 called R1, "a faggot."</p> <p>R4's progress note dated 9/29/20, at 4:56 p.m. included, "[R4] came into social services office yelling saying, "You need to do something about him (referring to [R2])." R4 said "He flicked me off." Redirected [R4] to calm down. Nurse gave resident her anxiety medication."</p> <p>R4's progress note dated 9/29/20, at 5:55 p.m. included, "loud screaming and yelling coming from dining room. [R4] was yelling towards other resident stating that "I am not going to take this anymore!" Resident [R4] refused to be re-directed out of the dining room by writer. Left the dining room on her own yelling, screaming and using profanity. Screaming she wants other resident "kicked out of here!"</p> <p>R2's progress note dated 9/29/20, at 5:58 p.m. indicated, "Loud screaming and yelling coming from dining room. [R2] stated that he was sitting in the dining room, "minding his own business" and watching the TV, when other resident came in she stated, "Fuck you, you fucking Indian mother-fucker!" Spoke with [R2] about resident's rights and asked him if he feels safe here. [R2] stated, "Yes, I feel safe. I just try my best to stay away from her." Assessed emotional status, he stated, "I am ok."</p> <p>R4's progress note dated 9/30/20, at 12:20 a.m. included, "Resident was agitated this afternoon and arguing with another resident. Resident is now on 30 minutes check list until further notice."</p>	F 740			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 740	<p>Continued From page 22</p> <p>R4's licensed psychologist note dated 10/2/20, included, "Altercation reported by [R4] between herself and another resident has continued with involvement by the state re [regarding]: follow up on report made which was triggered by [R4]'s allegation of negative interaction with the other resident. This date she reports return to nightmares and sleep disturbance, increased mistrust of others including staff as well as residents she used to feel she could trust."</p> <p>R4's progress notes dated 10/7/20, included, "Resident also stated that she is no longer coming to staff with any concerns or questions she has regarding her interactions with other residents. she sated that she is calling the Ombudsman for Long Term care and they will be calling the "state" on three way call. Resident was advised by writer that it is her right to have the Ombudsman assist her in contacting the state."</p> <p>R4's Risk Management Incident Report dated 10/9/20, at 9:10 a.m. included, "[R4] stated that another resident wants to 'kick her ass.'"</p> <p>R2's licensed psychologist visit report dated 10/9/20, included, "[R2] has again been involved in conflict with another resident (reported appropriately per facility protocol) and remains with frustration about this." "He continues to remain in his room to avoid conflict though he is noted out in community area often interacting with another resident who was also involved in the conflict noted above."</p> <p>R6's Risk Management Incident Report dated 10/9/20, at 9:00 a.m. indicated R6 told the social worker that another resident was going to kick</p>	F 740			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 740	<p>Continued From page 23</p> <p>her ass. The report included, "Offered to have [R6] contact the supervisor on call any time she felt unsafe or threatened."</p> <p>R6's licensed psychologist visit report dated 10/9/20, included, "Nursing engaged in [sic] assist [R6] to consider options for treatment available in the community. This date, [R6] noted she is open to alcohol treatment."</p> <p>R4's licensed psychologist visit report dated 10/9/20, included, "[R4]'s accusation of being threatened by another resident. Today she is again tense, restless, angry, reports poor sleep, nightmares, discomfort and "I'm better off in my tent."</p> <p>R6's licensed psychologist visit report dated 10/9/20, included, "Per staff and her [R6] own report, she was again involved in verbal altercation with other resident." "[R6] describes frustration and anger toward the other resident, was accused of threatening, noted she also was "provoked" and called names."</p> <p>R4's Risk Management Incident Report dated 10/10/20, at 2:40 p.m. included, "[R4] stated that during a verbal confrontation between her and resident [R6], [R2] intervened, was yelling at her then slapped at my head, he missed and only caught my hair, did not pull my hair. This occurred in the afternoon. in [sic] the dining room when [R4] was coming in from the smoking area. resident [sic] also stated that [R6] had said "I will beat your ass." After lunch when resident was outside smoking [R2] and [R6] were yelling and swearing at her with [R6] say [sic] he [sic] wanted to 'suck her tits.'"</p>	F 740			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	<p>Continued From page 24</p> <p>R6's progress note dated 10/10/20, at 7:05 p.m. included, "Both residents [R3 and R6] started shouting at each other using profanity. Writer hard [sic] noise and came and removed [R3] to North hallway, [R6] chased after [R3] threatening that she will lead her a long way. [R3] answered and told [R6] that she will squeeze breath out of her if she dears [sic] get close to her. Writer asked [R6] to go to her hallway but she refused and continued shouting."</p> <p>R4's progress note dated 10/10/20, at 3:19 p.m. included, "[R4] is on a restricted smoking schedule due to confrontations with other residents. She is non compliant, refusing to follow the schedule."</p> <p>R6's progress note dated 10/15/20, at 3:19 p.m. included, "[R6] continued to yell and scream. Difficult to redirect. [R6] was complaining about another resident."</p> <p>R6's licensed psychologist visit report dated 10/16/20, included, "[R6] was approached first this date during episode of her escalation after verbal altercation between her and another resident. She was tearful, yelling, pacing, repeating frustrated statements. Escalation happed on a few occasions this date, each time [R6] removed herself or complied with staff prompting her to move to another direction."</p> <p>R4's licensed psychologist visit report dated 10/16/20, included, "[R4] was tearful, yelling, agitated, restless, repeated "it's not fair" and c/o [concerns of] stress re [regarding]: interactions with other residents in questions (same as last) [R2 and R6]. Staff indicated conflict (verbal altercation) continues."</p>	F 740		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 740	<p>Continued From page 25</p> <p>R6's progress note dated 10/17/20, at 12:09 a.m. included, "Resident refused her HS [night] medications said, "I aren't [sic] taking that shit, u [sic] all planning to kill me" The nurse attempted to get R6 to come with her to the medication cart to check the medications. "Resident walked out to the dinning [sic] and continued shouting and talking to any resident that willing to listen to her. Re-approached resident for her meds, resident continued with her inappropriate use of language."</p> <p>When interviewed on 10/19/20, at 10:10 a.m. licensed practical nurse (LPN)-A stated she observed [R4] call [R6] racial slurs. "[R6] gets extremely upset. It will be constant. I've had to come between them." LPN-A stated she had told both residents to "be civil" and "encourage them to avoid each other." "That seems to help. [R4] called [R6] a bitch just because she saw her. That was a couple days ago, maybe Saturday? I got [R6] to her room. I talked to [R4] in the lunch room. Everyone calmed down." LPN-A stated the problem between R6, R4, and R2 has been going on, "At least a month and a half." LPN-A does not report this because it is constant and management knows.</p> <p>When interviewed on 10/19/20, at 11:30 a.m. nursing assistant (NA)-C stated R4's behaviors include, "yelling, being abusive to staff and sometimes the other residents." Behavioral interventions include, "having the nurse intervene, separate her from the other resident, or not have them meet. She has certain times she can smoke." NA-C was aware of confrontations between R1, R2, R3, R4 and R6, but did not know of any interventions that really helped with</p>	F 740			

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

PRINTED: 11/07/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 740	<p>Continued From page 26 them.</p> <p>When interviewed on 10/19/20, at 11:44 a.m. activity assistant (AA)-B stated behavioral interventions for R2, R4, and R6 include, "make sure they don't cross paths as best as we can." "Every time they would fight or argue. It could even be looks. They want [R4] escorted here [smoking area], but she refuses that." The confrontations between R2, R4, R6 have been going on for months with no resolution.</p> <p>When interviewed on 10/19/20, at 1:43 p.m. AA-A stated she saw R2 call R1 a, "fucking faggot" a "week or so ago." AA-A added, "they were coming into the dining room. [R1] was in the dining room and [R2] started cussing at him." AA-A was aware of continual confrontations between R2 and R1, R2, R4 and R6, but did not know of any interventions that were effective to deescalate them.</p> <p>When interviewed on 10/19/20, at 3:10 p.m. SS-A stated, she had witnessed R2 call R1 a faggot. The incident occurred in the dining room and she informed both R1 and R2 to, "go to their rooms." "Verbal abuse would be someone calling you names. It depends on how you internalize it. It depends on the person. It didn't have any adverse effects on [R2] so there wasn't any interventions. He told me, 'I'm a big boy.'" SS-A stated things had been, "pretty calm," until R6 moved in about 2 months ago, "The last couple weeks it's been escalating. It's been every day. We have to figure out how we can all live here." SS-A stated she is aware of the continual name calling, verbal threats and intimidation between R1, R2, R3, R4, and R6. She talks to each</p>	F 740			

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

PRINTED: 11/07/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 740	<p>Continued From page 27</p> <p>resident individually, then R2 and R4 together and R6 and R4 together. SS-A stated the house psychologist comes weekly to help come up with some kind of solution. This included relocation services for R6 and R4. On 10/9/20, they came up with a behavioral contract for R4 to go out and smoke when R2 and R6 are not out smoking and not in the same dining room either. SS-A stated initially the behavioral contract was helpful, but now R2, R4 and R6 are saying, "But what if we don't follow it? Then what are they going to do? How are they going to enforce it?" We redirect them. Sometimes R4 would say, or R6 would say, 'why me?' The one who is disrupting the living environment is going to be redirected back to her room. R4 chose the [smoking] times. Now she wants to go out more often. Maybe she is instigating it? It has been challenging." SS-A stated she is not involved staff education and is not involved in change of shift meetings. "[RN-A] is the educator." Education on how to deescalate a resident or manage resident to resident altercations, "Depends on the person. We try to identify the root cause. We work closely as a team. Everyone helps educate. The psychologist does in-services." SW-A was unable to provide a date of the most recent in-service or find when any training of their staff had been completed for behavioral interventions.</p> <p>When interviewed on 10/19/20, at 3:50 p.m. RN-A provided a handout being used to educate staff on abuse. "This is due to the trio [R2, R4, R6]." "What we have been focusing on at this point is more the neglect portion of things. Neglecting to keep the residents safe from abuse. And what is particularly emotional abuse. Just yelling at each other is emotional abuse." RN-A added the training was started today. "Everyone is going to</p>	F 740			

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

PRINTED: 11/07/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 740	<p>Continued From page 28</p> <p>be done. I've talked to some in each department. I sometimes do one on one or a small groups. I would prefer to do this in a full class setting, but we are under a crunch because you guys [state surveyors] were here." RN-A added he would recruit social services to help calm a specific situation, but the social worker is not involved with staff education. RN-A stated there is behavioral intervention training but, "I'm not convinced a lot of them [staff] understand." RN-A listed potential behavioral interventions as scheduled smoking, scheduled eating, sending the residents back to their respective hallways, and escorts. RN-A described this as "very time consuming and very tiring." RN-A was unable to provide any previous training the staff had received on behavioral interventions.</p> <p>When interviewed on 10/19/20, at 4:14 p.m. the director of nursing (DON) stated they were, "in the middle" of completing a behavioral training for staff and another training was done "a few weeks ago" as well. The DON added, "We talk about behaviors too." The DON listed the behavioral interventions for R2, R4, and R6 to include, "deescalate the situation, remove the resident from the situation." The DON added that all three residents signed a behavior contract and about a month ago she and SW-A met with R2 and R4 and encouraged taking turns talking and using, "I statements." For R6 the DON added, "We try to take her away from the situation and deescalate. Sometimes that gets her pretty upset. She really likes to talk one-to-one. Sit down and talk with her. Bring her to her room. She is more receptive to that rather than talking in front of everyone." "We offer our time to sit and talk to residents. We make it a priority because it seems to be very relevant in this facility." "The psychologist is also</p>	F 740			

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

PRINTED: 11/07/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 740	<p>Continued From page 29</p> <p>involved in helping to give them the emotional and mental support that they need." The DON added other behavioral interventions can include, "10 minute checks, 30 minute checks, and escorts to and from smoking area." The DON stated staff are educated on a residents specific behavioral interventions through verbal report and all behavioral interventions should be listed in the care plan and Kardex. The DON stated that social services is not involved in behavioral health education.</p> <p>When interviewed on 10/20/20, at 8:28 a.m. NA-D stated behavioral interventions she would, "Try and deescalate and try and get the aggressor away, get them to go to their room. If they are not listening call a supervisor." NA-D stated she received education on behavioral interventions and resident behavioral health during orientation and in annual training. NA-D said she has been employed at the facility since 2016. NA-D was aware of continual confrontations involving R1, R2, R3, R4 and R6, but was not aware of any interventions that really worked to decrease the confrontations.</p> <p>When interviewed on 10/20/20, at 8:34 a.m. Nursing Administrative Staff (NAS)-A stated "If something is going on remove the resident out of harm's way. Protect the rest of the residents." NAS-A stated her knowledge of behavioral intervention comes from previous experience. "I have been doing it for years." Education at the facility included, "I believe they had an in-service on behaviors maybe last year," but wasn't sure when it occurred. "[SW-A] will give some direction when they [resident] first come it. Nothing after that. The psychologist lets us know." Regarding specific behavioral interventions for R2, R4, and</p>	F 740			

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

PRINTED: 11/07/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 740	<p>Continued From page 30</p> <p>R6, NAS-A stated, "I don't really know how to answer."</p> <p>When interviewed on 10/20/20, at 8:40 a.m. AA-C stated it had been, "awhile" since she had received any education regarding behavioral interventions or resident behavioral health. Behavioral interventions for any resident includes, discourage confrontation, allow time to vent, separate, and monitor. AA-C was not aware of any individualized behavior interventions for residents.</p> <p>When interviewed on 10/20/20, at 8:45 a.m. LPN-E stated her knowledge of behavioral intervention and behavioral management came from previous training prior to current employment. "I know that on my own." When a resident's behavior escalates LPN-E stated she would "try to redirect them. It depends on the cause. Most times with R4 I try to redirect her, allow her to explain herself. Listen." LPN-E stated she has not received education or recommendations on how to manage the behavioral needs of the residents from anyone at the current facility. LPN-E stated she is not aware of any recommendations from the psychologist and added, "the social worker is not involved at all."</p> <p>When interviewed on 10/20/20, at 9:02 a.m. SS-A stated she would be the designated staff member to provide behavioral health training to the staff. "I am the educator on this." SS-A said she provided basic vulnerable adult training and resident rights to all new staff at orientation. SS-A stated behavioral interventions take, "different approaches and sometimes you change your approach, you change your reaction, you change</p>	F 740			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2020
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 740	<p>Continued From page 31</p> <p>their behaviors. We work on approaches individually."</p> <p>When interviewed on 10/20/20, at 10:28 a.m. the DON stated, employee behavioral health education includes a video during new employee orientation and annual training. "The social worker does some abuse training in the annual training as well." The DON stated that a resident's specific behavioral interventions would be added to the care plan by her or SS-A. The DON stated her expectation is that the care plan would be updated within 24 hours.</p> <p>When interviewed on 10/20/20, at 11:30 a.m. the administrator stated behavioral intervention and behavioral health education is provided by the psychologist. "The [psychologist] is here two times a week. We meet with them for immediate findings and certain findings. We update the care plan and Kardex." The Administrator stated the nurses and nursing assistants are informed of resident specific interventions by reviewing the Kardex. Even though the administrator felt interventions had been placed to prevent resident to resident altercations for R1, R2, R3, R4, and R6, the altercations continued.</p> <p>The facility's behavioral health policy requested but not received.</p>	F 740			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 4, 2020

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

Re: Event ID: TGIF11

Dear Administrator:

The above facility survey was completed on October 20, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A rectangular box containing a handwritten signature in black ink that reads "Kamala Fiske-Downing".

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/20/2020
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 10/19/20 and 10/20/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure.</p> <p>The following complaints were found to be SUBSTANTIATED: H5544156C, H5544157C,</p>	2 000		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/06/20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/20/2020
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	<p>Continued From page 1</p> <p>H5544158C and H5544159C. No licensing orders were issued.</p> <p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.</p> <p>Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		