

Electronically delivered December 19, 2021

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

RE: CCN: 245544 Cycle Start Date: December 2, 2021

Dear Administrator:

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

On December 2, 2021, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

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

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

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for Victory Health & Rehabilitation Center December 19, 2021 Page 2

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; 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 January 3, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Victory Health & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 3, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same

Victory Health & Rehabilitation Center December 19, 2021 Page 3

deficient practice.

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

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor Metro B 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: jamie.perell@state.mn.us Office: (651) 245-8094

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

Victory Health & Rehabilitation Center December 19, 2021 Page 4 SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 2, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

Victory Health & Rehabilitation Center December 19, 2021 Page 5

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

		& MEDICAID SERVICES			-	M APPROVED D. 0938-0391
STATEMENT OF		(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		TE SURVEY
AND PLAN OF CO		IDENTIFICATION NUMBER:	. ,	G		MPLETED
		245544	B. WING _		1:	C 2/ 02/2021
NAME OF PROV	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
	EALTH & REHABIL	ITATION CENTER		512 49TH AVENUE NORTH		
				MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000 IN	ITIAL COMMENT	S	F 00	0		
ab Yo wit Re Th SL H5 cit H5 Cit H5 C Cit H5 C C C C C C C C C C C C C C C C C C	bbreviated survey bur facility was fou th the requirement equirements for Lo be following comp JBSTANTIATED: 5544247C (MN00 ed at F677. 5544239C (MN00 ed at F677. 5544278C (MN00 ed at F580. 5544248C (MN00 ed at F580. 5544252C (MN00 ed at F580. 5544279C (MN00 ed at F580 and F be following comp JBSTANTIATED, ere cited due to ac cility prior to surve IN00058115), H55 5544122C (MN00 IN00060483), H55 5544237C (MN00 IN00077584). be following comp NSUBSTANTIATED	laints was found to be however, NO deficiencies ctions implemented by the ey: H5544271C 544253C (MN00067762), 060108), H5544267C 544276C (MN00068073), 075523), and H5544259C laints were found to be ED, however, related				
LABORATORY DIF	RECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

Electronically Signed

12/27/2021

PRINTED: 01/04/2022

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.

DEDADTMENT OF LIEALTH AND LIUMANN CEDVICES

		AND HUMAN SERVICES			FOR	D: 01/04/2022 M APPROVED O. 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	TIPLE CONSTRUCTION	()	ATE SURVEY OMPLETED C
		245544	B. WING		1	2/02/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY	, STATE, ZIP CODE	
VICTOR	Y HEALTH & REHABI	LITATION CENTER		512 49TH AVENUE NO MINNEAPOLIS, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S X (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	The following comp UNSUBSTANTIATI H5544256C (MN00 (MN00057021), H5 H5544272C (MN00 (MN00058601), H5 H5544266C (MN00 (MN00061562), H5 H5544249C (MN00 (MN00063846), H5 H5544245C (MN00 (MN00066083), H5 H5544255C (MN00 (MN00071065), H5 H5544263C (MN00 (MN00075552), H5 H5544261C (MN00 (MN00077317), H5 H5544261C (MN00 (MN00077826), H5 H5544240C (MN00 (MN00077826), H5 H5544277C (MN00 The facility's plan o as your allegation o Departments accep enrolled in ePOC, y at the bottom of the form. Your electron be used as verifica Upon receipt of an onsite revisit of you validate that substa regulations has bee	blaints were found to be ED: 0055236), H5544236C 5544273C (MN00057643), 0057811), H5544270C 5544268C (MN00060411), 0060990), H5544265C 5544269C (MN00058685), 0061566), H5544251C 5544257C (MN00063321), 0063651), H5544246C 5544243C (MN00064999), 0066066), H5544254C 5544244C (MN0007088), 0069148), H5544250C 5544254C (MN00076082), 0077139, MN00076082), 0077139, MN00076082), 0077301), H5544260C 5544241C (MN00077689), 0077301), H5544274C 5544258C (MN00077787), and 0078748). If correction (POC) will serve of compliance upon the bance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an ar facility may be conducted to antial compliance with the en attained.	FO			
F 580 SS=D	Notify of Changes	(Injury/Decline/Room, etc.)	F 5	Eacility ID: 00166		1/10/22

If continuation sheet Page 2 of 38

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					(c
		245544	B. WING _		12/0	02/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY	(HEALTH & REHABIL	ITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	CFR(s): 483.10(g)(1 §483.10(g)(14) Noti (i) A facility must im consult with the res consistent with his of representative(s) w (A) An accident invo- results in injury and physician intervention (B) A significant char mental, or psychoso deterioration in hea status in either life- clinical complication (C) A need to alter the a need to discontine treatment due to add commence a new fr (D) A decision to tra- resident from the fa §483.15(c)(1)(ii). (ii) When making no- (14)(i) of this section all pertinent informa- is available and pro- physician. (iii) The facility mus resident and the res- when there is- (A) A change in roo as specified in §483 (B) A change in res State law or regulat (e)(10) of this section (iv) The facility mus	14)(i)-(iv)(15) fication of Changes. mediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is- blving the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lth, mental, or psychosocial threatening conditions or ns); treatment significantly (that is, ue an existing form of lverse consequences, or to orm of treatment); or ansfer or discharge the ucility as specified in otification under paragraph (g) n, the facility must ensure that ation specified in §483.15(c)(2) vided upon request to the t also promptly notify the sident representative, if any, m or roommate assignment 3.10(e)(6); or ident rights under Federal or ions as specified in paragraph on. t record and periodically (mailing and email) and	F 58			

If continuation sheet Page 3 of 38

		AND HUMAN SERVICES			FOI	ED: 01/04/2022 RM APPROVED IO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245544	B. WING	à		C 12/02/2021	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY	Y HEALTH & REHABIL	LITATION CENTER		-	312 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 580	that is a composite §483.5) must disclo its physical configur locations that comp part, and must spee room changes betw under §483.15(c)(9 This REQUIREMEN by: Based on interview facility failed to notif transferred to the h reviewed for chang Findings include: R29's significant ch (MDS) dated 9/23/2 cognitively intact an included vertigo, hy pressure), and anxi Review of R29's pro following: - 11/22/21, at 11:16 hospitalized. - 11/26/21, at 9:64 at	apposite distinct part. A facility distinct part (as defined in ose in its admission agreement ration, including the various orise the composite distinct cify the policies that apply to veen its different locations). NT is not met as evidenced v and document review, the fy the physician a resident was ospital 1 of 4 residents (R29) e of condition.	F	580		re D d	
	complaints of vision Clostridioides diffici causes severe diar colon) and had no r Review of R29's me	n changes, was ruled out for a le infection (bacteria which rhea and inflammation of the			in emergency page the physician for prompt response. Director of nursing and/or designee is responsible for compliance. Audits on MD notification on resident change in condition will begin 2x wk for weeks, weekly x 2 weeks then monthly	2	

Facility ID: 00166

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO (X3) DAT	E SURVEY	
ND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:		G	`´CΟΝ	IPLETED	
		245544	B. WING			C / 02/2021	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
VICTORY	(HEALTH & REHABI	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 580	Continued From pa	age 4	F 580				
	social worker (SW) to the emergency of was placed on obso with a chief complathrive.	on 12/1/21, at 3:18 p.m. -A stated R29 was transferred lepartment on 11/22/21, and ervation status at the hospital int of vertigo and failure to		ensure compliance. Audit results will be reviewed by Administrator and the Administr take the audit results to QAPI for and recommendation. Compliance: 1/10/ 2022	ator will		
	LPN-B stated R29 medications on 11/ provider. R29 was concerns regarding	22/21, and had notified the not aware of any other 9 R29 during their shift and 7e not aware R29 was					
	licensed practical nurse observed R29 near the 11/30/21, at approxima when arriving for his sh had already left for the	on 11/30/21, at 2:50 p.m. hurse (LPN)-A stated he the facility entrance on timately 3:00 p.m. calling 911 s shift. He was notified R29 the hospital when he started did not receive any detail went to the hospital.					
	physician assistant call notes dictated was at the hospital LPN-B called to red the resident, did no stated they learned chart review on 11/ preparing for a visit expected to notify t when a resident wa	on 12/1/21, at 10:59 a.m. (PA)-A stated there were no on 11/22/21, indicating R29 , however there was a note quest R29 be rounded on as t seem like themselves. PA-A of R29's hospitalization during 26/21, or 11/29/21, when t. PA-A stated staff were he provider, or call center, as transferred to the hospital ted the lack of notification was					

Facility ID: 00166

If continuation sheet Page 5 of 38

		AND HUMAN SERVICES				FORM	01/04/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTR		(X3) DATE SURVEY COMPLETED C	
		245544	B. WING _) 02/2021
NAME OF I	PROVIDER OR SUPPLIER		•		DRESS, CITY, STATE, ZIP CODE	•	
VICTORY	/ HEALTH & REHABIL	LITATION CENTER			VENUE NORTH OLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E/	PROVIDER'S PLAN OF CORRECTIO ACH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 580	hospitalization. During an interview director of nursing (why R29 was hospi up to R29 going to the R28's medical reco R29 was hospitalized notification. The DC to notify providers at Facility policy titled Condition or Status facility would promp resident's medical of condition/status. ADL Care Provided CFR(s): 483.24(a)(2) §483.24(a)(2) A reso out activities of daily services to maintain personal and oral h This REQUIREMEN by: Based on observat review, the facility fa hygiene was provid who was dependen daily living (ADL). Findings include: R28's Admission Re R28 had diagnoses	 con 12/2/21, at 10:10 a.m. the (DON) stated she did not know talized or the events leading the hospital. The DON verified rd lacked indication of why ed or subsequent provider DN stated she expected staff and document the notification. A Change in a Resident's (undated), indicated the otly notify the physician of a change or change in for Dependent Residents 2) sident who is unable to carry y living receives the necessary n good nutrition, grooming, and 	F 5	77 R 28 A prefere as nee in the e since b and wil facility satisfad respon medica	ADL care plan and resident ences was reviewed and upo ded. R 28 refusals will be re electronic medical record. R been placed on hospice serv Il have a follow up visit with social worker to assess resi ction of ADL cares. R 28's ise will be recorded in the el al record. Current residents	ecorded 28 has vices the ident ectronic who	1/10/22
	Findings include: R28's Admission R R28 had diagnoses arthritis (causes pa	which included rheumatoid		and wil facility satisfac respon medica receive	Il have a follow up visit with social worker to assess resi ction of ADL cares. R 28's se will be recorded in the el al record. Current residents	the ident ectronic who I and	

Facility ID: 00166

If continuation sheet Page 6 of 38

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	0938-039
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	ā		PLETED
		245544	B. WING		C 12/02/2021	
NAME OF I	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE		
VICTOR	' HEALTH & REHABII	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 677	Continued From pa	ige 6	F 677	7		
	10/27/21, indicated and had no docume was totally depende transfers, toilet use had impairments of extremities and was R28's care plan dat an ADL self-care de knee amputations, the spine connects weakness, and rhe directed to provide cares, assist with to Review of R28's AE 11/30/21, indicated 11/30/21, staff docu completed for 16 of no documented refi hospitalized on 11/2 Review of R28's AE 12/2/21, indicated f was completed for user no documente During an observat R28 was observed a pillow slightly und fingernails were rou brownish/black resi fingernails. R28's gums with breath had a n	24/21. DL Task Record Record dated rom 12/1/21, staff documented 1 of 3 opportunities. There		as needed. There has been no fu ADL care concerns voiced from ex- residents or resident representative Future residents will be assessed their ADL ability will be care planner interventions implemented. Nursing staff will be in-serviced on ADL Support Policy and Procedure emphasis on item #4 to assess to the cause of the refusal and to re-approach. Director of nursing and/or designer responsible for compliance. Audits on ADL care and document refusal/reapproach for care will be wk for 2 weeks, weekly x 2 weeks monthly to ensure compliance. Audit results will be reviewed by th Administrator and the Administrato take the audit results to QAPI for r and recommendation.	kisting es. and ed and the e with identify e is tation of gin 2x then then or will	

If continuation sheet Page 7 of 38

DEPART	MENT OF HEALTH	AND HUMAN SERVICES	P		APPROVED		
		& MEDICAID SERVICES				MB NO. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(-)	E SURVEY PLETED
			A. DOILD	inta		(С
		245544	B. WING			12/02/2021	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY	' HEALTH & REHABIL	LITATION CENTER			12 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIZ TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
F 677		7					
F 0//	Continued From pa	ge /	F 6	677			
	During an observati	ion on 11/30/21, at 9:41 a.m.					
		nd provided a bed bath by					
		IA)-A. NA-A did not offer nail roughout the observation.					
	NA-A stated the eve	ening or night shift can provide					
		care. Further, R28's long nails					
	underneath.	cleaned because of unit					
	During on interview	an 11/00/01 at 0:00 n m					
		on 11/30/21, at 2:28 p.m. urse (LPN)-C stated it was the					
	responsibility of nur	sing assistants to provide ADL					
		resident's care plan directed 8 required every day. LPN-C					
		aw dirt build up under R28's					
	nails.						
	During an observati	ion on 12/1/21, at 9:39 a.m.					
	R28's fingernails re	mained roughly two inches					
	long with browning/	black residue underneath.					
		on 12/1/21, at 10:00 a.m. R28					
		cleaned her fingernails or					
	•	for many days; maybe ous week. R28 stated she					
		her teeth daily when she was					
		own. R28 expressed she					
	cares provided.	ner nails cleaned and oral					
	·						
		on 12/1/21, at 1:45 p.m. the f nursing (ADON) stated she					
		ares were not provided to					
	R28.	·					
	During an interview	on 12/1/21, at 1:42 p.m. the					
	director of nursing ((DON) explained she had not					
	heard of R28 refusi	ng cares. The DON stated					

If continuation sheet Page 8 of 38

		AND HUMAN SERVICES			FORM	01/04/2022 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245544	B. WING		C 12/02/2021	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
VICTOR	Y HEALTH & REHABII	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 677 F 686 SS=G	hygiene care and d expectation was for completed every sh stated she felt there complete cares, bu did not always war The DON confirme were long. Facility policy titled (ADL's) (undated) of unable to carry out receive services to grooming, and pers Treatment/Svcs to CFR(s): 483.25(b)(§483.25(b) Skin Int §483.25(b)(1) Pres Based on the comp resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that f (ii) A resident with p necessary treatmen with professional st promote healing, pu new ulcers from de This REQUIREMEN by: Based on observat review, the facility f reassess and imple	should provide daily personally ocument refusals. Her r personal hygiene cares to be hift and as needed. The DON e was enough staff to t the facility culture was nurses t to help nursing assistants. d she knew R28's fingernails Activities of Daily Living directed residents who were ADLs independently would maintain good nutrition, sonal and oral hygiene. Prevent/Heal Pressure Ulcer 1)(i)(ii) egrity sure ulcers. orehensive assessment of a must ensure that- res care, consistent with ards of practice, to prevent d does not develop pressure idividual's clinical condition they were unavoidable; and oressure ulcers receives nt and services, consistent andards of practice, to revent infection and prevent	F 6		1 and weekly new Braden	1/10/22

Facility ID: 00166

If continuation sheet Page 9 of 38

	-	I AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: FORM OMB NO.	APPROVE	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COMI	E SURVEY PLETED	
		245544	B. WING _		C 12/02/2021		
	PROVIDER OR SUPPLIER Y HEALTH & REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 686	the risk of complication of the risk of complication of the research of the re	ations of an existing pressure dents (R28) reviewed for he resulted in actual harm for resening stage IV pressure finition: posed bone, tendon, or eschar (Dead tissue that is ire, usually black, brown, or ay appear scab-like. Eschar mly adherent to the base of en the sides/edges of the esent. It often includes ardly visible wound margins) sageways underneath the b. ecord dated 12/2/21, indicated cluded diabetes, pressure on (area where the spine ver half of the body), and ad left leg above knee. himum Data Set (MDS) dated I R28 was cognitively intact ented rejection of care. R28 ent of two staff with bed and toilet use. R28 had an upper and lower extremities continent of bowel. R28 had stage IV pressure ulcers which admission. Several treatments ncluded pressure reducing	F 68		vas reviewed MD will be tation was 21 and the l in the ther vere entation were ded. Future ds will have and their and l on the icy with nation and sician on and placement ere also of turning pressure ments will or high risk se will be ily wound ignee is and for 2 weeks, ly to ensure by the strator will		

Facility ID: 00166

DEPART	FORM	APPROVED					
		& MEDICAID SERVICES					0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
			AL BOILD				C
		245544	B. WING				- 02/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY	' HEALTH & REHABIL	ITATION CENTER			12 49TH AVENUE NORTH		
				M	IINNEAPOLIS, MN 55430		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP		DATE
			1		DEFICIENCY)		
F 686	Continued From no	ao 10	–				
F 000	Continued From pa	ge io	F 6	986	and recommandation		
	R28s Care Area As	sessment (CAA) dated 5/7/21,			and recommendation.		
		totally dependent of staff for					
	bed mobility, dressi	ng, toilet use, and personal					
		urther indicated R28 required					
		staff, with the use of hoyer lift R28 required extensive					
		taff to turn and reposition in					
		s and as necessary.					
		ed 9/19/21 indicated R28 had lcers on her sacrum right					
		c part of the hip bone), and left					
		blan further identified R28 had					
	the potential to deve	elop additional pressure ulcers					
		nce, immobility, and					
		are plan included several ing to conduct weekly skin					
		provide wound care per orders.					
		s revised on 12/2/21, to					
		28 to sit up in tilt-in-space					
		ressure reducing cushion for s not to exceed two hours of					
	sitting to offload pre						
		ary Report dated 12/2/21,					
		to offload R28, per facility					
		be" up in chair two hours per al one hour after a two-hour					
		g and afternoon. Further, R28					
	was to be reposition	ned every two hours and have					
		completed every Tuesday					
		and care orders included:					
		and sacrum wound care: s of silver alginate (product					
		bund healing) were removed					
	from the wound bed	d. Saturate 4 x 4 gauze with					
		nser). The saturated gauze					
	was then to be plac	ed in R28's wound beds and					

If continuation sheet Page 11 of 38

DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES			F		APPROVED
		& MEDICAID SERVICES				MB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	`́сом	E SURVEY PLETED
		245544	B. WING				C 02/2021
NAME OF	PROVIDER OR SUPPLIER			ç	STREET ADDRESS, CITY, STATE, ZIP CODE		
VICTOR	(HEALTH & REHABIL	ITATION CENTER			512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	undermining areas minutes. Remove (g alginate. Place a for morning. An Interdisciplinary dated 12/1/21, at 7: hospitalized from 10 severe sepsis seco wound abscess (co infection) and osteo was under observat 11/24/21, related to R28's Wound Physi medical doctor (MD the following: - R28's stage IV sac measured 3.5 centi cm. with underminin o'clock position. The granulation (new tis fascia (thin casing of holds muscle in-pla exudate (clear, thin stage IV pressure w measured 1.0 cm. > abnormal granulation margins. R28's stage right ischium measu cm with 100 percent Recommendations and repositioning pe be up for two hours after a two-hour bree Review of R28's No	and allow to sit for five gauze) and place silver am boarder dressing in the team (IDT) progress note 17 p.m. indicated R28 was 0/1/21, to 10/20/21 due to ndary to a decubitus sacral llection of puss related to omyelitis. Additionally, R28 tion in the hospital on chest pain. ician Progress Note written by 0)-C dated 11/18/21, revealed cral pressure wound meters (cm.) x 3.0 cm. x 2.0 ng of 5.0 cm. at the three e wound had 80 percent sue), 20 percent muscle and of connective tissue which ce), and moderate serous , and watery fluid). R28's wound to her left ischium x 1.0 cm. x 1.5 cm with on present within the wound ge IV pressure wound to her ured 0.8 cm. x 0.8 cm. x 1.0 it granulation present. included offloading the wound er facility protocol. R28 may in their chair and one hour	Fé	586	,		

If continuation sheet Page 12 of 38

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(-)	E SURVEY PLETED
			7			(C
		245544	B. WING			12/0	02/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY	(HEALTH & REHABIL	ITATION CENTER		-			
			1	N	MINNEAPOLIS, MN 55430		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID PREF	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
			1				
F 686	Continued From pa	ae 12	Fé	686			
	were no documente	-		.00			
		cember 2021 Task Record,					
		rring/bed mobility was not f 3 opportunities. There were					
	no documented refu						
	Review of R28's Wo notes revealed:	eekly Skin Check Progress					
		o.m. indicated R28 was on a					
		oning program and had a					
		progress note lacked					
	assessment of R28	's wound. umentation was provided,					
		r skin assessments on					
	11/1/21, 11/8/21, ar						
	During a souther						
		s observation conducted on a.m. to 11:43 a.m. R28 was					
		at on her back, in bed, with a					
		her bed. R28's eyes were					
		s noted to be moaning and					
		or help. At 10:30 a.m., R28 h." At 11:43 a.m., R28 called					
		ted she had pain. At 11:44					
	a.m., licensed pract	tical nurse (LPN)-C was					
		vised R28 had not been					
		he continuous observation LPN-C stated she would notify					
		Throughout the observation,					
	no staff entered R2	8's room, nor responded to					
		g out periodically. Three hours					
	and 13 minutes had	1 passeu.					
		ion on 11/29/21, at 10:25 a.m.					
		und care to R28. R28					
		ain and noted facial grimacing to her left side and throughout					
		dressing was noted to be					

If continuation sheet Page 13 of 38

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MET	PLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		MPLETED
		245544	B. WING		C 12/02/2021	
NAME OF	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD		
VICTOR	Y HEALTH & REHABII	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 686	completely saturate which also soaked product and the she was also observed electrocardiogram (which were remove Zoll electrodes mus since her emergend 11/24/21. LPN-B re the sacral, right, an wounds. LPN-B the Vashe solution on g R28's sacral and rig wounds. The gauze with Vashe solution the gauze was rem alginate to R28's sa pressure wounds. T cut round and roug did not cover the er wound. LPN-B ther foam dressings. Im dressing change LF aware the gauze ne Vashe solution or th needed to cover the During an interview assistant director or started a performar wound care and as concerns regarding assessed, staff role providing wound ca provider. The ADOI assessed by a wou	ad with bloody red drainage through to R28's incontinence eet below her. Further, R28 to have four Zoll (EKG) electrodes on her back ad by LPN-B. LPN-B stated the st had been on R28's back cy department visit on moved the old dressing from d left ischium pressure en poured a small amount of gauze and placed the gauze on ght and left ischium pressure e was not completely saturated b. After roughly five minutes, oved and LPN-B applied silver acral, right, and left ischium The piece silver alginate was hly 1.5 inches in diameter and ntire wound bed of the sacral n covered R28's wounds with a mediately following the PN-B stated she was not eeded to be saturated with he silver alginate dressing e entire wound bed. o on 11/30/21, at 12:45 p.m. the f nursing (ADON) stated she nce improvement plan for sessments as she discovered p how wounds were being as and responsibilities, and are as directed by the medical N stated R28 had not been nd provider for a few weeks as o be evaluated after being	F 68	6		

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	D: 01/04/2022 MAPPROVED D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION G		TE SURVEY MPLETED C
		245544	B. WING	i		12	2/ 02/2021
NAME OF F	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CC		<u> </u>
VICTORY	(HEALTH & REHABI	LITATION CENTER			512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	Continued From pa	age 14	F	686	6		
	the director of nurs director of nursing is sacral and right and wounds. The ADON her left side and reip product. The DON had a large copious non-odorous drainat through the dressin outside of the sacra Vashe soaked gauat five minutes. The D and inserted silver The silver alginate bed where underm then applied a foan During an interview director of nursing observed R28's drea appeared wound ca ordered. She confir dressing did not co as directed, and flu R28's dressing and product. The DON bloody discharge a lacked granulation today which was no The DON confirme and included sever weekly skin checks timely repositioning care. The DON also	y on 12/1/21, at 1:45 p.m. the (DON) stated when she essing change on 11/30/21, it are was not completed as rmed the silver alginate ver R28's entire wound bed, id had saturated through d onto R28's incontinence described the drainage as nd stated R28's wound bed upon her wound assessment oted on previous assessments. d R28's wound had worsened al reasons which included s not being completed, lack of g, and no consistent wound o stated R28 had stool on her					
	care. The DON also incontinent product was completed on						

Facility ID: 00166

If continuation sheet Page 15 of 38

		AND HUMAN SERVICES				FORM	: 01/04/2022 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY IPLETED C
		245544	B. WING				02/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
VICTORY	HEALTH & REHABI	LITATION CENTER			12 49TH AVENUE NORTH		
		ATEMENT OF DEFICIENCIES		IV	AINNEAPOLIS, MN 55430 PROVIDER'S PLAN OF CORRECTI		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	bandages became changed. During an observat MD-C, the ADON, a care to R28. LPN-E her left side. R28 e had facial grimacin incontinence produ R28's old dressing right and left ischiu small amount of lig on her incontinence noted on R28's skii sacral wound. The the skin with wound R28's wounds and alginate were noted told the ADON and applicator to asses pieces of silver algi inserted Vashe soa beds for five minute gauze and complet wounds with silver then covered with a stated to the ADON piece of alginate we covered the entire of healing. MD-C also completely.	age 15 bt reporting to the nurse when soiled and needed to be ion on 12/2/21, at 12:00 p.m. and LPN-D provided wound D assisted R28 reposition to xpressed pain to MD-C and g. The ADON removed R28's ct and subsequently removed located on the sacrum and m pressure wounds. R28 had ht brown colored stool noted e product. Stool was also n roughly three inches from the ADON proceeded to cleanse d cleanser. MD-C assessed additional pieces of silver d in the sacral wound. MD-C LPN-D to use a cotton tipped s the wound and ensure all nate were removed. MD-C ked gauze into R28's wound es. MD-C hen removed the rely covered R28's pressure alginate. The wounds were a foam dressing. MD-C then I and LPN-D to ensure a full as used so it completed wound bed to promote proper o instructed staff to offload R28	F 6	86			
	wounds two weeks ulcer and measure	ago. R28's sacral pressure ments increased in length and eling. MD-C attributed					

Facility ID: 00166

If continuation sheet Page 16 of 38

		AND HUMAN SERVICES			FORM): 01/04/2022 MAPPROVED). 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED C
		245544	B. WING _		12	/ 02/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
VICTORY	HEALTH & REHABIL	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
F 689	hours. MD-C stated deterioration include continuity of wound MD-C stated during in her incontinence on R28's skin when MD-C stated she ex- reposition R28 ever wheelchair cushion care, and change d A subsequent Woun- written by MD-C dar following: - R28's stage IV sate measured 3.5 cm serous excaudate v slough (dead tissue Further, the wound measured 5.5 cm a 4.5 cm. at the nine at the 12 o'clock po had "deteriorated" s R28's wound was d devitalized tissue (r cm. Facility policy titled (undated) directed to pressure injuries ar injuries. Staff were plan and assess for resident, pressure i surfaces, and status	g to not being fully being repositioned every two d the reasons for wound ed: need to offload the wound, care, and incontinence care. g her visit today, R28 had stool product and staff left the stool wound care was provided. Appected the facility to ry two hours, provide R28 a , provide good incontinence ressings immediately if soiled. And Physician Progress Note ted 12/2/21, revealed the cral pressure wound (x 4.0 cm. x 1.5 cm. Moderate vas noted with 10 percent e) and 90 percent granulation. had undermining which at the three o'clock position, o'clock position, and 7.5 cm. sition. R28's sacral wound since her last visit on 11/18/21. lebrided of 1.4 cm. of non-viable) at a depth of 1.6 Pressure Injury Treatment to provide care of existing nd the prevention of additional to review the residents care r any special needs of the njury care, current support s of the injury. azards/Supervision/Devices	F 6			1/10/22

		AND HUMAN SERVICES			FORM	01/04/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		245544	B. WING) 2/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY	Y HEALTH & REHABII	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 17	F 689			
	as free of accident §483.25(d)(2)Each supervision and ass accidents. This REQUIREMEN by: Based on interview facility failed to ens in accordance with practice to reduce t accident hazards for was administered of Findings include: R28's Admission Re R28's diagnoses in (inflammation of lur respiratory failure. R28's Order Summ directed staff to app into both of R28's no R28's care plan dat received oxygen the exchange and direct at 1 liter per minute Review of R28's Tru (TAR) dated 11/30/2 apply a small amou R28's nostrils twice	asure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced v and document review, the ure oxygen was administered acceptable standards of he likelihood of potential or 1 of 1 resident (R28) who oxygen therapy. ecord dated 12/2/21, indicated cluded pneumonitis ng tissue) and chronic ary Report dated 11/30/21, bly a small amount of Vaseline iostrils twice daily for dryness. red 9/17/21, indicated R28 erapy related to ineffective gas cted staff to administer oxygen		MD was contacted and Vaseline or R 28 was discontinued. No adverse effects were experienced during us this petroleum agent. All other resid who receive oxygen therapy orders reviewed for petroleum agent use a their care plans were updated as ne Future resident oxygen orders will b reviewed and no orders for petroleu based products will be utilized. The will be contacted for residents who experience nostril dryness for alterr method of oxygen therapy and/or administer humidified oxygen thera Nursing staff was in-serviced on the Oxygen Administration policy indica remove all flammable items and en that no petroleum based products a added while oxygen is being deliver Director of nursing and/or designee responsible for compliance. Audits on oxygen therapy administr orders and resident tolerance will b wk for 2 weeks, weekly x 2 weeks t monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator take the audit results to QAPI for re	e of lents were ind beded. be im mative py. e MD hative py. e tring to sure are red. e is ation egin 2x hen	

Facility ID: 00166

		AND HUMAN SERVICES				FORM	01/04/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245544	B. WING _				C 02/2021
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY	(HEALTH & REHABII	LITATION CENTER			2 49TH AVENUE NORTH INNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	11/24/21, in which I facility. During an interview consultant pharmac recommended usin a petroleum-based potential problems lubricant with liquid when there was an could react violently cause significant bu During an interview director of nursing surprised an order used in the nostrils R28 had an order for nostrils and could of spark or flame. The	oper, with the exception of R28 was noted to not be at the on 11/30/21, at 4:25 p.m. the cist (CP) stated he ig a water-based lubricant over lubricant. The CP stated of using a petroleum-based oxygen could cause burning open flame. Further, oxygen y with oily substances and	F 6	89	and recommendation.		
	discontinuing the or Facility policy titled (undated), directed flammable items su and smoking article where oxygen was Tube Feeding Mgm CFR(s): 483.25(g)(§483.25(g)(4)-(5) E (Includes naso-gas both percutaneous percutaneous endo enteral fluids). Base	Oxygen Administration staff to remove all potentially uch as lotions, oils, alcohol, es from the immediate areas to be administered. ht/Restore Eating Skills 4)(5) Enteral Nutrition tric and gastrostomy tubes, endoscopic gastrostomy and oscopic jejunostomy, and	F 69	93			1/10/22

Facility ID: 00166

If continuation sheet Page 19 of 38

		AND HUMAN SERVICES				FORM	01/04/2022 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUC G		СОМ	E SURVEY PLETED
		245544	B. WING _) 02/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRI	ESS, CITY, STATE, ZIP CO		
VICTORY	' HEALTH & REHABII	LITATION CENTER		512 49TH AVE	INUE NORTH IS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	OVIDER'S PLAN OF CORF H CORRECTIVE ACTION S REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 693	Continued From pa ensure that a reside	-	F 69	3			
	eat enough alone o enteral methods un condition demonstr clinically indicated a resident; and	ident who has been able to r with assistance is not fed by less the resident's clinical ates that enteral feeding was and consented to by the					
	means receives the services to restore, and to prevent com including but not lin diarrhea, vomiting, abnormalities, and	ident who is fed by enteral appropriate treatment and if possible, oral eating skills plications of enteral feeding nited to aspiration pneumonia, dehydration, metabolic nasal-pharyngeal ulcers. NT is not met as evidenced					
	Based on observative review, the facility facili	tion, interview, and document ailed to ensure a tube feeding is ordered for 1 of 2 residents I a tube feeding.		enteral fe experient feeding c feeding c care plar	D was notified on 12/ eeding was omitted. ce any ill effects from omission. R 28 oral a order was reviewed a n. Updates were ma All other residents re	R 28 did not n this enteral and enteral along with the de as	
	R28's diagnoses in arthritis (causes pa of function in joints) R28's quarterly Min 10/27/21, indicated	ecord dated 12/2/21, indicated cluded diabetes, rheumatoid in, swelling, stiffness, and loss and a pressure ulcer. imum Data Set (MDS) dated R28 was cognitively intact.		enteral fe reviewed be follow Licensed enteral fe focus on	eeding orders and ca l and updated as nee enteral feeding admi red per MD order. I Nurses was in-serv eeding policy and pro recording the date/ti	are plan was eded. Future inistration will iced on the ocedure with ime when	
	feeding. R28's admission ca	indication R28 received a tube are area assessment (CAA) ated R28 required tube er nutritional needs.		that the e checked Director o responsil Audits or	eeding was hung on enteral feeding order against the physicia of nursing and/or des ble for compliance. n enteral feeding adn re will begin 2x wk fo	was n order. signee is ninistration	

Facility ID: 00166

If continuation sheet Page 20 of 38

	T OF DEFICIENCIES	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		IDENTIFICATION NUMBER.	A. BUILDIN	G		C
		245544	B. WING			02/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VICTOR	Y HEALTH & REHAB	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 693	R28's care plan da at risk for impaired received a tube fee needs due to a his swallowing) and hi The care plan inclu including providing supplements, wate R28's Order Summ directed staff to pro- flushes every four plastic tube placed abdomen into the intestine) and Isos mL per hour for 12 The tube feeding v and turned off at 1 During an observa R28's Isosource tu on a pole and the Isosource formula remaining in the bo the Isosource form and not connected and tubing lacked	tted 7/13/21, indicated R28 was I nutrition and hydration. R28 eding to meet her nutritional tory of dysphasia (difficulty story of aspiration pneumonia. uded several interventions vitamin and mineral er flushes, and feedings. nary Report dated 11/30/21, ovide 100 milliliter (mL) water hours through a j-tube (soft, I through the skin of the midsection of the small ource (nutrition formula) 100 hours per day, as tolerated. vas to be started at 10:45 a.m. 0:45 p.m. tion on 11/29/21, at 3:00 p.m. ibe feeding formula was hung feeding pump was shut off. The bottle had 700 mL of solution ottle. The tubing connected to pula was hung over the pole to R28. The Isosource formula	F 69	3 weekly x 2 weeks then monthly compliance. Audit results will be reviewed b Administrator and the Administ take the audit results to QAPI f and recommendation.	y the rator will	
	mL per hour for 12 The tube feeding v and turned off at 1 During an observa R28's Isosource tu on a pole and the Isosource formula remaining in the bo the Isosource form and not connected and tubing lacked During an observa R28 was observed was at a 25-to-30- connected to the tu bottle of Isosource Dried formula was feeding and 700 m Isosource bottle. A nurse (LPN)-C was	hours per day, as tolerated. vas to be started at 10:45 a.m. 0:45 p.m. tion on 11/29/21, at 3:00 p.m. be feeding formula was hung feeding pump was shut off. The bottle had 700 mL of solution ottle. The tubing connected to bula was hung over the pole to R28. The Isosource formula a date/time. tion on 11/30/21, at 7:25 a.m.				

If continuation sheet Page 21 of 38

		AND HUMAN SERVICES				F	TED: 01/04/20 ORM APPROVE NO. 0938-03
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		245544	B. WING	à			12/02/2021
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	ODE	
VICTOR	Y HEALTH & REHABI	LITATION CENTER			512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	E (X5) COMPLETIC DATE
F 693	connect R28 to the confirmed the tubin formula had dried s A progress note da indicated R28's phy missed tube feedin given to restart the hour on/off cycle. During an observat R28 was laying in b connected to the tu LPN-C confirmed s tube feeding during During an observat R28 still was not co During an interview medical doctor (ME and provided a veri order, to immediate and monitor for def had been multiple of which orders were directed. MD-B star feeding could poter expected the facility During an interview assistant director o tube feeding did no on 11/30/21. The A immediately start F reported the incider	tube feeding. LPN-C ag connected to the Isosource substance on the end. ted 11/30/21, at 11:07 a.m. ysician was notified of the g (11/29/21) and an order was tube feeding and follow a 12 tion on 11/30/21, at 2:25 p.m. bed and awake. R28 was not be feeding. At 2:28 p.m. she did not complete R28's g the shift as she was busy. tion on 11/30/21, at 4:00 p.m. onnected to the tube feeding. y on 11/30/21, at 9:30 a.m. D)-B stated he assessed R28 bal order, and later signed an ely resume R28's tube feeding nydration. MD-B stated there occasions at the facility in not followed, or started, as ted not starting R28's tube ntially cause harm and y to follow orders as given. y on 12/1/21, at 1:43 p.m. the f nursing (ADON) stated R28's of get restarted until 10:45 p.m. DON stated she told LPN-C to R28's tube feeding and	F	69	3		

If continuation sheet Page 22 of 38

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 01/04/2022 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245544	B. WING		12	2/ 02/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
VICTORY	HEALTH & REHABIL	ITATION CENTER			12 49TH AVENUE NORTH /INNEAPOLIS, MN 55430	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697 SS=G	and nursing supervision should had restarter instructed to do so he DON stated R28 we without receiving nurse of the Aprogress note data indicated MD-B was feeding. Facility policy titled Precautions (undater responsible for prepadministering eternations) (undater responsibilities. Fur date, time, and initia hung and administer Pain Management CFR(s): 483.25(k) Pain Ma The facility must en provided to resident consistent with profithe comprehensive and the residents' g This REQUIREMEN by: Based on observat review, the facility famedication as order resident (R28) review actual harm for R28 signs of pain when a pain medication was pain med	s provided by the physician isor. The DON stated LPN-C d R28's tube feeding when by the ADON on 11/30/21. The ent more than 24 hours strition. ed 12/1/21, at 6:41 p.m. a notified R28 missed a tube Enteral Feedings Safety ed) directed all staff paring, storing, and al nutrition formulas will be nd competent of ther, staff were directed to al the label when formula was pred.		693 697	R 28 MD was made aware that the pain medication was inadvertently crushed and administered to the resident. The MD response will be recorded in the resident electronic medical record. R 28 had a new pain assessment completed, pain medication reviewed and care plan updated as needed. All existing residents	E

Facility ID: 00166

If continuation sheet Page 23 of 38

		AND HUMAN SERVICES				FORM A	01/04/202 APPROVE 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (SURVEY PLETED
		245544	B. WING				<i>,</i>)2/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY	' HEALTH & REHABI	LITATION CENTER		-	12 49TH AVENUE NORTH IINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETIC DATE
F 697	Continued From pa	ige 23	Fe	697			
	intervention.				who are receiving narcotic pain medications were reviewed and their	r care	
	Findings include:				plan was updated as needed. Future residents will have medications deliv	e	
		ecord dated 12/2/21, indicated cluded diabetes, pressure			as ordered. Director of nursing and/or designee		
	ulcer of sacral region	on (area where the spine			responsible for compliance.		
		ver half of the body), and I left leg above knee.			Nurses and TMA's will be in-serviced Crushing Medication policy with focu	is on	
	10/27/21, indicated and had scheduled pain medications, a interventions. The I	imum Data Set (MDS) dated R28 was cognitively intact pain medications, as needed and non-medication MDS further indicated pain activities and she rated her			item #2 that if a medication that shou be crushed, a physician must docum reason and an order must be obtained along with medicating residents. Licensed nurses will be in-serviced of Pain Management Policy and proced with emphasis on identify cause(s) of	on that shouldn't nust document t be obtained idents . I-serviced on the and procedure	
	pain at 8 out of 10 R28's Care Area As	(0 to ten scale). ssessment (CAA) dated			and request pre-medication pain ord before treatments/therapy etc. to ensitive pain is adequately controlled.	lers sure	
	rheumatoid arthritis of the spinal colum	R28 had pain related to c, cervical stenosis (narrowing n) with chronic pain, peripheral decreased blood flow to limbs),			Consultant pharmacy will be contact perform medication competency and be scheduled as they are available. Audits on medication administration		
	causes pain). The opioids (narcotic pa directed to adminis Pain impacted R28	amage to the nerves which CAA further indicated R28 took ain medication) and staff were ter medications as ordered. 's ability to sleep at night and			procedure will begin 2x wk for 2 wee weekly x 2 weeks then monthly to er compliance. Audit results will be reviewed by the Administrator and the Administrator	begin 2x wk for 2 weeks, eks then monthly to ensure vill be reviewed by the	
	administer pain me treatment and antic relief. Additionally, immediately to com	ain frequently. Staff were to dication 30 minutes prior to sipate R28's need for pain staff were to respond plaints of pain and monitor for pain. R28 reported her pain at of 10.			take the audit results to QAPI for rev and recommendation.	/IEW	
	received pain medi	ted 5/2/21, indicated R28 cation related to her disease plan included several					

If continuation sheet Page 24 of 38

		AND HUMAN SERVICES				FORM	01/04/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245544	B. WING				C 02/2021
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VICTORY	(HEALTH & REHABII	LITATION CENTER			12 49TH AVENUE NORTH IINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	analgesic medication R28's care plan ind related to rheumato neuropathy and dire analgesia 30 minuti and offer nonmedic as distraction, warm gentle massage. A Physician's Progri indicated R28 had of cervical stenosis sta permanently conne sacral pressure ulc identified R28's chr cervical myopathy (rheumatoid arthritis extremity contractu R28's Order Summ 8:57 a.m. indicated ordered a dysphasi mechanical soft die may have medication for easy swallowing Review of R28's No Administration Rec the following medic - Gabapentin Liquid milliliter (mL). Give times a day for neu started on 11/15/21 - Morphine Sulfate pain medication). G times a day for chro	irected staff to administer ons, as ordered. Additionally, licated R28 had chronic pain oid arthritis, diabetic ected staff to administer es prior to treatments or cares sinal forms of pain relief such n packs, cold packs, and ress Note dated 11/8/21, diagnoses of chronic pain, atus post-fusion (surgery to ct two or more vertebrae) and er. The progress note also onic pain was related to (compression of spinal cord), s, sacral pressure ulcer, upper re and immobility. ary Report printed 12/2/21, at R28 had a tube feeding, was a (difficulty swallowing) et with nectar thick liquids. Staff ons crushed with applesauce between the same states of the same stations ordered for pain: d 250 milligrams (mg) /5 300 mg (6 mL) by mouth three ropathic pain. The order was Extended-Release (narcotic aive 15 mg by mouth three		97			

If continuation sheet Page 25 of 38

		AND HUMAN SERVICES				Pr		APPROVED
		& MEDICAID SERVICES				0		0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245544	B. WING _				C 12/02/2021	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CO	DE		
VICTORY	Y HEALTH & REHABIL	ITATION CENTER		-	12 49TH AVENUE NORTH IINNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 697	hours as needed fo - Prednisone (steroimg. Give one table pain. Further, the M R28 was administer 11/5/21, 11/6/21, 11 11/29/21, and 11/30 not available. A Pain Management 11/29/21, indicated pain and had pain a her buttock, leg, and which was describe R28 received morphile R28 received morphile Suffate exits to 15 mg three time continue administer hours, as needed. Fa administer 6 mL of a times daily. During a continuous 11/29/21, from 8:30 noted to be lying fla pillow to the right of closed, and she wa called out to staff to moaning, "ouch." Affor help and stated licensed practical m Throughout the obs R28's room, nor resonance calling out periodica	r pain. id; reduces inflammation) 5 via g-tube one time daily for IAR lacked documentation red Prednisone on 11/4/21, /7/21, 11/8/21, 11/11/21, 0/21, as the medication was at Progress Note dated R28 was frustrated with her all day. R28's reported pain in d had increased arm pain, ed as sharp, achy, and sore. hine and gabapentin for pain. d continue to work with ational therapy. R28's stended release was increased as a day. Staff was also to ring acetaminophen every six Further, staff were to gabapentin 250 mg/5mL three s observation conducted on a.m. to 11:43 a.m. R28 was it on her back, in bed, with a finer bed. R28's eyes were s noted to be moaning and o help. At 10:30 a.m., R28 was t 11:43 a.m., R28 called out she had pain. At 11:44 a.m., urse (LPN)-C was notified. servation, no staff entered sponded to R28 who was ally. Three hours and 14 d. LPN-C stated they would	F 6	97				

If continuation sheet Page 26 of 38

		AND HUMAN SERVICES				FORM	01/04/2022 APPROVED 0938-0391
						(X3) DATE SURVEY COMPLETED C	
		245544	B. WING				02/2021
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VICTOR	(HEALTH & REHABI	LITATION CENTER		-	12 49TH AVENUE NORTH		
				M	INNEAPOLIS, MN 55430		i
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 697	Continued From pa	age 26	F 6	97			
	stated she had a lo never be under cor so uncomfortable v provided cares. R2 of 10 and felt she v pain was 3 out of 1 a good quality of life bad. During an observat LPN-C crushed mor release 15 mg table placed in a plastic r the medications, LF asked R28 if she h "Yes, I hurt all over R28's G-tube and of G-Tube to administ to LPN-C, "I hurt re grimacing and was pour multiple medic medication cup, ad cup, and dumped in medication administ During observation her pain or offer no pain relief. During an interview LPN-C stated all of crushed because th	y on 11/29/21, at 9:02 a.m. R28 th of pain and it seemed to htrol. R28 verbalized she was when staff moved her or 8 reported her pain was 8 out would be able to manage if her 0. R28 stated she did not have e because her pain was so tion on 11/30/21, at 9:13 a.m. orphine sulfate extended et with a pill crusher and medication cup. After crushing PN-C entered R28's room and ad pain and R28 responded, ." LPN-C proceeded to flush connected the syringe to the ter the medications. R28 stated eally bad." R28 had facial grunting. LPN-C proceeded to cations together in a ded water in the medication nto the syringe. LPN-C finished stration and left the room. LPN-C did not ask R28 to rate on-pharmacological methods of y on 11/30/21, at 9:20 a.m. R28's medications could be here was an order. LPN-C medications worked the same					
	feeding. LPN-C exp medications to R28 was an order from she was not aware	ed, given by mouth, or via tube blained on days she passed 3; she crushed all pills as there the physician. LPN-C stated morphine sulfate extended pposed to be crushed or					

Facility ID: 00166

If continuation sheet Page 27 of 38

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA). 0938-039 TE SURVEY MPLETED
				NG	С	
NAME OF	VAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		/02/2021
VICTOR	Y HEALTH & REHABII	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 697	impacted pain relie did not offer as nee other methods of pr comfortable. Subsequent review Medication Adminis indicated licensed p administered exten on 11/15/21, 11/16/ 11/24/21, 11/25/21, 11/30/21. For each R28's pain was rate a 0 to 10 scale). During an observat R28 was observed a bed bath by nursi complained of pain her right arm was n facial grimacing wh During an interview NA-A stated R28 ha was worse when st such as incontinent confirmed R28 yelle day and when her r During an interview medical doctor (ME R28's extended-reli- crushed or given vi- nursing staff should morphine as all the at once and not pro- should. MD-A state much morphine at d	age 27 f. LPN-C also confirmed she ided acetaminophen to R28 or ain relief to keep R28 f of R28's November 2021 stration Record (MAR) practical nurse (LPN)-C ded-release morphine to R28 21, 11/17/21, 11/19/21, 11/26/21, 11/29/21, and of these administrations, ed from 3 to 5 out of 10 (using ion on 11/30/21, at 9:41 a.m. lying in bed and was provided ng assistant (NA)-A. R28 when repositioned and when noved. R28 also had noted en she received cares. f on 11/30/21, at 9:50 a.m. ad a lot of pain and R28's pain aff attempted to perform cares ce cares or bathing. NA-A ed out in pain throughout the ight arm was touched. f on 11/30/21, at 1:55 p.m. 0)-A stated he was not aware ease morphine was being a a tube feeding. MD-A stated d not crush extended-release medication would release all ovide coverage for pain as it d R28 could also receive too once instead of receiving the over time. This could cause	F 6	97		

If continuation sheet Page 28 of 38

		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES		(X2) MULT	IPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:				COM	PLETED
		245544	B. WING _				C 02/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
VICTORY	HEALTH & REHABIL	LITATION CENTER		-	12 49TH AVENUE NORTH		
				IV	MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 697	Continued From pa	ae 28	F 69	97			
	•	roblems or relate to R28's	10.	57			
	concerns regarding	poor pain control. MD-A					
		feel the facility provided ntrol and management for					
	R28.						
	During an interview	on 11/30/21, at 4:25 p.m., the					
	consultant pharmad	cist (CP) stated crushing					
		norphine possibly could not time needed and caused R28					
	5	te coverage for her chronic					
	pain. The CP stated	d the peak (highest level of a					
		lood) for immediate release hour and extended release					
	was three hours. If	extended-release morphine					
		Id peak between one and t last the full 12 hours as					
	intended and cause						
	management.						
	During an observati	ion on 12/1/21, at 12:00 p.m.					
	R28 was provided w	wound care to her stage IV					
		d moaned and complained of ned. R28 was tearful and was					
	noted to flinch and	had facial grimacing when					
		alized she had pain in her 28 was not observed to be					
		ation prior to wound care.					
	•	of R28's November 2021 and AR indicated R28 was					
	administered as ne	eded Acetaminophen Solution					
		ng) on 11/12/21, 11/14/21, 6/21. There was no indication					
	Acetaminophen wa	s consistently used prior to					
	dressing changes of identified she was h	or other times when R28					
		iavilly paill.					
	During an interview	on 12/1/21, at 1:42 p.m. the					

If continuation sheet Page 29 of 38

TATEMENT	F OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		245544	B. WING	C 12/02/2021		
	PROVIDER OR SUPPLIER Y HEALTH & REHAB		ę	STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 697 F 745 SS=D	aware R28's exten crushed. If crushed as indicated or a re medication at once expected staff to a ordered and follow impacted a resider During an interview MD-C stated R28 care visits. MD-C st to staff to manage repositioned every wheelchair, and ha care. MD-C stated she had complaine Facility policy titled (ADLs) undated, d interventions to mi include appropriate Provision of Medic CFR(s): 483.40(d) §483.40(d) The fac medically-related s maintain the highe and psychosocial of This REQUIREME by: Based on observa- review, the facility comprehensive as discharge planning had ongoing allega	 (DON) stated she was not ded-release morphine was d, may not provide pain relief esident could receive too much e. The DON stated she dminister medication as r-up with the physician if pain ht's quality of life. v on 12/1/21, at 12:25 p.m. had a lot of pain during wound stated she had given direction R28's pain so she could be two hours, sit up in her ave less pain during wound during her visit today with R28, ed of pain. Activities of Daily Living irected to offer alternative nimize functional decline and e pain management. ally Related Social Service cility must provide social services to attain or st practicable physical, mental well-being of each resident. NT is not met as evidenced 	F 697		s of ve . R d	

Event ID:CRPT11

Facility ID: 00166

If continuation sheet Page 30 of 38

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	COM	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C		
	245544		B. WING		12/02/2021	
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
VICTORY	' HEALTH & REHABI	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 745	Continued From pa	age 30	F 74	5		
	Findings include:			facility. All other residents p		
	11/12/21, identified impairment and wa activities of daily liv included age-relate abuse. R500's care plan re R500 was, "At risk to] poor impulse co dementia, level 1 s	inimum Data Set (MDS) dated R500 had a severe cognitive as independent with all ving (ADLs). R500's diagnoses ed cognitive decline and alcohol evised on 9/23/21, identified of abusing others r/t [related ontrol, alcohol induced ex offender." The care plan		discharge will be reviewed a planning will be documented residents will be assessed u admission for discharge plan discharge potential will be ca reviewed per policy. Social Services designee wi in-serviced on the transfer, of policy and procedure with er notification 30 days in advan impending discharge and as all aspects addressed for the	I. Future pon ns and are plan and li be lischarge nphasis on ice for sistance with	
	touch[ing] another south hall." On 9/23 care plan instructed female residents," alternative placeme making sexual ges redirect him back t enter a female resi immediately," [R50 besides South hall "[R500] will not ent	8/27/21 resident accused of resident inappropriately near 3/21, "accused of kissing." The d staff to, "Redirect away from "Assist in looking [for] ent," If staff hear [R500] tures tell him to stop and o his room," "If staff see [R500] dent's room, remove resident 0] is not to be in any other hall without supervision," and er north hall, will stay away nt" related to allegations of vior.		resident. Social Services and/or desig responsible for compliance. Audits on resident discharge procedure will begin 2x wk for weekly x 2 weeks then mont compliance. Audit results will be reviewed Administrator and the Admin take the audit results to QAF and recommendation.	e planning or 2 weeks, hly to ensure d by the iistrator will	
	outlined, "Boundari inappropriate beha - Refrain from touc if they request a hu - Refrain from enter	hing any female resident, even Ig from you. Fring female resident's rooms. Ins areas refrain from making				

If continuation sheet Page 31 of 38

		I AND HUMAN SERVICES E & MEDICAID SERVICES				F	ORM A	01/04/2022 PPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3		SURVEY LETED
		245544	B. WING					2/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, Z	ZIP CODE		
VICTOR	(HEALTH & REHABI	LITATION CENTER			512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430			
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF	COBBECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE		(X5) COMPLETION DATE
F 745	with female resider recommendations i with males." A progress note da included, "Spoke w reviewed transition expressed understa best interest." A Mental Health Pr 9/24/21, included, " [R500] kiss a fema previously shown ir she is not intereste find an all-male pla ambivalent about th on the location." During an interview R501 stated that R physical with her ar to do that." R501 st boobs. I don't like t Additionally, R500 and she did not wa don't feel good abo During an interview R500 stated he tho and "a friend." R50 R501 or any other t inappropriately. During an interview	ted 9/23/21, at 1:47 p.m. with resident and daughter, to another facility. Daughter anding and knowing it ws in his ovider Progress Note dated 'A resident reported seeing le resident who he has nerest in and who has stated d." "Staff continue to work to cement for [R500]. [R500] is his, but agreeable depending on 11/29/21, at 10:04 a.m. 500 wanted to be more nd, "I told him, no. I don't want tated R500 liked to "touch my hat. I tell him, don't do that." stated R501 liked to kiss her nt to kiss him. R500 stated, "I out it." on 11/29/21, at 11:39 a.m. hught R501 was a "Nice lady" 0 denied touching or kissing female resident or 011/29/21, at 1:00 p.m.	F	745				
	was a level 1 sex o "couple" of reports	A stated she was aware R500 ffender and there had been a of R500 displaying sexually vior directed towards R501						

Facility ID: 00166

If continuation sheet Page 32 of 38

TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245544			C 12/02/2021	
NAME OF	PROVIDER OR SUPPLIER	243344	D. M	STREET ADDRESS, CITY, STATE, ZIP		/02/2021
VICTOR	(HEALTH & REHABII	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 745	during his stay at the allegations, R500 widifferent hallway the educated R500 and other. SW-A stated placement in an all- unsuccessful. This placement at one at facility approximate facility was unable status as a sex offer additional inquiries placement. SW-A second considering transition facility or group hore During an interview director of rehabilita "be reasonable" to an alternative level or a group home co independence with During an interview the administrator and (ADON) the admini implemented interview tacility. The ADON team had agreed to ongoing risk of inap facility's female ress thought referrals to to multiple all-male declined at each fa sex offender. The A	the nursing home. Due to the vas moved to a room in a an R501 and staff were d R501 were not to touch each she attempted to find R500 -male facility, but was included inquiring about Iternative skilled nursing by two months ago, but the to accept R500 due to his ender. SW-A confirmed no were made for alternative stated R500 was "due for a on" and she could talk to see if they were open to oning to an assisted living ne.	F 7	45		

If continuation sheet Page 33 of 38

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION (X3) D	ATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:			OMPLETED
		045544			С
		245544			2/02/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH	
VICTOR	(HEALTH & REHABIL	ITATION CENTER		MINNEAPOLIS, MN 55430	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETIO DATE
F 745	or group home. The was unsuccessful w intervention he wou shared with the inter brainstorming. The facility Transfer dated 2001, include permitted to remain transferred or disch of individuals in the clinical or behaviora	d transfer to an assisted living e administrator stated if SW-A vith implementing a behavior ld expect the information to be rdisciplinary team for s and Discharges Policy d, "Each resident will be in the facility, and not be arged unless: C. the safety facility is engaged due to the l status of the resident."	F 745		
F 759 SS=D	CFR(s): 483.45(f)(1 §483.45(f) Medicati The facility must en §483.45(f)(1) Medic percent or greater; This REQUIREMEN by:	on Errors. sure that its- cation error rates are not 5 NT is not met as evidenced	F 759		1/10/22
	review, the facility fa were administered i orders and professi 1 of 2 residents (R2 medication during the facility medication a 30% (percent). Findings include: R28's Admission Re R28's diagnoses includer of sacral region	ion, interview, and document ailed to ensure medications n accordance with physician onal standards of practice for (8) observed to receive ne survey. This resulted in a dministration error rate of ecord dated 12/2/21, indicated cluded diabetes, pressure on (area where the spine er half of the body), and		R 28 MD was notified that medications were not administered as ordered during survey observation. The MD's response will be recorded in the resident medical record. R 28 did not experience any adverse reaction to this incorrect procedure. All other residents receiving medications from the staff nurse were reviewed and no adverse effects were noted. Future residents will have their medication administered per MD order and nursing standard practice. Nurses and TMA staff were in-serviced of the medication administration policy and enteral administration policy and	on

Facility ID: 00166

If continuation sheet Page 34 of 38

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		045544				C
		245544	B. WING			02/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH	_	
VICTORY	(HEALTH & REHABI	LITATION CENTER		MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 759	Continued From pa	age 34	F 759	9		
		id left leg above knee.		procedure with emphasis on a	dministering	
	-	-		per physician order and medic	ations that	
		r dated 7/26/21, indicated R28 dication crushed and given		need crushing must have a spennet to administer medications of		
	with applesauce fo			the tube and administering eac		
				medication separately.		
		ovember 2021 Medication ord (MAR), indicated staff		Director of Nursing and/or desible responsible for compliance.		
		the following medications by		Audits on medication administr		
	mouth:	Ç î		procedure will begin 2x wk for	2 weeks,	
		(antibiotic). Give one tablet by		weekly x 2 weeks then monthly	to ensure	
	mouth two times a	nilligram tablet. Give 100		compliance. Audit results will be reviewed b	v the	
		h every 12 hours for bone and		Administrator and the Administ		
	joint infection.	· · · · · ·		take the audit results to QAPI f	or review	
	- Morphine sulfate	(pain medication) ablet 15 mg. Give one tablet by		and recommendation.		
		daily for chronic pain.				
	- Famotidine 20 mg	g tablet (treats heartburn). Give				
	20 mg twice daily.	250mg/5mL. Give 300 mg (6				
		nouth two times daily for				
	neuropathic pain	-				
		21 MAR further indicated the				
	g-tube (tube feedin	ns were to be administered via				
		9). id) 5 mg tablet. Give one				
	tablet daily via g-tu	be for chronic pain.				
	- Amlodipine 5 mg daily for high blood	tablet. Give 1 tablet via g-tube				
		tablet. Give 1 tablet via g-tube				
	every Tuesday for	depression.				
	 Metoprolol Tartrat times daily for high 	e. Give 50 mg via g-tube two blood pressure.				
	On 11/30/21, at 9:1	3 a.m. licensed practical nurse rved preparing medications for				

If continuation sheet Page 35 of 38

		AND HUMAN SERVICES				FORM): 01/04/2022 / APPROVED). 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				TE SURVEY MPLETED C
		245544	B. WING			12	/ 02/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP COD		
VICTORY	(HEALTH & REHABI	LITATION CENTER			512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 759	 Famotidine 20 mg Metoprolol Tartrat Gabapentin 6 mL Prednisone 5 mg medication was un On 11/30/21, at 9:1 to crush the above them in medication poured Gabapentir medication cup with cup (with measurin was unable to be d Gabapentin was in then gathered supp LPN-C connected o g-tube and pulled b G-tube, using a syr mixed four medication administered in G-1 next administered the medication and flus administered the la mixed together with and flushed with was During an interview LPN-C stated all m for R28 because th stated she was late administration and tablets were not av confirmed she pour 	ng extended-release 15 mg g e 50 mg 250mg/5mL give 300 mg was not prepared as the available. 3 a.m. LPN-C was observed noted medications and placed cups. Additionally, LPN-C a 250mg/5mL into a plastic in measurement lines on the g lines labeled 2.5, 5, 7.5). It etermined it 6 mL of the medication cup. LPN-C blies and went into R28's room. connected the syringe to R28's back. LPN-C then flushed the inge, with water. LPN-C then tions together with water and tube with water flush. LPN-C the liquid gabapentin shed with water. LPN-C then st three crushed medication in water, gave in R28's G-tube, ater.	F 7	759			

Facility ID: 00166

If continuation sheet Page 36 of 38

		AND HUMAN SERVICES				FORM	: 01/04/2022 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	CON	E SURVEY IPLETED
		245544	B. WING	ì			C / 02/2021
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
VICTOR	Y HEALTH & REHABII	LITATION CENTER			512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 759	 was not available. I given R28 too much accurately. Further, to crush medication was to place the medication was to place the medication of the place to admini place medication order. The practice to use a sy gabapentin to ensure the place the place the place of the place the place of the place the place of th	had used a syringe, but one _PN-C stated she could had h gabapentin it not measured , she knew R28 had an order ns, but was not aware to order edication in applesauce and J-C stated the physicians order and the physician should be questions. LPN-C confirmed s were cocktailed and given via on 11/30/21, at 1:55 p.m. D)-A stated he expected staff to s ordered to ensure proper	F	759	9		

If continuation sheet Page 37 of 38

		AND HUMAN SERVICES				FORM	01/04/2022 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245544	B. WING				C D2/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
VICTOR	Y HEALTH & REHABII	LITATION CENTER		512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 759	dose, right medicat before medications individual had ques should ask prior to stated medications via a tube feeding, considered a medic should not estimate DON stated LPN-C medication errors a education and gues error. Facility policy titled Medications (undat administering medi	ion, right route, and right time were administered. If an tions about an order, they administration. The DON which were crushed and given rather than by mouth, were cation error. Further, LPN-C e a dose of gabapentin. The would need to write up and she would provide staff ased all staff made the same	F 759				

Facility ID: 00166

If continuation sheet Page 38 of 38



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 19, 2021

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

Re: State Nursing Home Licensing Orders Event ID: CRPT11

Dear Administrator:

The above facility was surveyed on November 29, 2021 through December 2, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

Victory Health & Rehabilitation Center December 19, 2021 Page 2

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jamie Perell, Unit Supervisor Metro B 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: jamie.perell@state.mn.us Office: (651) 245-8094

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

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

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program

Victory Health & Rehabilitation Center December 19, 2021 Page 3 Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

Minnesc	ta Department of He	alth				
-		EFFCIENCIES (M) PROVIDERSUPPLIENCLIA DENTIFICATION NUMBER: (Pa) MULTIPLE CONSTRUCTION A BUILDING: (PA) BUTTIFICATION NUMBER: (PA) BUILDING: (CONFILTED) B (DIS) DATE SUPPLIEN STREET ADDRESS, CITY, STATE, ZIP CODE (CONFILTED) (CONFILTED) SUMMARY STATEMENT OF DEFICIENCIES STATE ADDRESS, CITY, STATE, ZIP CODE (CONFILTED) (CONF				
		00166	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VICTOR	/ HEALTH & REHABII	ITATION CENTEI				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE
2 000	D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C 00166 B. WING C B. WING 12/02/2021 ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CTORY HEALTH & REHABILITATION CENTEI 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 K4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REFIX TAG ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CMPLETE COMPLETE DATE 2 000 Initial Comments 2 000 2000 Initial Comments 2 000					
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of will corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du	ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited betted, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health. hether a violation has been compliance with all a rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon uny item of multi-part rule will sment of a fine even if the item				
	that may result from orders provided that the Department wit	n non-compliance with these at a written request is made to hin 15 days of receipt of a				
	On 11/29/21, throug was conducted at y the Minnesota Dep facility was found N State Licensure. Pl plan of correction y and identify the dat	gh 12/2/21, a complaint survey your facility by surveyors from artment of Health (MDH). Your IOT in compliance with the MN ease indicate in your electronic ou have reviewed these orders				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 12/27/21

Electronically Signed

STATE FORM

If continuation sheet 1 of 35

Minnesc	ota Department of He	alth			TORM	APPROVE
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00166	B. WING			C 02/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE		
VICTOR	Y HEALTH & REHABIL	ITATION CENTER	AVENUE NO			
040 15		MINNEAI TEMENT OF DEFICIENCIES	POLIS, MN 55	PROVIDER'S PLAN OF (
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED: H5544247C (MN00 cited at 0920. H5544239C (MN00 deficiencies cited at deficiencies were ic H5544278C (MN00 cited at 0265. H5544248C (MN00 cited at 0265. H5544279C (MN00 cited at 0265 and 0 The following comp SUBSTANTIATED, were cited due to au facility prior to surve (MN00058115), H5 H5544122C (MN00 (MN00060483), H5 H5544237C (MN00 (MN00077584). The following comp UNSUBSTANTIATE deficiencies were ci (MN00077000) with The following comp UNSUBSTANTIATE H5544256C (MN00 (MN00057021), H5 H5544266C (MN00	065151), with a deficiency 066995), MN00067027), with t 0930 and 1545. Additional dentified and 0830. 078872), with a deficiency 071021), with a deficiency 068284), with a deficiency 078922), with a deficiency 900. Naints was found to be however, NO deficiencies ctions implemented by the ey: H5544271C 544253C (MN00067762), 060108), H5544267C 544276C (MN00068073), 075523), and H5544259C Naints were found to be ED, however, related ited: H5544242C n a deficiency cited at 1475.				

Minnesota Department of Health

6899

CRPT11

STATE FORM

Minnesc	ta Department of He	ealth			FORM	APPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00166	B. WING			C 02/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
VICTOR	Y HEALTH & REHABII	ITATION CENTEI	AVENUE NO OLIS, MN 55			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLETE DATE
2 000	Continued From pa	ige 2	2 000			
	(MN00062019), H5 H5544245C (MN00 (MN00063846), H5 H5544255C (MN00 (MN00066083), H5 H5525275C (MN00 (MN00071065), H5 H5544263C (MN00 (MN00075552), H5 H5544261C (MN00 (MN00077317), H5 H5544240C (MN00	0061566), H5544251C 544257C (MN00063321), 0063651), H5544246C 544243C (MN00064999), 0066066), H5544254C 544244C (MN00067088), 0069148), H5544250C 544254C (MN00071120), 0071185), H5544238C 544235C (MN00076082), 0077139, MN00076082), 0077301), H5544260C 544241C (MN00077689), 0077755), H5544274C 544258C (MN00077787), and 0078748).				
	the State Licensing Federal software. T assigned to Minnes Nursing Homes. Th appears in the far-le Tag." The state stat listed in the "Summ column and replace the correction order the findings which a statute after the stat as evidence by." For	nent of Health is documenting Correction Orders using Tag numbers have been sota state statutes/rules for ne assigned tag number eft column entitled "ID Prefix atute/rule out of compliance is nary Statement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state ttement, "This Rule is not met ollowing the surveyor's findings Method of Correction and rrection.				
linnoseta D	receipt of State lice the Minnesota Dep Informational Bullet https://www.health. n/infobulletins/ib14_	participate in the electronic ensure orders consistent with artment of Health tin 14-01, available at state.mn.us/facilities/regulatio _1.html The State licensing ed on the attached Minnesota				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C	
		00166	B. WING			02/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
ICTORY	Y HEALTH & REHABI		I AVENUE NOI POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 000	Continued From pa	ige 3	2 000			
	you electronically. is necessary for Sta enter the word "CC available for text. Y electronic State lice heading completion be corrected prior to the Minnesota Dep is enrolled in ePOC not required at the state form. PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA	N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 200	Resident Health St A nursing home mu policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, a attending physician development of the have criteria which appropriate notifica A. an accident	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for: involving the resident which I has the potential for requiring				1/10/22

If continuation sheet 4 of 35

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00166	B. WING			C 12/02/2021	
					12/	02/2021	
	PROVIDER OR SUPPLIER	512 49T	HAVENUE N	STATE, ZIP CODE			
/ICTOR	/ HEALTH & REHABII	ITATION CENTER	POLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 265	Continued From pa	ige 4	2 265				
	physical, mental, o example, a deterior psychosocial status conditions or clinica						
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;					
	D. a decision t resident from the n	o transfer or discharge the ursing home; or					
T t f t	E. expected an	d unexpected resident deaths					
	by: Based on interview facility failed to noti transferred to the h	ent is not met as evidenced and document review, the fy the physician a resident was ospital 1 of 4 residents (R29)	3	Corrected			
	reviewed for chang Findings include:	e of condition.					
	R29's significant change Minimum Data Set (MDS) dated 9/23/21, indicated R29 was cognitively intact and had diagnoses which included vertigo, hypotension (low blood pressure), and anxiety disorder.						
	following: - 11/22/21, at 11:16 hospitalized.	ogress notes revealed the p.m. indicated R29 was a.m. indicated R29 was at the					
	hospital on observa complaints of visior	ation status. R29 had n changes, was ruled out for a ile infection (bacteria which					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _		COM	E SURVEY PLETED C	
		00166	B. WING		12/	12/02/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
VICTOR	/ HEALTH & REHABII	ITATION CENTEI	AVENUE NO OLIS, MN 55				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE	
2 265	Continued From pa	ige 5	2 265				
	causes severe diar colon) and had no r	rhea and inflammation of the new diagnoses.					
		edical record lacked indication notified R29 was transferred to					
	social worker (SW) to the emergency d was placed on obse	on 12/1/21, at 3:18 p.m. -A stated R29 was transferred lepartment on 11/22/21, and ervation status at the hospital int of vertigo and failure to					
	LPN-B stated R29 medications on 11/2 provider. R29 was more concerns regarding	22/21, and had notified the not aware of any other R29 during their shift and re not aware R29 was					
	licensed practical n observed R29 near 11/30/21, at approx when arriving for hi had already left for his shift, however, o	on 11/30/21, at 2:50 p.m. urse (LPN)-A stated he the facility entrance on imately 3:00 p.m. calling 911 s shift. He was notified R29 the hospital when he started did not receive any detail went to the hospital.					
	physician assistant call notes dictated of was at the hospital, LPN-B called to rec the resident, did no stated they learned chart review on 11/2	on 12/1/21, at 10:59 a.m. (PA)-A stated there were no on 11/22/21, indicating R29 however there was a note quest R29 be rounded on as t seem like themselves. PA-A of R29's hospitalization during 26/21, or 11/29/21, when the PA-A stated staff were					

Minnesc	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
			A. BUILDING	·		С
		00166	B. WING			02/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
VICTORY	/ HEALTH & REHABIL					
	SUMMARY STA			PROVIDER'S PLAN OF CORR	ECTION	(Y5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 6	2 265			
	when a resident wa and further verbaliz not an isolated incid	ne provider, or call center, s transferred to the hospital ed the lack of notification was dent for the facility. PA-A snow what lead to R29's				
	director of nursing (why R29 was hospi up to R29 going to R28's medical reco R29 was hospitalize notification. The DC	on 12/2/21, at 10:10 a.m. the DON) stated she did not know talized or the events leading the hospital. The DON verified rd lacked indication of why ed or subsequent provider DN stated she expected staff and document the notification.				
	Condition or Status facility would promp	A Change in a Resident's (undated), indicated the otly notify the physician of a change or change in				
	director of nursing (review and revise p providers are notifie change of condition The DON, or design on the policies and	HOD OF CORRECTION: The DON), or designee, could olicies to ensure medical ed when a resident has a and/or sent to the hospital nee, could then educate staff procedures and develop ng and monitoring consistent				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and e; General	2 830			1/10/22
	Subpart 1. Care in	general. A resident must				
/linnesota D	epartment of Health		ļ			1
TATE FOR	M		6899	CRPT11	If continua	ation sheet 7 of

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING	:	с
		00166	B. WING		12/02/2021
AME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
CTORY	HEALTH & REHABIL		AVENUE NO POLIS, MN 5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE
2 830	Continued From pa	ge 7	2 830		
	custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.			
	by: Based on interview facility failed to ensi in accordance with practice to reduce t	ent is not met as evidenced and document review, the ure oxygen was administered acceptable standards of he likelihood of potential or 1 of 1 resident (R28) who xygen therapy.		Corrected	
	Findings include:				
	R28's diagnoses in	ecord dated 12/2/21, indicated cluded pneumonitis ng tissue) and chronic			
	directed staff to app	ary Report dated 11/30/21, bly a small amount of Vaseline ostrils twice daily for dryness.			
	received oxygen the	ed 9/17/21, indicated R28 erapy related to ineffective gas sted staff to administer oxygen (LPM).			
and P		eatment Administration Record			
esota De	epartment of Health M		6899	CRPT11	If continuation sheet 8

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED	
		00166	B. WING			2/02/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
VICTOR	Y HEALTH & REHABI		I AVENUE NO POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 830	Continued From pa	age 8	2 830				
	(TAR) dated 11/30/21, indicated staff were to apply a small amount of Vaseline into both of R28's nostrils twice daily for dryness. Staff documented the intervention as completed, throughout November, with the exception of 11/24/21, in which R28 was noted to not be at th facility.						
	During an interview on 11/30/21, at 4:25 p.m. the consultant pharmacist (CP) stated he recommended using a water-based lubricant over a petroleum-based lubricant. The CP stated potential problems of using a petroleum-based lubricant with liquid oxygen could cause burning when there was an open flame. Further, oxygen could react violently with oily substances and cause significant burns.						
	director of nursing surprised an order used in the nostrils R28 had an order f nostrils and could of spark or flame. The	on 12/1/21, at 1:20 p.m. the (DON) stated she was for petroleum jelly was to be for R28. The DON confirmed or petroleum jelly to R28's cause burning if ignited by a e DON stated she would ary physician regarding rder.					
	(undated), directed flammable items su and smoking article	Oxygen Administration staff to remove all potentially uch as lotions, oils, alcohol, es from the immediate areas to be administered.					
	director of nursing review and revise p regarding safe adm relates to using nor	THOD OF CORRECTION: The (DON), or designee, could polices and procedures ninistration of oxygen as it n-flammable substances in erapy. The DON, or designee,					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION ()	(3) DATE SURVEY COMPLETED C
		00166	B. WING		12/02/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
VICTOR	/ HEALTH & REHABIL	ITATION CENTEI	AVENUE NO OLIS, MN 5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
2 830	Continued From pa	ge 9	2 830		
	could then educate monitoring system t appropriate care.	staff and develop a to ensure residents receive the			
	TIME FRAME FOR (21) Days	CORRECTION: Twenty-one			
2 900	MN Rule 4658.0528 Ulcers	5 Subp. 3 Rehab - Pressure	2 900		1/10/22
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which			
	without pressure so pressure sores unle condition demonstra	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and			
	receives necessary	ho has pressure sores y treatment and services to revent infection, and prevent veloping.			
	by: Based on observati review, the facility fa reassess and imple by the physician to the risk of complica ulcer for 1 of 3 resic pressure ulcers. Th	ent is not met as evidenced on, interview, and document ailed to comprehensively ment interventions as ordered promote healing and reduce tions of an existing pressure dents (R28) reviewed for e resulted in actual harm for sening stage IV pressure		Corrected	

TATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00166	B. WING			C 02/2021
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
ICTOR	/ HEALTH & REHABI	I ITATION CENTEL	I AVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	age 10	2 900			
	Findings include:					
	Pressure Ulcer Def	inition:				
	muscle. Slough or of hard or soft in textu tan in color, and ma tissue is usually firr and wound and ofte wound), may be pro- undermining (outwa	posed bone, tendon, or eschar (Dead tissue that is ire, usually black, brown, or ay appear scab-like. Eschar nly adherent to the base of en the sides/edges of the esent. It often includes ardly visible wound margins) sageways underneath the b.				
	R28's diagnoses in ulcer of sacral region connects to the low	ecord dated 12/2/21, indicated cluded diabetes, pressure on (area where the spine ver half of the body), and id left leg above knee.				
	10/27/21, indicated and had no docume was totally depende mobility, transfers, impairment to both and was always inc three documented were present upon	imum Data Set (MDS) dated R28 was cognitively intact ented rejection of care. R28 ent of two staff with bed and toilet use. R28 had an upper and lower extremities continent of bowel. R28 had stage IV pressure ulcers which admission. Several treatments ncluded pressure reducing d bed.				
	indicated R28 was bed mobility, dress hygiene. The CAA	esessment (CAA) dated 5/7/21, totally dependent of staff for ing, toilet use, and personal further indicated R28 required o staff, with the use of hoyer lift				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00166	B. WING			C 02/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ICTORY	(HEALTH & REHABI	I ITATION CENTEI	HAVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	age 11	2 900			
	assistance of two s	R28 required extensive staff to turn and reposition in rs and as necessary.				
	stage IV pressure of ischium (lower bac ischium. The care of the potential to dev related to incontine weakness. R28's c interventions include assessments and of R28's care plan wa include assisting R wheelchair with a p	ted 9/19/21 indicated R28 had ulcers on her sacrum right k part of the hip bone), and left plan further identified R28 had relop additional pressure ulcers ence, immobility, and are plan included several ding to conduct weekly skin provide wound care per orders as revised on 12/2/21, to 28 to sit up in tilt-in-space pressure reducing cushion for as not to exceed two hours of essure.	3			
	indicated staff were protocol, and "may day and an addition break in the mornin was to be repositio weekly skin checks morning. R28's wor - Right/left ischium Make sure all piece used to promote we from the wound be Vashe (wound clear was then to be place undermining areas minutes. Remove (hary Report dated 12/2/21, e to offload R28, per facility be" up in chair two hours per hal one hour after a two-hour ing and afternoon. Further, R28 ned every two hours and have is completed every Tuesday und care orders included: and sacrum wound care: es of silver alginate (product ound healing) were removed d. Saturate 4 x 4 gauze with inser). The saturated gauze ced in R28's wound beds and and allow to sit for five (gauze) and place silver oam boarder dressing in the				
		r team (IDT) progress note :17 p.m. indicated R28 was				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING:			С	
		00166	B. WING			02/2021	
ME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
CTORY	HEALTH & REHABI	I ITATION CENTEI	HAVENUE NO POLIS, MN 55				
X4) ID REFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	age 12	2 900				
	hospitalized from 10/1/21, to 10/20/21 due to severe sepsis secondary to a decubitus sacral wound abscess (collection of puss related to infection) and osteomyelitis. Additionally, R28 was under observation in the hospital on 11/24/21, related to chest pain.						
	medical doctor (ME the following: - R28's stage IV sa measured 3.5 centi cm. with undermini o'clock position. Th granulation (new tis fascia (thin casing o holds muscle in-pla exudate (clear, thin stage IV pressure of measured 1.0 cm. abnormal granulation margins. R28's stage right ischium meas cm with 100 percer Recommendations and repositioning p be up for two hours after a two-hour brack						
	revealed no transfe documented for 46 were no documente						
	revealed no transfe documented for 2 c no documented ref	ecember 2021 Task Record, erring/bed mobility was not of 3 opportunities. There were usals.					
	Review of R28's W						

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	СОМ	E SURVEY PLETED
		00166	B. WING		C 12/02/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
/ICTORY	HEALTH & REHABI	LITATION CENTEI	HAVENUE NO POLIS, MN 55			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	age 13	2 900			
	notes revealed:					
		p.m. indicated R28 was on a				
	turning and repositi	ioning program and had a				
	coccyx wound. The	e progress note lacked				
	assessment of R28					
		umentation was provided,				
		or skin assessments on				
	11/1/21, 11/8/21, ar	nd 11/22/21.				
	During a continuou	s observation conducted on				
	5) a.m. to 11:43 a.m. R28 was				
		lat on her back, in bed, with a				
		f her bed. R28's eyes were				
		as noted to be moaning and				
		or help. At 10:30 a.m., R28				
		h." At 11:43 a.m., R28 called				
		ated she had pain. At 11:44				
		tical nurse (LPN)-C was				
		lvised R28 had not been				
		the continuous observation				
		LPN-C stated she would notify. Throughout the observation,	y l			
		28's room, nor responded to				
		ig out periodically. Three hours				
	and 13 minutes had					
		ion on 11/29/21, at 10:25 a.m.				
		ound care to R28. R28				
		ain and noted facial grimacing				
		to her left side and throughout				
		dressing was noted to be ed with bloody red drainage				
		through to R28's incontinence				
		eet below her. Further, R28				
	was also observed					
		(EKG) electrodes on her back				
		ed by LPN-B. LPN-B stated the				
		st had been on R28's back				
	since her emergen	cy department visit on				
		moved the old dressing from				

Minnesota Department of Health STATE FORM

6899

CRPT11

If continuation sheet 14 of 35

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	СОМ	E SURVEY PLETED	
		00166	B. WING			C 12/02/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
VICTORY	HEALTH & REHABI		I AVENUE NO POLIS, MN 55				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	age 14	2 900				
	wounds. LPN-B the Vashe solution on g R28's sacral and rig wounds. The gauze with Vashe solution the gauze was rem alginate to R28's sa pressure wounds. cut round and roug did not cover the er wound. LPN-B ther foam dressings. Im dressing change Lf aware the gauze ne Vashe solution or th needed to cover the During an interview assistant director o started a performan wound care and as concerns regarding assessed, staff role providing wound car provider. The ADO	Id left ischium pressure en poured a small amount of gauze and placed the gauze or ght and left ischium pressure e was not completely saturated a. After roughly five minutes, oved and LPN-B applied silver acral, right, and left ischium The piece silver alginate was hly 1.5 inches in diameter and ntire wound bed of the sacral n covered R28's wounds with a mediately following the PN-B stated she was not eeded to be saturated with ne silver alginate dressing e entire wound bed. o on 11/30/21, at 12:45 p.m. the f nursing (ADON) stated she nce improvement plan for sessments as she discovered g how wounds were being es and responsibilities, and are as directed by the medical N stated R28 had not been and provider for a few weeks as to be evaluated after being					
	11/24/21. During an observat the director of nurs	ion on 12/1/21, at 10:00 a.m. ing (DON) and assistant provided wound care to R28's					
	sacral and right and wounds. The ADON her left side and rep product. The DON	d left ischium pressure N assisted R28 to reposition to moved an incontinence removed the dressings which					
		s amount of yellow/brown age with blood which soaked					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00166	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 12/02/2021		
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		12/	<u>-/UZ/ZUZ I</u>	
	FROVIDEN ON SUFFLIEN		AVENUE NO				
/ICTOR	Y HEALTH & REHABI	LITATION CENTEL	POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 900	Continued From pa	age 15	2 900				
	through the dressin outside of the sacra Vashe soaked gaua five minutes. The D and inserted silver The silver alginate bed where underm then applied a foan During an interview director of nursing observed R28's dre appeared wound ca ordered. She confir dressing did not co as directed, and flu R28's dressing and product. The DON bloody discharge a lacked granulation today which was no The DON confirme and included sever weekly skin checks timely repositioning care. The DON also incontinent product was completed on ensure R28 was ke stated staff were no bandages became changed. During an observat MD-C, the ADON, a care to R28. LPN-D her left side. R28 e had facial grimacin	ng. The DON cleansed the al pressure wound and applied ze to R28's wound beds for DON then removed the gauze alginate into R28's wounds. did not cover the entire wound ining was located. The DON					

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		COM	E SURVEY PLETED	
		00166	B. WING			12/02/2021	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
/ICTORY	Y HEALTH & REHABII		HAVENUE NO POLIS, MN 55				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	ige 16	2 900				
	small amount of lig on her incontinence noted on R28's skir sacral wound. The the skin with wound R28's wounds and alginate were noted told the ADON and applicator to assess pieces of silver algi inserted Vashe soa beds for five minute gauze and complet wounds with silver then covered with a stated to the ADON piece of alginate wa covered the entire w healing. MD-C also completely.	m pressure wounds. R28 had ht brown colored stool noted e product. Stool was also n roughly three inches from the ADON proceeded to cleanse d cleanser. MD-C assessed additional pieces of silver d in the sacral wound. MD-C LPN-D to use a cotton tipped s the wound and ensure all nate were removed. MD-C ked gauze into R28's wound es. MD-C hen removed the ely covered R28's pressure alginate. The wounds were a foam dressing. MD-C then I and LPN-D to ensure a full as used so it completed wound bed to promote proper instructed staff to offload R28					
	interviewed and sta deteriorated from w wounds two weeks ulcer and measured						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		IDENTIFICATION NOWIDEN.	A. BUILDING: _	·····			
		00166	B. WING			C 12/02/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
/ICTOR)	(HEALTH & REHABI	I ITATION CENTEI	HAVENUE NOI POLIS, MN 55				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	age 17	2 900				
	written by MD-C da following: - R28's stage IV sa measured 3.5 cm. serous excaudate slough (dead tissue Further, the wound measured 5.5 cm a 4.5 cm. at the nine at the 12 o'clock po had "deteriorated" R28's wound was o	and Physician Progress Note ated 12/2/21, revealed the acral pressure wound x 4.0 cm. x 1.5 cm. Moderate was noted with 10 percent e) and 90 percent granulation. I had undermining which at the three o'clock position, o'clock position, and 7.5 cm. osition. R28's sacral wound since her last visit on 11/18/21. debrided of 1.4 cm. of non-viable) at a depth of 1.6					
	(undated) directed pressure injuries a injuries. Staff were plan and assess for	Pressure Injury Treatment to provide care of existing nd the prevention of additional to review the residents care or any special needs of the injury care, current support us of the injury.					
	director of nursing review and revise p prevention and trea could then educate and procedures. A monitoring consiste developed, with the	THOD OF CORRECTION: The (DON), or designee, could policies on pressure ulcer atment. The DON, or designee e staff on the facility's policies system for evaluating and ent implementation could be e results of these audits being ity's Quality Assurance ew.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE SURVEY COMPLETED	
		00166	B. WING		C 12/02/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
/ICTOR	Y HEALTH & REHABI	I ITATION CENTEI	HAVENUE N POLIS, MN 🖇	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
2 920	Continued From pa	age 18	2 920			
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920		1/10/22	
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	by: Based on observat review, the facility f hygiene was provid	ent is not met as evidenced ion, interview, and document ailed to ensure assistance with led for 1 of 3 residents (R28) at upon staff for activities of	ו	Corrected		
	Findings include:					
	R28 had diagnoses arthritis (causes pa	ecord dated 12/2/21, indicated s which included rheumatoid in, swelling, stiffness, and loss) and chronic pain syndrome.				
	10/27/21, indicated and had no docum was totally depende transfers, toilet use had impairments of	imum Data Set (MDS) dated R28 was cognitively intact ented rejection of care. R28 ent of two staff for bed mobility , and personal hygiene. R28 f both upper and lower s always incontinent of bowel.	, ,			
	an ADL self-care de knee amputations, the spine connects weakness, and rhe	ted 5/2/21, identified R28 had eficit related to bilateral above a sacral wound (area where to the lower half of the body), umatoid arthritis. Staff were assistance with all hygiene				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			С
		00166	B. WING			02/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
/ICTOR	Y HEALTH & REHABI	I ITATION CENTEI	I AVENUE NO POLIS, MN 55			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 920	Continued From pa	age 19	2 920			
	cares, assist with t	oileting, bathing, and dressing.				
	11/30/21, indicated 11/30/21, staff doc completed for 16 o	DL Task Record dated I from 11/1/21, through umented hygiene was f 87 opportunities. There were fusals and R28 was 24/21.				
	12/2/21, indicated	DL Task Record Record dated from 12/1/21, staff documented 1 of 3 opportunities. There ed refusals.	ł			
	R28 was observed a pillow slightly und fingernails were ro brownish/black res fingernails. R28's s hands. R28's gums with breath had a r	tion on 11/29/21, at 9:00 a.m. laying in bed on her back with der her right side. R28's ughly two inches long and a idue was noted under her skin was dry and flaking on her s were noted to be red in color noticeable odor. Further, R28's I with a whitish/yellow colored				
	R28 laying in bed a nursing assistant (care or oral care th NA-A stated the ev oral cares and nail	tion on 11/30/21, at 9:41 a.m. and provided a bed bath by NA)-A. NA-A did not offer nail proughout the observation. rening or night shift can provide care. Further, R28's long nails r cleaned because of dirt				
unacota D	licensed practical r responsibility of nu cares. She stated a staff of the care R2	v on 11/30/21, at 2:28 p.m. hurse (LPN)-C stated it was the rsing assistants to provide ADL a resident's care plan directed 28 required every day. LPN-C saw dirt build up under R28's				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
					С		
		00166	B. WING	B. WING		12/02/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ICTOR	/ HEALTH & REHABI	ITATION CENTER	HAVENUE NO POLIS, MN 55				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 920	Continued From pa	age 20	2 920				
	nails.						
	R28's fingernails re	ion on 12/1/21, at 9:39 a.m. mained roughly two inches /black residue underneath.					
	stated no one had o provided oral cares sometime the previ previously brushed able to do it on her	on 12/1/21, at 10:00 a.m. R28 cleaned her fingernails or for many days; maybe lous week. R28 stated she her teeth daily when she was own. R28 expressed she her nails cleaned and oral	3				
	assistant director o	on 12/1/21, at 1:45 p.m. the f nursing (ADON) stated she cares were not provided to					
	director of nursing heard of R28 refusion nursing assistants hygiene care and d expectation was for completed every sh stated she felt there complete cares, but did not always wan	on 12/1/21, at 1:42 p.m. the (DON) explained she had not ing cares. The DON stated should provide daily personally locument refusals. Her r personal hygiene cares to be hift and as needed. The DON e was enough staff to t the facility culture was nurses t to help nursing assistants. d she knew R28's fingernails					
	(ADL's) (undated) of unable to carry out receive services to	Activities of Daily Living directed residents who were ADLs independently would maintain good nutrition, sonal and oral hygiene.					
	SUGGESTED MET	THOD OF CORRECTION: The					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 12/02/2021	
		00166	B. WING			
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
(ICTOR)	(HEALTH & REHABI		HAVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	age 21	2 920			
	review applicable p ensure residents and care with personal manner; then educ ongoing complianc					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
2 930	MN Rule 4658.052 Nasogastric, Gastr	5 Subp. 7 B. Rehab - ostomy tubes	2 930			1/10/22
	and feeding syringes. Based o	tric tubes, gastrostomy tubes, on the comprehensive resident sing home must ensure that:				
	gastrostomy tube c appropriate treatmo aspiration pneumo dehydration, metab	who is fed by a nasogastric or or feeding syringe receives the ent and services to prevent nia, diarrhea, vomiting, polic abnormalities, and policers and to restore, if reding function.				
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview, and document ailed to ensure a tube feeding as ordered for 1 of 2 residents		Corrected		
	(R28) who received Findings include:					
	-	operal data d 10/0/01 indiante				
	nzos Aumissium R	ecord dated 12/2/21, indicated				

STATE FORM

CRPT11

If continuation sheet 22 of 35

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 12/02/2021	
		00166			12/	02/202 I
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
VICTORY	(HEALTH & REHABII		I AVENUE NO POLIS, MN 55			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO T		COMPLET DATE
-				DEFICIENC'	Y)	
2 930	Continued From pa	ige 22	2 930			
	B28's diagnoses in	cluded diabetes, rheumatoid				
		in, swelling, stiffness, and loss				
), and a pressure ulcer.				
		imum Data Set (MDS) dated				
		R28 was cognitively intact. indication R28 received a tube				
	feeding.					
	Ũ					
		are area assessment (CAA)				
		ated R28 required tube				
	reedings to meet ne	er nutritional needs.				
	R28's care plan dat	ted 7/13/21, indicated R28 was	6			
	at risk for impaired	nutrition and hydration. R28				
		ding to meet her nutritional				
		ory of dysphasia (difficulty				
		story of aspiration pneumonia. ded several interventions				
		vitamin and mineral				
		r flushes, and feedings.				
		ary Report dated 11/30/21, wide 100 milliliter (mL) water				
		nours through a j-tube (soft,				
		through the skin of the				
		nidsection of the small				
		purce (nutrition formula) 100				
		hours per day, as tolerated.				
	and turned off at 10	ras to be started at 10:45 a.m.				
		ion on 11/29/21, at 3:00 p.m.				
		be feeding formula was hung				
		eeding pump was shut off. The bottle had 700 mL of solution)			
		ttle. The tubing connected to				
		ula was hung over the pole				
	and not connected	to R28. The Isosource formula	a			
	and tubing lacked a	a date/time.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00166		B. WING			02/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
/ICTOR	(HEALTH & REHABII		HAVENUE NOI POLIS, MN 55			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
2 930	Continued From pa	ge 23	2 930			
	R28 was observed was at a 25-to-30-c connected to the tu bottle of Isosource Dried formula was feeding and 700 ml Isosource bottle. At nurse (LPN)-C was did not disconnect f LPN-C stated it app connect R28 to the confirmed the tubin formula had dried s A progress note dat indicated R28's phy missed tube feedin	ion on 11/30/21, at 7:25 a.m. sleeping in her bed. R28's bed legree angle, and she was not be feeding at this time. The formula lacked a date/time. noted on the end of the tube _ of formula was noted in the to formula was noted in the trian formula was noted in the the tube feeding from R28. beared evening shift did not tube feeding. LPN-C g connected to the Isosource substance on the end. ted 11/30/21, at 11:07 a.m. visician was notified of the g (11/29/21) and an order was tube feeding and follow a 12				
	R28 was laying in b connected to the tu LPN-C confirmed s	ion on 11/30/21, at 2:25 p.m. bed and awake. R28 was not be feeding. At 2:28 p.m. he did not complete R28's the shift as she was busy.				
	During an observat R28 still was not co	ion on 11/30/21, at 4:00 p.m. Innected to the tube feeding.				
	medical doctor (ME and provided a vert order, to immediate and monitor for der had been multiple of which orders were	on 11/30/21, at 9:30 a.m. b)-B stated he assessed R28 bal order, and later signed an ely resume R28's tube feeding hydration. MD-B stated there boccasions at the facility in not followed, or started, as ted not starting R28's tube				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00166		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 12/02/2021		
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
/ICTOR)	Y HEALTH & REHABIL	ITATION CENTEI	H AVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 930	Continued From pa	ge 24	2 930			
	expected the facility	/ to follow orders as given.				
	assistant director of tube feeding did no on 11/30/21. The Al	on 12/1/21, at 1:43 p.m. the f nursing (ADON) stated R28's t get restarted until 10:45 p.m. DON stated she told LPN-C to 28's tube feeding and ht to MD-B.				
	director of nursing (staff to follow order and nursing superv should had restarte instructed to do so	on 12/1/21, at 1:45 p.m. the DON) stated she expected s provided by the physician isor. The DON stated LPN-C d R28's tube feeding when by the ADON on 11/30/21. The ent more than 24 hours utrition.	9			
		ted 12/1/21, at 6:41 p.m. s notified R28 missed a tube				
	Precautions (undate responsible for prep administering etern trained, qualified, a responsibilities. Fur	al nutrition formulas will be nd competent of ther, staff were directed to al the label when formula was				
	director of nursing (review applicable p ensure residents ar ordered. The DON,	HOD OF CORRECTION: The DON), or designee, could rocedures and policies to e receiving tube feedings as or designee, could then nplement a monitoring system compliance.				

If continuation sheet 25 of 35

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
				·	С
		00166	B. WING	12/02/2021	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
VICTOR	(HEALTH & REHABIL	ITATION CENTER	AVENUE NO POLIS, MN 5	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
2 930	Continued From pa	ge 25	2 930		
	(21) days.				
21475	MN Rule 4658.1008 General Requireme	5 Subp. 1 Social Services: ents	21475		1/10/22
	home must have ar department or prog related social servic nursing home must collaborate with out who is in need of ac	I requirements. A nursing n organized social services ram to provide medically ces to each resident. A make referrals to or side resources for a resident dditional mental health, or financial services.			
	by: Based on observati review, the facility facomprehensive ass discharge planning had ongoing allegat	ent is not met as evidenced on, interview, and document ailed to provide sistance with potential for 1 of 1 resident (R500) who tions of sexually inappropriate emale residents (R501).		Corrected	
	Findings include:				
	11/12/21, identified impairment and wa activities of daily liv	nimum Data Set (MDS) dated R500 had a severe cognitive s independent with all ing (ADLs). R500's diagnoses d cognitive decline and alcohol			
	R500 was, "At risk of to] poor impulse co dementia, level 1 se also included, "On 8	evised on 9/23/21, identified of abusing others r/t [related ntrol, alcohol induced ex offender." The care plan B/27/21 resident accused of resident inappropriately near			

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00166	B. WING	B. WING		02/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
/ICTOR	Y HEALTH & REHABI		I AVENUE NOI POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21475	Continued From pa	age 26	21475			
	care plan instructed female residents," ' alternative placeme making sexual ges redirect him back to enter a female resi immediately," [R50 besides South hall "[R500] will not enter	3/21, "accused of kissing." The d staff to, "Redirect away from "Assist in looking [for] ent," If staff hear [R500] tures tell him to stop and o his room," "If staff see [R500] dent's room, remove resident 0] is not to be in any other hall without supervision," and er north hall, will stay away nt" related to allegations of vior.				
	outlined, "Boundari inappropriate beha - Refrain from touc if they request a hu - Refrain from ente	hing any female resident, even Ig from you. ring female resident's rooms. Is areas refrain from making				
	included, "Met with with female resider	ted 9/3/21, at 3:04 p.m. resident, reviewed concerns nts. Reviewed for transition to another facility				
	included, "Spoke w reviewed transition	ted 9/23/21, at 1:47 p.m. ith resident and daughter, to another facility. Daughter anding and knowing it ws in his	8			
	9/24/21, included, ' [R500] kiss a fema previously shown ir she is not intereste	ovider Progress Note dated 'A resident reported seeing le resident who he has nterest in and who has stated d." "Staff continue to work to cement for [R500]. [R500] is				

ATTENENT OF DEFICIENCIES IND PLAN OF CORRECTION (X1) IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 00166 (X2) MULTIPLE CONSTRUCTION A. BUILDING: 	Minneso	ta Department of He	alth			FORM	APPROVE
00166 B. WING	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
Summary statement of DeFICIENCIES ID PROVIDERS PLAN OF CORRECTION (X4) ID PEFIX TAG ISLAMMARY STATEMENT OF DEFICIENCIES ID PREFIX REGULATORY OR LSC DENTFYING INFORMATION ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCIES TO THE APPROPRIATE DEFICIENCY) 0/ DV 21475 Continued From page 27 ambivalent about this, but agreeable depending on the location." 21475 21475 During an interview on 11/29/21, at 10:04 a.m. R501 stated that R500 wanted to be more physical with her and, "It told him, no. I don't want to do that." R501 stated R501 liked to 'touch my boobs. I don't like that. I tell him, don't do that." Additionally, R500 stated R501 liked to kiss her and she did not want to kiss him. R500 stated, "I don't feel good about it." During an interview on 11/29/21, at 11:39 a.m. R500 stated he thought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 mer not to touch each other. SW-A stated she attempted to find R500			00166	B. WING		C 12/02/2021	
COTORY HEALTH & REHABILITATION CENTEI MINNEAPOLIS, MN 55430 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PROEDED B PY FULL TAG ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH OPERCENCY EACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 0 21475 Continued From page 27 ambivalent about this, but agreeable depending on the location." 21475 During an interview on 11/29/21, at 10:04 a.m. R501 stated that R500 wanted to be more physical with her and, "I told him, no. I don't want to do that." R501 stated R500 liked to "touch my boobs. I don't like that. I tell him, don't do that." Additionally, R500 stated R500 liked to "touch my boobs. I don't like that. I tell him, don't do that." Additionally, R500 stated R501 liked to kiss her and she did not want to kiss him. R500 stated, "I don't feel good about it." During an interview on 11/29/21, at 11:39 a.m. R500 stated he thought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MINNEAPOLIS, MN 55430 WINNEAPOLIS, MN 55430 PHEFX TAG SUMMARY STATEMENT OF DEFICIENCY REGULATORY OR LSC IDENTIFYING INFORMATION) Image: Deficiency MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Image: Deficiency MUST BE PRECEDED BY FULL TAG Image: Deficiency MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Image: Deficiency MUST BE PRECEDED BY FULL TAG Image: Deficiency MUST BE PRECED TO THE APPROPRIATE DEFICIENCY) Image: Deficiency MUST BE PRECED TO THE APPROPRIATE DURING an interview on 11/29/21, at 10:04 a.m. R500 stated R500 liked to 'mouch my boobs. I don't like that. I tell him, don't do that." Additionally, R500 stated R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. Image: During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff w			512 49TH	AVENUE NO	RTH		
interview TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRIETX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COM DEFICIENCY) 21475 Continued From page 27 ambivalent about this, but agreeable depending on the location." 21475 21475 During an interview on 11/29/21, at 10:04 a.m. R501 stated that R500 wanted to be more physical with her and, "I told him, no. I don't want to do that." R501 stated R500 liked to "touch my boobs. I don't like that. I tell him, don't do that." Additionally, R500 stated R501 like to to stated, "I don't feel good about it." During an interview on 11/29/21, at 11:39 a.m. R500 stated her tought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500	VICTORY	HEALTH & REHABI	LITATION CENTEI MINNEAF	OLIS, MN 55	5430		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE D// 21475 Continued From page 27 21475 21475 21475 ambivalent about this, but agreeable depending on the location." 21475 21475 21475 During an interview on 11/29/21, at 10:04 a.m R501 stated that R500 wanted to be more physical with her and, "I told him, no. I don't want to do that." R501 stated R500 liked to 'touch my boobs. I don't like that. I tell him, don't do that." Additionally, R500 stated R501 liked to kiss her and she did not want to kiss him. R500 stated, "I don't feel good about it." During an interview on 11/29/21, at 11:39 a.m R500 stated he thought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R501 and R501 were not to touch each other. SW-A stated she attempted to find R500 Here Hambian Ambian Am	(X4) ID						(X5)
21475 Continued From page 27 21475 ambivalent about this, but agreeable depending on the location." 21475 During an interview on 11/29/21, at 10:04 a.m. R501 stated that R500 wanted to be more physical with her and, "I told him, no. I don't want to do that." R5051 stated R500 liked to 'touch my boobs. I don't like that. I tell him, don't do that." Additionally, R500 stated R501 liked to kiss her and she did not want to kiss him. R500 stated, "I don't feel good about i." During an interview on 11/29/21, at 11:39 a.m. R500 stated he thought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500							COMPLETE DATE
ambivalent about this, but agreeable depending on the location." During an interview on 11/29/21, at 10:04 a.m. R501 stated that R500 wanted to be more physical with her and, "I told him, no. I don't want to do that." R501 stated R500 liked to "touch my boobs. I don't like that. I tell him, don't do that." Additionally, R500 stated R501 liked to kiss her and she did not want to kiss him. R500 stated, "I don't feel good about it." During an interview on 11/29/21, at 11:39 a.m. R500 stated he thought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500	in to		,	in to	DEFICIENCY))	
ambivalent about this, but agreeable depending on the location." During an interview on 11/29/21, at 10:04 a.m. R501 stated that R500 wanted to be more physical with her and, "I told him, no. I don't want to do that." R501 stated R500 liked to "touch my boobs. I don't like that. I tell him, don't do that." Additionally, R500 stated R501 liked to kiss her and she did not want to kiss him. R500 stated, "I don't feel good about it." During an interview on 11/29/21, at 11:39 a.m. R500 stated he thought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500	21475	Continued From pa	ne 27	21475			
on the location." During an interview on 11/29/21, at 10:04 a.m. R501 stated that R500 wanted to be more physical with her and, "I told him, no. I don't want to do that." R501 stated R500 liked to "touch my boobs. I don't like that. I tell him, don't do that." Additionally, R500 stated R501 liked to kiss her and she did not want to kiss him. R500 stated, "I don't feel good about it." During an interview on 11/29/21, at 11:39 a.m. R500 stated he thought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500			-				
R501 stated that R500 wanted to be more physical with her and, "I told him, no. I don't want to do that." R501 stated R500 liked to "touch my boobs. I don't like that. I tell him, don't do that." Additionally, R500 stated R501 liked to kiss her and she did not want to kiss him. R500 stated, "I don't feel good about it." During an interview on 11/29/21, at 11:39 a.m. R500 stated he thought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500			his, but agreeable depending				
R501 stated that R500 wanted to be more physical with her and, "I told him, no. I don't want to do that." R501 stated R500 liked to "touch my boobs. I don't like that. I tell him, don't do that." Additionally, R500 stated R501 liked to kiss her and she did not want to kiss him. R500 stated, "I don't feel good about it." During an interview on 11/29/21, at 11:39 a.m. R500 stated he thought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500		During an interview	$a = \frac{11}{29}$				
 physical with her and, "I told him, no. I don't want to do that." R501 stated R500 liked to "touch my boobs. I don't like that. I tell him, don't do that." Additionally, R500 stated R501 liked to kiss her and she did not want to kiss him. R500 stated, "I don't feel good about it." During an interview on 11/29/21, at 11:39 a.m. R500 stated he thought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500 							
to do that." R501 stated R500 liked to "touch my boobs. I don't like that. I tell him, don't do that." Additionally, R500 stated R501 liked to kiss her and she did not want to kiss him. R500 stated, "I don't feel good about it." During an interview on 11/29/21, at 11:39 a.m. R500 stated he thought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500							
Additionally, R500 stated R501 liked to kiss her and she did not want to kiss him. R500 stated, "I don't feel good about it." During an interview on 11/29/21, at 11:39 a.m. R500 stated he thought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500		to do that." R501 st	ated R500 liked to "touch my				
and she did not want to kiss him. R500 stated, "I don't feel good about it." During an interview on 11/29/21, at 11:39 a.m. R500 stated he thought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500							
 don't feel good about it." During an interview on 11/29/21, at 11:39 a.m. R500 stated he thought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500 							
During an interview on 11/29/21, at 11:39 a.m. R500 stated he thought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500			-				
R500 stated he thought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500		don't leel good abo	ut it.				
R500 stated he thought R501 was a "Nice lady" and "a friend." R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500		During an interview	on 11/29/21, at 11:39 a.m.				
R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500		R500 stated he tho	ught R501 was a "Nice lady"				
inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500							
During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500			emale resident				
social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500		inappropriately.					
social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500		During an interview	on 11/29/21. at 1:00 p.m.				
was a level 1 sex offender and there had been a "couple" of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500							
inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500							
during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500							
allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500							
different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500							
educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500							
other. SW-A stated she attempted to find R500							
placement in an all-male facility, but was							
unsuccessful. This included inquiring about							
placement at one alternative skilled nursing							
facility approximately two months ago, but the							
facility was unable to accept R500 due to his status as a sex offender. SW-A confirmed no							
additional inquiries were made for alternative							
placement. SW-A stated R500 was "due for a							
care conference soon" and she could talk to		•					
R500's daughter to see if they were open to							
considering transitioning to an assisted living		considering transition	oning to an assisted living				
facility or group home.			ne.				

Minnesota Department of Health STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
		00166	B. WING		12/	12/02/2021	
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S				
ICTOR	(HEALTH & REHABI		AVENUE NO POLIS, MN 55				
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
21475	Continued From pa	age 28	21475		•)		
		0					
	director of rehabilita "be reasonable" to						
	the administrator a (ADON) the admini- implemented interval alternative placeme facility. The ADON team had agreed to ongoing risk of inag- facility's female res- thought referrals to to multiple all-male declined at each fa- sex offender. The A- appropriate to asse- determine if he cou- or group home. Th- was unsuccessful v- intervention he wou	y on 12/2/21, at 10:50 a.m. with nd assistant director of nursing istrator stated the facility had ventions which included pursing ent for R500 at an all-male l added the interdisciplinary of this intervention to mitigate opropriate interaction with the sidents. The administrator of transfer R500 had been sent care facilities, but had been scility due to being a registered ADON added it would be ease R500's care needs to ald transfer to an assisted living e administrator stated if SW-A with implementing a behavior ald expect the information to be erdisciplinary team for					
	dated 2001, include permitted to remain transferred or disch of individuals in the	ers and Discharges Policy ed, "Each resident will be in in the facility, and not be harged unless: C. the safety e facility is engaged due to the al status of the resident."					
	The administrator,	THOD FOR CORRECTION: or designee, could review es and procedures related to					

STATE FORM

Minneso	ta Department of He	ealth				AFFNOVLD
					(X3) DATE SURVEY COMPLETED	
		00166	B. WING			C)2/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE. ZIP CODE		
		512 4 9TI	HAVENUE NO			
VICTORY	(HEALTH & REHABI	LITATION CENTEI MINNEA	POLIS, MN 55	5430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21475	Continued From pa	ige 29	21475			
	monitoring systems	port the findings to the Quality				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21545	MN Rule 4658.132	0 A.B.C Medication Errors	21545			1/10/22
	percent as describe Guidelines for Code 42, section 483.25 the State Operation Surveyors for Long incorporated by refe purposes of this pa (1) a discrepa prescribed and wha administered to res (2) the admini- medications. B. It is free of a error. A significant (1) an error discomfort or jeopa safety; or (2) medication erquires the medica be titrated to a spec medication error co precipitate a reoccu toxicity. All medicat prescribed. An inco error report must be that occurs. Any si	ast ensure that: on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of as Manual, Guidance to -Term Care Facilities, which is erence in part 4658.1315. For rt, a medication error means: ncy between what was at medications are actually idents in the nursing home; or stration of expired any significant medication medication error is: which causes the resident ardizes the resident's health or on from a category that usually ation in the resident's blood to cific blood level and a single build alter that level and urrence of symptoms or ions are administered as sident report or medication error gnificant medication errors or must be reported to the				

	ta Department of He	alth (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00166			:	(X3) DATE SURVEY COMPLETED	
		B. WING	C 12/02/2021		
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE	
/ICTOR)	(HEALTH & REHABI	ITATION CENTEI			
		MINNEA	POLIS, MN 5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE
21545	Continued From page 30		21545		
	resident or the resid designated represe must be made in th C. All medication prescribed. An incomposition report must be filed occurs. Any signific resident reactions of physician or the phy resident or the resid designated represe	the physician's designee and the e resident's legal guardian or epresentative and an explanation e in the resident's clinical record. edications are administered as An incident report or medication error be filed for any medication error that significant medication errors or tions must be reported to the the physician's designee and the e resident's legal guardian or epresentative and an explanation e in the resident's clinical record.			
	by: Based on observative review, the facility for were administered orders and profess 1 of 2 residents (R2 medication during to	ent is not met as evidenced ion, interview, and document ailed to ensure medications in accordance with physician ional standards of practice for 28) observed to receive he survey. This resulted in a administration error rate of		Corrected	
	Findings include:				
	R28's diagnoses in ulcer of sacral region connects to the low	ecord dated 12/2/21, indicated cluded diabetes, pressure on (area where the spine ver half of the body), and d left leg above knee.			
		dated 7/26/21, indicated R28 dication crushed and given reasy swallowing.			
		ovember 2021 Medication			
nesota De	epartment of Health M		6899	CRPT11	f continuation sheet 31

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00166		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED	
						С
		B. WING		12/	02/2021	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
ICTOR	(HEALTH & REHABIL		I AVENUE NO POLIS, MN 55			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21545	Continued From pa	ige 31	21545			
	Administration Rec	ord (MAR), indicated staff				
		the following medications by				
	mouth:					
	mouth two times a	(antibiotic). Give one tablet by	, 			
		nilligram tablet. Give 100				
	milligrams by mouth every 12 hours for bone and					
	joint infection.	-				
	- Morphine sulfate ((pain medication)				
		ablet 15 mg. Give one tablet by	/			
	mouth three times daily for chronic pain.					
	- Famotidine 20 mg tablet (treats heartburn). Give		•			
	20 mg twice daily. - Gabapentin 6 mL 250mg/5mL. Give 300 mg (6					
	milliliters [mL]) by mouth two times daily for					
	neuropathic pain.	····,				
	The November 202	1 MAR further indicated the				
		ns were to be administered via	ι			
	g-tube (tube feeding					
		id) 5 mg tablet. Give one				
	tablet daily via g-tube for chronic pain. - Amlodipine 5 mg tablet. Give 1 tablet via g-tube					
	daily for high blood					
		tablet. Give 1 tablet via g-tube	•			
	every Tuesday for c					
		e. Give 50 mg via g-tube two				
	times daily for high	blood pressure.				
	On 11/30/21 at 0.1	3 a.m. licensed practical nurse				
		ved preparing medications for				
	R28 which included					
	- Cefuroxime Axetil					
	- Amlodipine 5 mg					
	- Duloxetine 20 mg					
	- Doxycycline 100 n					
		extended-release 15 mg				
	 Famotidine 20 mg Metoprolol Tartrate 					
	- Gabapentin 6 mL					

STATE FORM

CRPT11

If continuation sheet 32 of 35

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00166		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00166	B. WING			C 02/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
VICTOR	Y HEALTH & REHABIL		AVENUE NOI POLIS, MN 55			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLETI DATE
21545	Continued From pa	ge 32	21545			
	 Prednisone 5 mg was not prepared as the medication was unavailable. On 11/30/21, at 9:13 a.m. LPN-C was observed to crush the above noted medications and placed them in medication cups. Additionally, LPN-C poured Gabapentin 250mg/5mL into a plastic medication cup with measurement lines on the cup (with measuring lines labeled 2.5, 5, 7.5). It was unable to be determined it 6 mL of Gabapentin was in the medication cup. LPN-C then gathered supplies and went into R28's room. LPN-C connected connected the syringe to R28's g-tube and pulled back. LPN-C then flushed the G-tube, using a syringe, with water. LPN-C then mixed four medications together with water and administered in G-tube with water flush. LPN-C next administered the liquid gabapentin medication and flushed with water. LPN-C then administered the last three crushed medication mixed together with water, gave in R28's G-tube, and flushed with water. 					
	LPN-C stated all me for R28 because the stated she was late administration and tablets were not avai confirmed she pour medication cup and stated she should he was not available. L given R28 too much accurately. Further, to crush medication	on 11/30/21, at 9:13 a.m. edications could be crushed ere was an order. LPN-C also with medication confirmed Prednisone 5 mg ailable. At 9:20 a.m. LPN-C red gabapentin into a plastic had estimated 6 mL. LPN-C had used a syringe, but one LPN-C stated she could had n gabapentin it not measured she knew R28 had an order as, but was not aware to order edication in applesauce and				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00166		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING			C 02/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		S12 49TH	AVENUE NO	RTH		
VICTORY	/ HEALTH & REHABII	MINNEAF	OLIS, MN 55	5430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From pa	uge 33	21545			
	all oral medications g-tube.	were cocktailed and given via				
	medical doctor (MD	on 11/30/21, at 1:55 p.m. 0)-A stated he expected staff to s ordered to ensure proper ef of symptoms.				
	consulting pharmac expected to admini physician order. Th practice to use a sy	on 12/1/21, at 9:00 a.m. the cist (CP) stated staff were ster medication based on the e CP stated it was best wringe when drawing up re the dose was correct.				
	MD-B stated he exp medication orders a were ordered by me given by mouth. If a condition, the physic request a change of	on 12/1/21, at 9:30 a.m. pected the facility to follow as directed. If medications outh, then they should be a resident had a change in ician should be notified and or to review orders. MD-B rould had clarified orders with				
	director of nursing of staff passing medic medication, and the expected staff to er dose, right medicat before medications individual had ques should ask prior to stated medications via a tube feeding,	on 12/1/21, at 1:42 p.m. the (DON) stated she expected cation to check orders, check en check again. Further, she nsure the right person, right ion, right route, and right time were administered. If an tions about an order, they administration. The DON which were crushed and given rather than by mouth, were cation error. Further, LPN-C				
	DON stated LPN-C	e a dose of gabapentin. The would need to write up and she would provide staff				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00166				(X3) DATE SURVEY COMPLETED		
		B. WING			C 02/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	1,	
	' HEALTH & REHABI	512 49TH	AVENUE NO			
		MINNEA	POLIS, MN 55			1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From pa	age 34	21545			
	education and gue error.	ssed all staff made the same				
	Medications (undat administering med	Administering Oral ted) directed the individual ication to verify physician care plan, and assess for				
	The director of nur review and/or revis medication adminis designee, could the monitoring system correctly administe	THOD OF CORRECTION: sing (DON), or designee, could be policies related to stration. The DON, or en educate staff and develop a to ensure medication were ared as ordered by the lity assurance committee could sures.				
	TIME PERIOD FO (21) days	R CORRECTION: Twenty-one				