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

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

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

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.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 12/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 11/29/21, through 12/2/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5544247C (MN00065151), with a deficiency cited at F677. H5544239C (MN00066995), MN00067027), with deficiencies cited at F693 and F759. Additional deficiencies were identified and F689 and F697. H5544278C (MN00078872), with a deficiency cited at F580. H5544248C (MN00071021), with a deficiency cited at F677. H5544252C (MN00068284), with a deficiency cited at F580. H5544279C (MN00078922), with a deficiency cited at F580 and F686. The following complaints was found to be SUBSTANTIATED, however, NO deficiencies were cited due to actions implemented by the facility prior to survey: H5544271C (MN00058115), H5544253C (MN00067762), H5544122C (MN00060108), H5544267C (MN00060483), H5544276C (MN00068073), H5544237C (MN00075523), and H5544259C (MN00077584). The following complaints were found to be UNSUBSTANTIATED, however, related deficiencies were cited: H5544242C (MN00077000) with a deficiency cited at F745.	F 000		

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

Electronically Signed | 12/27/2021

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F 000	Continued From page 1 The following complaints were found to be UNSUBSTANTIATED: H5544256C (MN00055236), H5544236C (MN00057021), H5544273C (MN00057643), H5544272C (MN00057811), H5544270C (MN00058601), H5544268C (MN00060411), H5544266C (MN00060990), H5544265C (MN00061562), H5544269C (MN00058685), H5544249C (MN00061566), H5544251C (MN00062019), H5544257C (MN00063321), H5544245C (MN00063651), H5544246C (MN00063846), H5544243C (MN00064999), H5544255C (MN00066066), H5544254C (MN00066083), H5544244C (MN00067088), H5525275C (MN00069148), H5544250C (MN00071065), H5544254C (MN00071120), H5544263C (MN00071185), H5544238C (MN00075552), H5544235C (MN00076082), H5544262C (MN00077139, MN00076989). H5544261C (MN00077301), H5544260C (MN00077317), H5544241C (MN00077689), H5544240C (MN00077755), H5544274C (MN00077826), H5544258C (MN00077787), and H5544277C (MN00078748). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.)	F 580		1/10/22

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F 580	Continued From page 2 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580		

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F 580	Continued From page 3 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician a resident was transferred to the hospital 1 of 4 residents (R29) reviewed for change of condition. Findings include: 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. Review of R29's progress notes revealed the following: - 11/22/21, at 11:16 p.m. indicated R29 was hospitalized. - 11/26/21, at 9:64 a.m. indicated R29 was at the hospital on observation status. R29 had complaints of vision changes, was ruled out for a Clostridioides difficile infection (bacteria which causes severe diarrhea and inflammation of the colon) and had no new diagnoses. Review of R29's medical record lacked indication the physician was notified R29 was transferred to	F 580	F 580 The physician for R 29 was notified resident went to the hospital on 11/22/2021 for vertigo. The physician response will be documented in the resident medical record. All other residents who discharged to the hospital from survey exit until present charts were reviewed for MD notification and any MD missing notification, the MD will be called and the response documented in the resident medical record. Future residents who have a change in condition, the MD will be notified and physician orders followed. Nursing staff will be in-serviced on resident change in condition physician notification with focus on item #6 contacting the MD based on urgency or if 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 2 weeks, weekly x 2 weeks then monthly to	

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F 580	Continued From page 4 the hospital. During an interview on 12/1/21, at 3:18 p.m. social worker (SW)-A stated R29 was transferred to the emergency department on 11/22/21, and was placed on observation status at the hospital with a chief complaint of vertigo and failure to thrive. During an interview on 11/30/21, at 1:35 p.m. LPN-B stated R29 refused to take any medications on 11/22/21, and had notified the provider. R29 was not aware of any other concerns regarding R29 during their shift and verbalized they were not aware R29 was transferred to the hospital. During an interview on 11/30/21, at 2:50 p.m. licensed practical nurse (LPN)-A stated he observed R29 near the facility entrance on 11/30/21, at approximately 3:00 p.m. calling 911 when arriving for his shift. He was notified R29 had already left for the hospital when he started his shift, however, did not receive any detail regarding why R29 went to the hospital. During an interview on 12/1/21, at 10:59 a.m. physician assistant (PA)-A stated there were no call notes dictated on 11/22/21, indicating R29 was at the hospital, however there was a note LPN-B called to request R29 be rounded on as the resident, did not seem like themselves. PA-A stated they learned of R29's hospitalization during chart review on 11/26/21, or 11/29/21, when preparing for a visit. PA-A stated staff were expected to notify the provider, or call center, when a resident was transferred to the hospital and further verbalized the lack of notification was not an isolated incident for the facility. PA-A	F 580	ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 1/10/ 2022	

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F 580	Continued From page 5 stated she did not know what lead to R29's hospitalization. During an interview on 12/2/21, at 10:10 a.m. the director of nursing (DON) stated she did not know why R29 was hospitalized or the events leading up to R29 going to the hospital. The DON verified R28's medical record lacked indication of why R29 was hospitalized or subsequent provider notification. The DON stated she expected staff to notify providers and document the notification. Facility policy titled A Change in a Resident's Condition or Status (undated), indicated the facility would promptly notify the physician of a resident's medical change or change in condition/status.	F 580		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assistance with hygiene was provided for 1 of 3 residents (R28) who was dependent upon staff for activities of daily living (ADL). Findings include: R28's Admission Record dated 12/2/21, indicated R28 had diagnoses which included rheumatoid arthritis (causes pain, swelling, stiffness, and loss of function in joints) and chronic pain syndrome.	F 677	R 28 ADL care plan and resident preferences was reviewed and updated as needed. R 28 refusals will be recorded in the electronic medical record. R 28 has since been placed on hospice services and will have a follow up visit with the facility social worker to assess resident satisfaction of ADL cares. R 28's response will be recorded in the electronic medical record. Current residents who receive total care were interviewed and their care plan was reviewed and updated	1/10/22

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F 677	Continued From page 6 R28's quarterly Minimum Data Set (MDS) dated 10/27/21, indicated R28 was cognitively intact and had no documented rejection of care. R28 was totally dependent of two staff for bed mobility, transfers, toilet use, and personal hygiene. R28 had impairments of both upper and lower extremities and was always incontinent of bowel. R28's care plan dated 5/2/21, identified R28 had an ADL self-care deficit related to bilateral above knee amputations, a sacral wound (area where the spine connects to the lower half of the body), weakness, and rheumatoid arthritis. Staff were directed to provide assistance with all hygiene cares, assist with toileting, bathing, and dressing. Review of R28's ADL Task Record dated 11/30/21, indicated from 11/1/21, through 11/30/21, staff documented hygiene was completed for 16 of 87 opportunities. There were no documented refusals and R28 was hospitalized on 11/24/21. Review of R28's ADL Task Record Record dated 12/2/21, indicated from 12/1/21, staff documented was completed for 1 of 3 opportunities. There were no documented refusals. During an observation on 11/29/21, at 9:00 a.m. R28 was observed laying in bed on her back with a pillow slightly under her right side. R28's fingernails were roughly two inches long and a brownish/black residue was noted under her fingernails. R28's skin was dry and flaking on her hands. R28's gums were noted to be red in color with breath had a noticeable odor. Further, R28's tongue was coated with a whitish/yellow colored thick film.	F 677	as needed. There has been no further ADL care concerns voiced from existing residents or resident representatives. Future residents will be assessed and their ADL ability will be care planned and interventions implemented. Nursing staff will be in-serviced on the ADL Support Policy and Procedure with emphasis on item #4 to assess to identify the cause of the refusal and to re-approach. Director of nursing and/or designee is responsible for compliance. Audits on ADL care and documentation of refusal/reapproach for care will begin 2x wk for 2 weeks, weekly x 2 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation.	

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F 677	Continued From page 7	F 677		

During an observation on 11/30/21, at 9:41 a.m. R28 laying in bed and provided a bed bath by nursing assistant (NA)-A. NA-A did not offer nail care or oral care throughout the observation. NA-A stated the evening or night shift can provide oral cares and nail care. Further, R28's long nails needed to be cut or cleaned because of dirt underneath.

During an interview on 11/30/21, at 2:28 p.m. licensed practical nurse (LPN)-C stated it was the responsibility of nursing assistants to provide ADL cares. She stated a resident's care plan directed staff of the care R28 required every day. LPN-C further stated she saw dirt build up under R28's nails.

During an observation on 12/1/21, at 9:39 a.m. R28's fingernails remained roughly two inches long with browning/black residue underneath.

During an interview on 12/1/21, at 10:00 a.m. R28 stated no one had cleaned her fingernails or provided oral cares for many days; maybe sometime the previous week. R28 stated she previously brushed her teeth daily when she was able to do it on her own. R28 expressed she would like to have her nails cleaned and oral cares provided.

During an interview on 12/1/21, at 1:45 p.m. the assistant director of nursing (ADON) stated she was unaware oral cares 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 refusing cares. The DON stated

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F 677	Continued From page 8 nursing assistants should provide daily personally hygiene care and document refusals. Her expectation was for personal hygiene cares to be completed every shift and as needed. The DON stated she felt there was enough staff to complete cares, but the facility culture was nurses did not always want to help nursing assistants. The DON confirmed she knew R28's fingernails were long. Facility policy titled Activities of Daily Living (ADL's) (undated) directed residents who were unable to carry out ADLs independently would receive services to maintain good nutrition, grooming, and personal and oral hygiene.	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess and implement interventions as ordered by the physician to promote healing and reduce	F 686	R 28 wounds were reassessed by the Medical Director on 12/4/2021 and weekly documentation continues. A new Braden and Pain assessment was completed	1/10/22

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F 686	Continued From page 9 the risk of complications of an existing pressure ulcer for 1 of 3 residents (R28) reviewed for pressure ulcers. The resulted in actual harm for R28 who had a worsening stage IV pressure ulcer. Findings include: Pressure Ulcer Definition: Stage IV Tissue loss with exposed bone, tendon, or muscle. Slough or eschar (Dead tissue that is hard or soft in texture, usually black, brown, or tan in color, and may appear scab-like. Eschar tissue is usually firmly adherent to the base of and wound and often the sides/edges of the wound), may be present. It often includes undermining (outwardly visible wound margins) and tunneling (passageways underneath the surface of the skin). R28's Admission Record dated 12/2/21, indicated R28's diagnoses included diabetes, pressure ulcer of sacral region (area where the spine connects to the lower half of the body), and absence of right and left leg above knee. R28's quarterly Minimum Data Set (MDS) dated 10/27/21, indicated R28 was cognitively intact and had no documented rejection of care. R28 was totally dependent of two staff with bed mobility, transfers, and toilet use. R28 had an impairment to both upper and lower extremities and was always incontinent of bowel. R28 had three documented stage IV pressure ulcers which were present upon admission. Several treatments were noted which included pressure reducing device for chair and bed.	F 686	along with a comprehensive skin assessment. The care plan was reviewed and updated as needed. The MD will be updated that wound documentation was inconsistent for November 2021 and the MD response will be recorded in the resident medical record. All other residents who have wounds were assessed and weekly documentation recorded and their care plans were reviewed and updated as needed. Future residents identified with wounds will have weekly wound assessments and their pressure care plan initiated and interventions implemented. Nursing staff were in-serviced on the Pressure Ulcer Treatment policy with emphasis on weekly documentation and prompt notification to the physician on resident refusals of treatment and following treatment orders for placement of product etc. Nurse aides were also in-serviced on the importance of turning and repositioning to alleviate pressure ulcer injury. Daily skin assessments will be implemented as needed for high risk residents and a dedicated nurse will be assigned for completion of daily wound care. Director of nursing and/or designee is responsible for compliance. Audits on weekly wound care, documentation and turning and repositioning will begin 2x wk for 2 weeks, weekly x 2 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review	

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F 686	Continued From page 10 R28s Care Area Assessment (CAA) dated 5/7/21, indicated R28 was totally dependent of staff for bed mobility, dressing, toilet use, and personal hygiene. The CAA further indicated R28 required a total assist of two staff, with the use of hoyer lift to transfer Further, R28 required extensive assistance of two staff to turn and reposition in bed every two hours and as necessary. R28's care plan dated 9/19/21 indicated R28 had stage IV pressure ulcers on her sacrum right ischium (lower back part of the hip bone), and left ischium. The care plan further identified R28 had the potential to develop additional pressure ulcers related to incontinence, immobility, and weakness. R28's care plan included several interventions including to conduct weekly skin assessments and provide wound care per orders. R28's care plan was revised on 12/2/21, to include assisting R28 to sit up in tilt-in-space wheelchair with a pressure reducing cushion for mealtimes. R28 was not to exceed two hours of sitting to offload pressure. R28's Order Summary Report dated 12/2/21, indicated staff were to offload R28, per facility protocol, and "maybe" up in chair two hours per day and an additional one hour after a two-hour break in the morning and afternoon. Further, R28 was to be repositioned every two hours and have weekly skin checks completed every Tuesday morning. R28's wound care orders included: - Right/left ischium and sacrum wound care: Make sure all pieces of silver alginate (product used to promote wound healing) were removed from the wound bed. Saturate 4 x 4 gauze with Vashe (wound cleanser). The saturated gauze was then to be placed in R28's wound beds and	F 686	and recommendation.	

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undermining areas and allow to sit for five minutes. Remove (gauze) and place silver alginate. Place a foam boarder dressing in the morning.

An Interdisciplinary team (IDT) progress note dated 12/1/21, at 7:17 p.m. indicated R28 was 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.

R28's Wound Physician Progress Note written by medical doctor (MD)-C dated 11/18/21, revealed the following:
- R28's stage IV sacral pressure wound measured 3.5 centimeters (cm.) x 3.0 cm. x 2.0 cm. with undermining of 5.0 cm. at the three o'clock position. The wound had 80 percent granulation (new tissue), 20 percent muscle and fascia (thin casing of connective tissue which holds muscle in-place), and moderate serous exudate (clear, thin, and watery fluid). R28's stage IV pressure wound to her left ischium measured 1.0 cm. x 1.0 cm. x 1.5 cm with abnormal granulation present within the wound margins. R28's stage IV pressure wound to her right ischium measured 0.8 cm. x 0.8 cm. x 1.0 cm with 100 percent granulation present. Recommendations included offloading the wound and repositioning per facility protocol. R28 may be up for two hours in their chair and one hour after a two-hour break.

Review of R28's November 2021 Task Record, revealed no transferring/bed mobility was not documented for 46 of 87 opportunities. There

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were no documented refusals.

Review of R28's December 2021 Task Record, revealed no transferring/bed mobility was not documented for 2 of 3 opportunities. There were no documented refusals.

Review of R28's Weekly Skin Check Progress notes revealed:
- 11/19/21, at 3:50 p.m. indicated R28 was on a turning and repositioning program and had a coccyx wound. The progress note lacked assessment of R28's wound.
- No additional documentation was provided, when requested, for skin assessments on 11/1/21, 11/8/21, and 11/22/21.

During a continuous observation conducted on 11/29/21, from 8:30 a.m. to 11:43 a.m. R28 was noted to be laying flat on her back, in bed, with a pillow to the right of her bed. R28's eyes were closed, and she was noted to be moaning and called out to staff for help. At 10:30 a.m., R28 was moaning, "ouch." At 11:43 a.m., R28 called out for help and stated she had pain. At 11:44 a.m., licensed practical nurse (LPN)-C was approached and advised R28 had not been repositioned since the continuous observation began at 8:30 a.m. LPN-C stated she would notify a nursing assistant. Throughout the observation, no staff entered R28's room, nor responded to R28 who was calling out periodically. Three hours and 13 minutes had passed.

During an observation on 11/29/21, at 10:25 a.m. LPN-B provided wound care to R28. R28 reported she had pain and noted facial grimacing when repositioned to her left side and throughout wound care. R28's dressing was noted to be

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F 686	Continued From page 13 completely saturated with bloody red drainage which also soaked through to R28's incontinence product and the sheet below her. Further, R28 was also observed to have four Zoll electrocardiogram (EKG) electrodes on her back which were removed by LPN-B. LPN-B stated the Zoll electrodes must had been on R28's back since her emergency department visit on 11/24/21. LPN-B removed the old dressing from the sacral, right, and left ischium pressure wounds. LPN-B then poured a small amount of Vashe solution on gauze and placed the gauze on R28's sacral and right and left ischium pressure wounds. The gauze was not completely saturated with Vashe solution. After roughly five minutes, the gauze was removed and LPN-B applied silver alginate to R28's sacral, right, and left ischium pressure wounds. The piece silver alginate was cut round and roughly 1.5 inches in diameter and did not cover the entire wound bed of the sacral wound. LPN-B then covered R28's wounds with a foam dressings. Immediately following the dressing change LPN-B stated she was not aware the gauze needed to be saturated with Vashe solution or the silver alginate dressing needed to cover the entire wound bed. During an interview on 11/30/21, at 12:45 p.m. the assistant director of nursing (ADON) stated she started a performance improvement plan for wound care and assessments as she discovered concerns regarding how wounds were being assessed, staff roles and responsibilities, and providing wound care as directed by the medical provider. The ADON stated R28 had not been assessed by a wound provider for a few weeks as she fell off the list to be evaluated after being transferred to the emergency department on 11/24/21.	F 686		

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During an observation on 12/1/21, at 10:00 a.m. the director of nursing (DON) and assistant director of nursing provided wound care to R28's sacral and right and left ischium pressure wounds. The ADON assisted R28 to reposition to her left side and removed an incontinence product. The DON removed the dressings which had a large copious amount of yellow/brown non-odorous drainage with blood which soaked through the dressing. The DON cleansed the outside of the sacral pressure wound and applied Vashe soaked gauze to R28's wound beds for five minutes. The DON then removed the gauze and inserted silver alginate into R28's wounds. The silver alginate did not cover the entire wound bed where undermining was located. The DON then applied a foam dressing.

During an interview on 12/1/21, at 1:45 p.m. the director of nursing (DON) stated when she observed R28's dressing change on 11/30/21, it appeared wound care was not completed as ordered. She confirmed the silver alginate dressing did not cover R28's entire wound bed, as directed, and fluid had saturated through R28's dressing and onto R28's incontinence product. The DON described the drainage as bloody discharge and stated R28's wound bed lacked granulation upon her wound assessment today which was noted on previous assessments. The DON confirmed R28's wound had worsened and included several reasons which included weekly skin checks not being completed, lack of timely repositioning, and no consistent wound care. The DON also stated R28 had stool on her incontinent product and sheet when wound care was completed on 11/30/21, and staff needed to ensure R28 was kept clean. Further, the DON

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stated staff were not reporting to the nurse when bandages became soiled and needed to be changed.

During an observation on 12/2/21, at 12:00 p.m. MD-C, the ADON, and LPN-D provided wound care to R28. LPN-D assisted R28 reposition to her left side. R28 expressed pain to MD-C and had facial grimacing. The ADON removed R28's incontinence product and subsequently removed R28's old dressing located on the sacrum and right and left ischium pressure wounds. R28 had small amount of light brown colored stool noted on her incontinence product. Stool was also noted on R28's skin roughly three inches from the sacral wound. The ADON proceeded to cleanse the skin with wound cleanser. MD-C assessed R28's wounds and additional pieces of silver alginate were noted in the sacral wound. MD-C told the ADON and LPN-D to use a cotton tipped applicator to assess the wound and ensure all pieces of silver alginate were removed. MD-C inserted Vashe soaked gauze into R28's wound beds for five minutes. MD-C hen removed the gauze and completely covered R28's pressure wounds with silver alginate. The wounds were then covered with a foam dressing. MD-C then stated to the ADON and LPN-D to ensure a full piece of alginate was used so it completed covered the entire wound bed to promote proper healing. MD-C also instructed staff to offload R28 completely.

Immediately following the observation, MD-C was interviewed and stated R28's sacral wound had deteriorated from when she had assessed R28's wounds two weeks ago. R28's sacral pressure ulcer and measurements increased in length and the amount of tunneling. MD-C attributed

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F 686	Continued From page 16 worsening tunneling to not being fully repositioned or not being repositioned every two hours. MD-C stated the reasons for wound deterioration included: need to offload the wound, continuity of wound care, and incontinence care. MD-C stated during her visit today, R28 had stool in her incontinence product and staff left the stool on R28's skin when wound care was provided. MD-C stated she expected the facility to reposition R28 every two hours, provide R28 a wheelchair cushion, provide good incontinence care, and change dressings immediately if soiled. A subsequent Wound Physician Progress Note written by MD-C dated 12/2/21, revealed the following: - R28's stage IV sacral pressure wound measured 3.5 cm. x 4.0 cm. x 1.5 cm. Moderate serous excaudate was noted with 10 percent slough (dead tissue) and 90 percent granulation. Further, the wound had undermining which measured 5.5 cm at the three o'clock position, 4.5 cm. at the nine o'clock position, and 7.5 cm. at the 12 o'clock position. R28's sacral wound had "deteriorated" since her last visit on 11/18/21. R28's wound was debrided of 1.4 cm. of devitalized tissue (non-viable) at a depth of 1.6 cm. Facility policy titled Pressure Injury Treatment (undated) directed to provide care of existing pressure injuries and the prevention of additional injuries. Staff were to review the residents care plan and assess for any special needs of the resident, pressure injury care, current support surfaces, and status of the injury.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		1/10/22

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F 689	Continued From page 17 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure oxygen was administered in accordance with acceptable standards of practice to reduce the likelihood of potential accident hazards for 1 of 1 resident (R28) who was administered oxygen therapy. Findings include: R28's Admission Record dated 12/2/21, indicated R28's diagnoses included pneumonitis (inflammation of lung tissue) and chronic respiratory failure. R28's Order Summary Report dated 11/30/21, directed staff to apply a small amount of Vaseline into both of R28's nostrils twice daily for dryness. R28's care plan dated 9/17/21, indicated R28 received oxygen therapy related to ineffective gas exchange and directed staff to administer oxygen at l liter per minute (LPM). Review of R28's Treatment Administration Record (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,	F 689	MD was contacted and Vaseline order for R 28 was discontinued. No adverse effects were experienced during use of this petroleum agent. All other residents who receive oxygen therapy orders were reviewed for petroleum agent use and their care plans were updated as needed. Future resident oxygen orders will be reviewed and no orders for petroleum based products will be utilized. The MD will be contacted for residents who experience nostril dryness for alternative method of oxygen therapy and/or administer humidified oxygen therapy. Nursing staff was in-serviced on the Oxygen Administration policy indicating to remove all flammable items and ensure that no petroleum based products are added while oxygen is being delivered. Director of nursing and/or designee is responsible for compliance. Audits on oxygen therapy administration orders and resident tolerance will begin 2x wk for 2 weeks, weekly x 2 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review	

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F 689	Continued From page 18 throughout November, with the exception of 11/24/21, in which R28 was noted to not be at the 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. During an interview on 12/1/21, at 1:20 p.m. the director of nursing (DON) stated she was surprised an order for petroleum jelly was to be used in the nostrils for R28. The DON confirmed R28 had an order for petroleum jelly to R28's nostrils and could cause burning if ignited by a spark or flame. The DON stated she would contact R28's primary physician regarding discontinuing the order. Facility policy titled Oxygen Administration (undated), directed staff to remove all potentially flammable items such as lotions, oils, alcohol, and smoking articles from the immediate areas where oxygen was to be administered.	F 689	and recommendation.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must	F 693		1/10/22

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F 693	Continued From page 19 ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a tube feeding was administered as ordered for 1 of 2 residents (R28) who received a tube feeding. Findings include: R28's Admission Record dated 12/2/21, indicated R28's diagnoses included diabetes, rheumatoid arthritis (causes pain, swelling, stiffness, and loss of function in joints), and a pressure ulcer. R28's quarterly Minimum Data Set (MDS) dated 10/27/21, indicated R28 was cognitively intact. R28's MDS lacked indication R28 received a tube feeding. R28's admission care area assessment (CAA) dated 5/7/21, indicated R28 required tube feedings to meet her nutritional needs.	F 693	R 28 MD was notified on 12/1/2021 that enteral feeding was omitted. R 28 did not experience any ill effects from this enteral feeding omission. R 28 oral and enteral feeding order was reviewed along with the care plan. Updates were made as needed. All other residents receiving enteral feeding orders and care plan was reviewed and updated as needed. Future resident enteral feeding administration will be followed per MD order. Licensed Nurses was in-serviced on the enteral feeding policy and procedure with focus on recording the date/time when enteral feeding was hung on the label and that the enteral feeding order was checked against the physician order. Director of nursing and/or designee is responsible for compliance. Audits on enteral feeding administration procedure will begin 2x wk for 2 weeks,	

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F 693	Continued From page 20 R28's care plan dated 7/13/21, indicated R28 was at risk for impaired nutrition and hydration. R28 received a tube feeding to meet her nutritional needs due to a history of dysphasia (difficulty swallowing) and history of aspiration pneumonia. The care plan included several interventions including providing vitamin and mineral supplements, water flushes, and feedings. R28's Order Summary Report dated 11/30/21, directed staff to provide 100 milliliter (mL) water flushes every four hours through a j-tube (soft, plastic tube placed through the skin of the abdomen into the midsection of the small intestine) and Isosource (nutrition formula) 100 mL per hour for 12 hours per day, as tolerated. The tube feeding was to be started at 10:45 a.m. and turned off at 10:45 p.m. During an observation on 11/29/21, at 3:00 p.m. R28's Isosource tube feeding formula was hung on a pole and the feeding pump was shut off. The Isosource formula bottle had 700 mL of solution remaining in the bottle. The tubing connected to the Isosource formula was hung over the pole and not connected to R28. The Isosource formula and tubing lacked a date/time. During an observation on 11/30/21, at 7:25 a.m. R28 was observed sleeping in her bed. R28's bed was at a 25-to-30-degree angle, and she was not connected to the tube feeding at this time. The bottle of Isosource formula lacked a date/time. Dried formula was noted on the end of the tube feeding and 700 mL of formula was noted in the Isosource bottle. At 7:26 a.m. licensed practical nurse (LPN)-C was interviewed and stated she did not disconnect the tube feeding from R28. LPN-C stated it appeared evening shift did not	F 693	weekly x 2 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation.	

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connect R28 to the tube feeding. LPN-C confirmed the tubing connected to the Isosource formula had dried substance on the end.

A progress note dated 11/30/21, at 11:07 a.m. indicated R28's physician was notified of the missed tube feeding (11/29/21) and an order was given to restart the tube feeding and follow a 12 hour on/off cycle.

During an observation on 11/30/21, at 2:25 p.m. R28 was laying in bed and awake. R28 was not connected to the tube feeding. At 2:28 p.m. LPN-C confirmed she did not complete R28's tube feeding during the shift as she was busy.

During an observation on 11/30/21, at 4:00 p.m. R28 still was not connected to the tube feeding.

During an interview on 11/30/21, at 9:30 a.m. medical doctor (MD)-B stated he assessed R28 and provided a verbal order, and later signed an order, to immediately resume R28's tube feeding and monitor for dehydration. MD-B stated there had been multiple occasions at the facility in which orders were not followed, or started, as directed. MD-B stated not starting R28's tube feeding could potentially cause harm and expected the facility to follow orders as given.

During an interview on 12/1/21, at 1:43 p.m. the assistant director of nursing (ADON) stated R28's tube feeding did not get restarted until 10:45 p.m. on 11/30/21. The ADON stated she told LPN-C to immediately start R28's tube feeding and reported the incident to MD-B.

During an interview on 12/1/21, at 1:45 p.m. the director of nursing (DON) stated she expected

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F 693	Continued From page 22 staff to follow orders provided by the physician and nursing supervisor. The DON stated LPN-C should had restarted R28's tube feeding when instructed to do so by the ADON on 11/30/21. The DON stated R28 went more than 24 hours without receiving nutrition. A progress note dated 12/1/21, at 6:41 p.m. indicated MD-B was notified R28 missed a tube feeding. Facility policy titled Enteral Feedings Safety Precautions (undated) directed all staff responsible for preparing, storing, and administering eternal nutrition formulas will be trained, qualified, and competent of responsibilities. Further, staff were directed to date, time, and initial the label when formula was hung and administered.	F 693		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to administer pain medication as ordered by the physician for 1 of 1 resident (R28) reviewed for pain. This resulted in actual harm for R28 who had verbal and physical signs of pain when extended-release narcotic pain medication was crushed and staff did not acknowledge or anticipate the need for pain	F 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	1/10/22

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F 697	Continued From page 23 intervention. Findings include: R28's Admission Record dated 12/2/21, indicated R28's diagnoses included diabetes, pressure ulcer of sacral region (area where the spine connects to the lower half of the body), and absence of right and left leg above knee. R28's quarterly Minimum Data Set (MDS) dated 10/27/21, indicated R28 was cognitively intact and had scheduled pain medications, as needed pain medications, and non-medication interventions. The MDS further indicated pain limited R28's daily activities and she rated her pain at 8 out of 10 (0 to ten scale). R28's Care Area Assessment (CAA) dated 5/13/21, indicated R28 had pain related to rheumatoid arthritis, cervical stenosis (narrowing of the spinal column) with chronic pain, peripheral vascular disease (decreased blood flow to limbs), and neuropathy (damage to the nerves which causes pain). The CAA further indicated R28 took opioids (narcotic pain medication) and staff were directed to administer medications as ordered. Pain impacted R28's ability to sleep at night and she experienced pain frequently. Staff were to administer pain medication 30 minutes prior to treatment and anticipate R28's need for pain relief. Additionally, staff were to respond immediately to complaints of pain and monitor for non-verbal signs of pain. R28 reported her pain was frequently 6 out of 10. R28's care plan dated 5/2/21, indicated R28 received pain medication related to her disease process. The care plan included several	F 697	who are receiving narcotic pain medications were reviewed and their care plan was updated as needed. Future residents will have medications delivered as ordered. Director of nursing and/or designee is responsible for compliance. Nurses and TMA's will be in-serviced on Crushing Medication policy with focus on item #2 that if a medication that shouldn't be crushed, a physician must document reason and an order must be obtained along with medicating residents . Licensed nurses will be in-serviced on the Pain Management Policy and procedure with emphasis on identify cause(s) of pain and request pre-medication pain orders before treatments/therapy etc. to ensure the pain is adequately controlled. Consultant pharmacy will be contacted to perform medication competency and will be scheduled as they are available. Audits on medication administration procedure will begin 2x wk for 2 weeks, weekly x 2 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation.	

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interventions and directed staff to administer analgesic medications, as ordered. Additionally, R28's care plan indicated R28 had chronic pain related to rheumatoid arthritis, diabetic neuropathy and directed staff to administer analgesia 30 minutes prior to treatments or cares and offer nonmedicinal forms of pain relief such as distraction, warm packs, cold packs, and gentle massage.

A Physician's Progress Note dated 11/8/21, indicated R28 had diagnoses of chronic pain, cervical stenosis status post-fusion (surgery to permanently connect two or more vertebrae) and sacral pressure ulcer. The progress note also identified R28's chronic pain was related to cervical myopathy (compression of spinal cord), rheumatoid arthritis, sacral pressure ulcer, upper extremity contracture and immobility.

R28's Order Summary Report printed 12/2/21, at 8:57 a.m. indicated R28 had a tube feeding, was ordered a dysphasia (difficulty swallowing) mechanical soft diet with nectar thick liquids. Staff may have medications crushed with applesauce for easy swallowing.

Review of R28's November 2021 Medication Administration Record (MAR) identified R28 had the following medications ordered for pain:
- Gabapentin Liquid 250 milligrams (mg) /5 milliliter (mL). Give 300 mg (6 mL) by mouth three times a day for neuropathic pain. The order was started on 11/15/21.
- Morphine Sulfate Extended-Release (narcotic pain medication). Give 15 mg by mouth three times a day for chronic pain.
- Acetaminophen (Tylenol) Solution 160mg/5mL. Give 650 mg via g-tube (tube feeding) every six

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hours as needed for pain.
- Prednisone (steroid; reduces inflammation) 5 mg. Give one table via g-tube one time daily for pain. Further, the MAR lacked documentation R28 was administered Prednisone on 11/4/21, 11/5/21, 11/6/21, 11/7/21, 11/8/21, 11/11/21, 11/29/21, and 11/30/21, as the medication was not available.

A Pain Management Progress Note dated 11/29/21, indicated R28 was frustrated with her pain and had pain all day. R28's reported pain in her buttock, leg, and had increased arm pain, which was described as sharp, achy, and sore. R28 received morphine and gabapentin for pain. Further, R28 should continue to work with physical and occupational therapy. R28's morphine sulfate extended release was increased to 15 mg three times a day. Staff was also to continue administering acetaminophen every six hours, as needed. Further, staff were to administer 6 mL of gabapentin 250 mg/5mL three times daily.

During a continuous observation conducted on 11/29/21, from 8:30 a.m. to 11:43 a.m. R28 was noted to be lying flat on her back, in bed, with a pillow to the right of her bed. R28's eyes were closed, and she was noted to be moaning and called out to staff to help. At 10:30 a.m., R28 was moaning, "ouch." At 11:43 a.m., R28 called out for help and stated she had pain. At 11:44 a.m., licensed practical nurse (LPN)-C was notified. Throughout the observation, no staff entered R28's room, nor responded to R28 who was calling out periodically. Three hours and 14 minutes had passed. LPN-C stated they would find a nursing assistant to assist R28.

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During an interview on 11/29/21, at 9:02 a.m. R28 stated she had a lot of pain and it seemed to never be under control. R28 verbalized she was so uncomfortable when staff moved her or provided cares. R28 reported her pain was 8 out of 10 and felt she would be able to manage if her pain was 3 out of 10. R28 stated she did not have a good quality of life because her pain was so bad.

During an observation on 11/30/21, at 9:13 a.m. LPN-C crushed morphine sulfate extended release 15 mg tablet with a pill crusher and placed in a plastic medication cup. After crushing the medications, LPN-C entered R28's room and asked R28 if she had pain and R28 responded, "Yes, I hurt all over." LPN-C proceeded to flush R28's G-tube and connected the syringe to the G-Tube to administer the medications. R28 stated to LPN-C, "I hurt really bad." R28 had facial grimacing and was grunting. LPN-C proceeded to pour multiple medications together in a medication cup, added water in the medication cup, and dumped into the syringe. LPN-C finished medication administration and left the room. During observation LPN-C did not ask R28 to rate her pain or offer non-pharmacological methods of pain relief.

During an interview on 11/30/21, at 9:20 a.m. LPN-C stated all of R28's medications could be crushed because there was an order. LPN-C stated all of R28's medications worked the same way whether crushed, given by mouth, or via tube feeding. LPN-C explained on days she passed medications to R28; she crushed all pills as there was an order from the physician. LPN-C stated she was not aware morphine sulfate extended release was not supposed to be crushed or

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impacted pain relief. LPN-C also confirmed she did not offer as needed acetaminophen to R28 or other methods of pain relief to keep R28 comfortable.

Subsequent review of R28's November 2021 Medication Administration Record (MAR) indicated licensed practical nurse (LPN)-C administered extended-release morphine to R28 on 11/15/21, 11/16/21, 11/17/21, 11/19/21, 11/24/21, 11/25/21, 11/26/21, 11/29/21, and 11/30/21. For each of these administrations, R28's pain was rated from 3 to 5 out of 10 (using a 0 to 10 scale).

During an observation on 11/30/21, at 9:41 a.m. R28 was observed lying in bed and was provided a bed bath by nursing assistant (NA)-A. R28 complained of pain when repositioned and when her right arm was moved. R28 also had noted facial grimacing when she received cares.

During an interview on 11/30/21, at 9:50 a.m. NA-A stated R28 had a lot of pain and R28's pain was worse when staff attempted to perform cares such as incontinence cares or bathing. NA-A confirmed R28 yelled out in pain throughout the day and when her right arm was touched.

During an interview on 11/30/21, at 1:55 p.m. medical doctor (MD)-A stated he was not aware R28's extended-release morphine was being crushed or given via a tube feeding. MD-A stated nursing staff should not crush extended-release morphine as all the medication would release all at once and not provide coverage for pain as it should. MD-A stated R28 could also receive too much morphine at once instead of receiving the medication slowly over time. This could cause

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serious breathing problems or relate to R28's concerns regarding poor pain control. MD-A stated they did not feel the facility provided appropriate pain control and management for R28.

During an interview on 11/30/21, at 4:25 p.m., the consultant pharmacist (CP) stated crushing extended-release morphine possibly could not cover the length of time needed and caused R28 to not have complete coverage for her chronic pain. The CP stated the peak (highest level of a medication in the blood) for immediate release morphine was one hour and extended release was three hours. If extended-release morphine was crushed it would peak between one and three hours and not last the full 12 hours as intended and cause inadequate pain management.

During an observation on 12/1/21, at 12:00 p.m. R28 was provided wound care to her stage IV pressure ulcers and moaned and complained of pain when repositioned. R28 was tearful and was noted to flinch and had facial grimacing when touched. R28 verbalized she had pain in her chest and arms. R28 was not observed to be offered pain medication prior to wound care.

Subsequent review of R28's November 2021 and December 2021 MAR indicated R28 was administered as needed Acetaminophen Solution 160mg/5mL (650 mg) on 11/12/21, 11/14/21, 11/15/21, and 11/26/21. There was no indication Acetaminophen was consistently used prior to dressing changes or other times when R28 identified she was having pain.

During an interview on 12/1/21, at 1:42 p.m. the

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F 697	Continued From page 29 director of nursing (DON) stated she was not aware R28's extended-release morphine was crushed. If crushed, may not provide pain relief as indicated or a resident could receive too much medication at once. The DON stated she expected staff to administer medication as ordered and follow-up with the physician if pain impacted a resident's quality of life. During an interview on 12/1/21, at 12:25 p.m. MD-C stated R28 had a lot of pain during wound care visits. MD-C stated she had given direction to staff to manage R28's pain so she could be repositioned every two hours, sit up in her wheelchair, and have less pain during wound care. MD-C stated during her visit today with R28, she had complained of pain. Facility policy titled Activities of Daily Living (ADLs) undated, directed to offer alternative interventions to minimize functional decline and include appropriate pain management.	F 697		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide comprehensive assistance with potential discharge planning for 1 of 1 resident (R500) who had ongoing allegations of sexually inappropriate behavior towards female residents (R501).	F 745	R 500 remains a resident at the facility. Resident care plan and MDS was reviewed and updated as needed. As of this writing, no further allegations have been recorded or reported for R 500. R 500 will meet with Social Service and discuss plans for discharge from the	1/10/22

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F 745	Continued From page 30 Findings include: R500's quarterly Minimum Data Set (MDS) dated 11/12/21, identified R500 had a severe cognitive impairment and was independent with all activities of daily living (ADLs). R500's diagnoses included age-related cognitive decline and alcohol abuse. R500's care plan revised on 9/23/21, identified R500 was, "At risk of abusing others r/t [related to] poor impulse control, alcohol induced dementia, level 1 sex offender." The care plan also included, "On 8/27/21 resident accused of touch[ing] another resident inappropriately near south hall." On 9/23/21, "accused of kissing." The care plan instructed staff to, "Redirect away from female residents," "Assist in looking [for] alternative placement," If staff hear [R500] making sexual gestures tell him to stop and redirect him back to his room," "If staff see [R500] enter a female resident's room, remove resident immediately," [R500] is not to be in any other hall besides South hall without supervision," and "[R500] will not enter north hall, will stay away from female resident" related to allegations of inappropriate behavior. A Behavior Contract signed by R500 on 11/13/20, outlined, "Boundaries related to allegations of inappropriate behavior: - Refrain from touching any female resident, even if they request a hug from you. - Refrain from entering female resident's rooms. - When in commons areas refrain from making sexual comments or gestures. A progress note dated 9/3/21, at 3:04 p.m. included, "Met with resident, reviewed concerns	F 745	facility. All other residents pending discharge will be reviewed and discharge planning will be documented. Future residents will be assessed upon admission for discharge plans and discharge potential will be care plan and reviewed per policy. Social Services designee will be in-serviced on the transfer, discharge policy and procedure with emphasis on notification 30 days in advance for impending discharge and assistance with all aspects addressed for the needs of the resident. Social Services and/or designee will be responsible for compliance. Audits on resident discharge planning procedure will begin 2x wk for 2 weeks, weekly x 2 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation.	

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	245544	A. BUILDING _____ B. WING _____	C 12/02/2021

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F 745	Continued From page 31	F 745		

with female residents. Reviewed recommendations for transition to another facility with males."

A progress note dated 9/23/21, at 1:47 p.m. included, "Spoke with resident and daughter, reviewed transition to another facility. Daughter expressed understanding and knowing it ws in his best interest."

A Mental Health Provider Progress Note dated 9/24/21, included, "A resident reported seeing [R500] kiss a female resident who he has previously shown interest in and who has stated she is not interested." "Staff continue to work to find an all-male placement for [R500]. [R500] is 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

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F 745	Continued From page 32	F 745		

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 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 facility or group home.

During an interview on 11/30/21, at 4:07 p.m. the director of rehabilitation services stated it would "be reasonable" to consider R500 for transfer to an alternative level of care such as assisted living or a group home considering R500's independence with ADLs.

During an interview on 12/2/21, at 10:50 a.m. with the administrator and assistant director of nursing (ADON) the administrator stated the facility had implemented interventions which included pursing alternative placement for R500 at an all-male facility. The ADON added the interdisciplinary team had agreed to this intervention to mitigate ongoing risk of inappropriate interaction with the facility's female residents. The administrator thought referrals to transfer R500 had been sent to multiple all-male care facilities, but had been declined at each facility due to being a registered sex offender. The ADON added it would be appropriate to assess R500's care needs to

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F 745	Continued From page 33 determine if he could transfer to an assisted living or group home. The administrator stated if SW-A was unsuccessful with implementing a behavior intervention he would expect the information to be shared with the interdisciplinary team for brainstorming. The facility Transfers and Discharges Policy dated 2001, included, "Each resident will be permitted to remain in the facility, and not be transferred or discharged unless: ... C. the safety of individuals in the facility is engaged due to the clinical or behavioral status of the resident."	F 745		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders and professional standards of practice for 1 of 2 residents (R28) observed to receive medication during the survey. This resulted in a facility medication administration error rate of 30% (percent). Findings include: R28's Admission Record dated 12/2/21, indicated R28's diagnoses included diabetes, pressure ulcer of sacral region (area where the spine connects to the lower half of the body), and	F 759	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 on the medication administration policy and enteral administration policy and	1/10/22

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F 759	Continued From page 34 absence of right and left leg above knee. A Physicians Order dated 7/26/21, indicated R28 may have their medication crushed and given with applesauce for easy swallowing. Review of R28's November 2021 Medication Administration Record (MAR), indicated staff were to administer the following medications by mouth: - Cefuroxime Axetil (antibiotic). Give one tablet by mouth two times a day for infection. - Doxycycline 100 milligram tablet. Give 100 milligrams by mouth every 12 hours for bone and joint infection. - Morphine sulfate (pain medication) extended-release tablet 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 2021 MAR further indicated the following medications were to be administered via g-tube (tube feeding): - Prednisone (steroid) 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 pressure. - Duloxetine 20 mg tablet. Give 1 tablet via g-tube every Tuesday for depression. - Metoprolol Tartrate. Give 50 mg via g-tube two times daily for high blood pressure. On 11/30/21, at 9:13 a.m. licensed practical nurse (LPN)-C was observed preparing medications for R28 which included:	F 759	procedure with emphasis on administering per physician order and medications that need crushing must have a specific order, not to administer medications directly into the tube and administering each medication separately. Director of Nursing and/or designee will be responsible for compliance. Audits on medication administration procedure will begin 2x wk for 2 weeks, weekly x 2 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation.	

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F 759	Continued From page 35 - Cefuroxime Axetil - Amlodipine 5 mg - Duloxetine 20 mg - Doxycycline 100 mg - Morphine sulfate extended-release 15 mg - Famotidine 20 mg - Metoprolol Tartrate 50 mg - Gabapentin 6 mL 250mg/5mL give 300 mg - 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. During an interview on 11/30/21, at 9:13 a.m. LPN-C stated all medications could be crushed for R28 because there was an order. LPN-C also stated she was late with medication administration and confirmed Prednisone 5 mg tablets were not available. At 9:20 a.m. LPN-C confirmed she poured gabapentin into a plastic medication cup and had estimated 6 mL. LPN-C	F 759		

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F 759	Continued From page 36	F 759		

stated she should had used a syringe, but one was not available. LPN-C stated she could had given R28 too much gabapentin it not measured accurately. Further, she knew R28 had an order to crush medications, but was not aware to order was to place the medication in applesauce and give by mouth. LPN-C stated the physicians order should be followed and the physician should be asked if there were questions. LPN-C confirmed all oral medications were cocktailed and given via g-tube.

During an interview on 11/30/21, at 1:55 p.m. medical doctor (MD)-A stated he expected staff to give medications as ordered to ensure proper absorption and relief of symptoms.

During an interview on 12/1/21, at 9:00 a.m. the consulting pharmacist (CP) stated staff were expected to administer medication based on the physician order. The CP stated it was best practice to use a syringe when drawing up gabapentin to ensure the dose was correct.

During an interview on 12/1/21, at 9:30 a.m. MD-B stated he expected the facility to follow medication orders as directed. If medications were ordered by mouth, then they should be given by mouth. If a resident had a change in condition, the physician should be notified and request a change or to review orders. MD-B stated the nurse should had clarified orders with the physician.

During an interview on 12/1/21, at 1:42 p.m. the director of nursing (DON) stated she expected staff passing medication to check orders, check medication, and then check again. Further, she expected staff to ensure the right person, right

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F 759	Continued From page 37 dose, right medication, right route, and right time before medications were administered. If an individual had questions about an order, they should ask prior to administration. The DON stated medications which were crushed and given via a tube feeding, rather than by mouth, were considered a medication error. Further, LPN-C should not estimate a dose of gabapentin. The DON stated LPN-C would need to write up medication errors and she would provide staff education and guessed all staff made the same error. Facility policy titled Administering Oral Medications (undated) directed the individual administering medication to verify physician orders, review the care plan, and assess for special needs.	F 759		

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

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,

Kamala Fiske-Downing

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

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/29/21, through 12/2/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5544247C (MN00065151), with a deficiency cited at 0920. H5544239C (MN00066995), MN00067027), with deficiencies cited at 0930 and 1545. Additional deficiencies were identified and 0830. H5544278C (MN00078872), with a deficiency cited at 0265. H5544248C (MN00071021), with a deficiency cited at 0920. H5544252C (MN00068284), with a deficiency cited at 0265. H5544279C (MN00078922), with a deficiency cited at 0265 and 0900. The following complaints was found to be SUBSTANTIATED, however, NO deficiencies were cited due to actions implemented by the facility prior to survey: H5544271C (MN00058115), H5544253C (MN00067762), H5544122C (MN00060108), H5544267C (MN00060483), H5544276C (MN00068073), H5544237C (MN00075523), and H5544259C (MN00077584). The following complaints were found to be UNSUBSTANTIATED, however, related deficiencies were cited: H5544242C (MN00077000) with a deficiency cited at 1475. The following complaints were found to be UNSUBSTANTIATED: H5544256C (MN00055236), H5544236C (MN00057021), H5544273C (MN00057643), H5544272C (MN00057811), H5544270C (MN00058601), H5544268C (MN00060411), H5544266C (MN00060990), H5544265C (MN00061562), H5544269C (MN00058685),	2 000		

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2 000	Continued From page 2 H5544249C (MN00061566), H5544251C (MN00062019), H5544257C (MN00063321), H5544245C (MN00063651), H5544246C (MN00063846), H5544243C (MN00064999), H5544255C (MN00066066), H5544254C (MN00066083), H5544244C (MN00067088), H5525275C (MN00069148), H5544250C (MN00071065), H5544254C (MN00071120), H5544263C (MN00071185), H5544238C (MN00075552), H5544235C (MN00076082), H5544262C (MN00077139, MN00076989). H5544261C (MN00077301), H5544260C (MN00077317), H5544241C (MN00077689), H5544240C (MN00077755), H5544274C (MN00077826), H5544258C (MN00077787), and H5544277C (MN00078748). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota	2 000		

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

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2 000	Continued From page 3 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention;	2 265		1/10/22

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2 265	Continued From page 4 B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician a resident was transferred to the hospital 1 of 4 residents (R29) reviewed for change of condition. Findings include: 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. Review of R29's progress notes revealed the following: - 11/22/21, at 11:16 p.m. indicated R29 was hospitalized. - 11/26/21, at 9:64 a.m. indicated R29 was at the hospital on observation status. R29 had complaints of vision changes, was ruled out for a Clostridioides difficile infection (bacteria which	2 265	Corrected	

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2 265	Continued From page 5	2 265		

causes severe diarrhea and inflammation of the colon) and had no new diagnoses.

Review of R29's medical record lacked indication the physician was notified R29 was transferred to the hospital.

During an interview on 12/1/21, at 3:18 p.m. social worker (SW)-A stated R29 was transferred to the emergency department on 11/22/21, and was placed on observation status at the hospital with a chief complaint of vertigo and failure to thrive.

During an interview on 11/30/21, at 1:35 p.m. LPN-B stated R29 refused to take any medications on 11/22/21, and had notified the provider. R29 was not aware of any other concerns regarding R29 during their shift and verbalized they were not aware R29 was transferred to the hospital.

During an interview on 11/30/21, at 2:50 p.m. licensed practical nurse (LPN)-A stated he observed R29 near the facility entrance on 11/30/21, at approximately 3:00 p.m. calling 911 when arriving for his shift. He was notified R29 had already left for the hospital when he started his shift, however, did not receive any detail regarding why R29 went to the hospital.

During an interview on 12/1/21, at 10:59 a.m. physician assistant (PA)-A stated there were no call notes dictated on 11/22/21, indicating R29 was at the hospital, however there was a note LPN-B called to request R29 be rounded on as the resident, did not seem like themselves. PA-A stated they learned of R29's hospitalization during chart review on 11/26/21, or 11/29/21, when preparing for a visit. PA-A stated staff were

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2 265	Continued From page 6 expected to notify the provider, or call center, when a resident was transferred to the hospital and further verbalized the lack of notification was not an isolated incident for the facility. PA-A stated she did not know what lead to R29's hospitalization. During an interview on 12/2/21, at 10:10 a.m. the director of nursing (DON) stated she did not know why R29 was hospitalized or the events leading up to R29 going to the hospital. The DON verified R28's medical record lacked indication of why R29 was hospitalized or subsequent provider notification. The DON stated she expected staff to notify providers and document the notification. Facility policy titled A Change in a Resident's Condition or Status (undated), indicated the facility would promptly notify the physician of a resident's medical change or change in condition/status. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise policies to ensure medical providers are notified when a resident has a change of condition and/or sent to the hospital.. The DON, or designee, could then educate staff on the policies and procedures and develop system for evaluating and monitoring consistent implementation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must	2 830		1/10/22

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2 830	Continued From page 7 receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure oxygen was administered in accordance with acceptable standards of practice to reduce the likelihood of potential accident hazards for 1 of 1 resident (R28) who was administered oxygen therapy. Findings include: R28's Admission Record dated 12/2/21, indicated R28's diagnoses included pneumonitis (inflammation of lung tissue) and chronic respiratory failure. R28's Order Summary Report dated 11/30/21, directed staff to apply a small amount of Vaseline into both of R28's nostrils twice daily for dryness. R28's care plan dated 9/17/21, indicated R28 received oxygen therapy related to ineffective gas exchange and directed staff to administer oxygen at l liter per minute (LPM). Review of R28's Treatment Administration Record	2 830	Corrected	

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2 830	Continued From page 8 (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 the 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. During an interview on 12/1/21, at 1:20 p.m. the director of nursing (DON) stated she was surprised an order for petroleum jelly was to be used in the nostrils for R28. The DON confirmed R28 had an order for petroleum jelly to R28's nostrils and could cause burning if ignited by a spark or flame. The DON stated she would contact R28's primary physician regarding discontinuing the order. Facility policy titled Oxygen Administration (undated), directed staff to remove all potentially flammable items such as lotions, oils, alcohol, and smoking articles from the immediate areas where oxygen was to be administered. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise polices and procedures regarding safe administration of oxygen as it relates to using non-flammable substances in conjunction with therapy. The DON, or designee,	2 830		

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2 830	Continued From page 9 could then educate staff and develop a monitoring system to ensure residents receive the appropriate care. TIME FRAME FOR CORRECTION: Twenty-one (21) Days	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess and implement interventions as ordered by the physician to promote healing and reduce the risk of complications of an existing pressure ulcer for 1 of 3 residents (R28) reviewed for pressure ulcers. The resulted in actual harm for R28 who had a worsening stage IV pressure ulcer.	2 900	Corrected	1/10/22

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2 900	Continued From page 10 Findings include: Pressure Ulcer Definition: Stage IV Tissue loss with exposed bone, tendon, or muscle. Slough or eschar (Dead tissue that is hard or soft in texture, usually black, brown, or tan in color, and may appear scab-like. Eschar tissue is usually firmly adherent to the base of and wound and often the sides/edges of the wound), may be present. It often includes undermining (outwardly visible wound margins) and tunneling (passageways underneath the surface of the skin). R28's Admission Record dated 12/2/21, indicated R28's diagnoses included diabetes, pressure ulcer of sacral region (area where the spine connects to the lower half of the body), and absence of right and left leg above knee. R28's quarterly Minimum Data Set (MDS) dated 10/27/21, indicated R28 was cognitively intact and had no documented rejection of care. R28 was totally dependent of two staff with bed mobility, transfers, and toilet use. R28 had an impairment to both upper and lower extremities and was always incontinent of bowel. R28 had three documented stage IV pressure ulcers which were present upon admission. Several treatments were noted which included pressure reducing device for chair and bed. R28s Care Area Assessment (CAA) dated 5/7/21, indicated R28 was totally dependent of staff for bed mobility, dressing, toilet use, and personal hygiene. The CAA further indicated R28 required a total assist of two staff, with the use of hoyer lift	2 900		

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2 900	Continued From page 11 to transfer Further, R28 required extensive assistance of two staff to turn and reposition in bed every two hours and as necessary. R28's care plan dated 9/19/21 indicated R28 had stage IV pressure ulcers on her sacrum right ischium (lower back part of the hip bone), and left ischium. The care plan further identified R28 had the potential to develop additional pressure ulcers related to incontinence, immobility, and weakness. R28's care plan included several interventions including to conduct weekly skin assessments and provide wound care per orders. R28's care plan was revised on 12/2/21, to include assisting R28 to sit up in tilt-in-space wheelchair with a pressure reducing cushion for mealtimes. R28 was not to exceed two hours of sitting to offload pressure. R28's Order Summary Report dated 12/2/21, indicated staff were to offload R28, per facility protocol, and "maybe" up in chair two hours per day and an additional one hour after a two-hour break in the morning and afternoon. Further, R28 was to be repositioned every two hours and have weekly skin checks completed every Tuesday morning. R28's wound care orders included: - Right/left ischium and sacrum wound care: Make sure all pieces of silver alginate (product used to promote wound healing) were removed from the wound bed. Saturate 4 x 4 gauze with Vashe (wound cleanser). The saturated gauze was then to be placed in R28's wound beds and undermining areas and allow to sit for five minutes. Remove (gauze) and place silver alginate. Place a foam boarder dressing in the morning. An Interdisciplinary team (IDT) progress note dated 12/1/21, at 7:17 p.m. indicated R28 was	2 900		

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2 900	Continued From page 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.

R28's Wound Physician Progress Note written by medical doctor (MD)-C dated 11/18/21, revealed the following:
- R28's stage IV sacral pressure wound measured 3.5 centimeters (cm.) x 3.0 cm. x 2.0 cm. with undermining of 5.0 cm. at the three o'clock position. The wound had 80 percent granulation (new tissue), 20 percent muscle and fascia (thin casing of connective tissue which holds muscle in-place), and moderate serous exudate (clear, thin, and watery fluid). R28's stage IV pressure wound to her left ischium measured 1.0 cm. x 1.0 cm. x 1.5 cm with abnormal granulation present within the wound margins. R28's stage IV pressure wound to her right ischium measured 0.8 cm. x 0.8 cm. x 1.0 cm with 100 percent granulation present. Recommendations included offloading the wound and repositioning per facility protocol. R28 may be up for two hours in their chair and one hour after a two-hour break.

Review of R28's November 2021 Task Record, revealed no transferring/bed mobility was not documented for 46 of 87 opportunities. There were no documented refusals.

Review of R28's December 2021 Task Record, revealed no transferring/bed mobility was not documented for 2 of 3 opportunities. There were no documented refusals.

Review of R28's Weekly Skin Check Progress

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2 900	Continued From page 13 notes revealed: - 11/19/21, at 3:50 p.m. indicated R28 was on a turning and repositioning program and had a coccyx wound. The progress note lacked assessment of R28's wound. - No additional documentation was provided, when requested, for skin assessments on 11/1/21, 11/8/21, and 11/22/21. During a continuous observation conducted on 11/29/21, from 8:30 a.m. to 11:43 a.m. R28 was noted to be laying flat on her back, in bed, with a pillow to the right of her bed. R28's eyes were closed, and she was noted to be moaning and called out to staff for help. At 10:30 a.m., R28 was moaning, "ouch." At 11:43 a.m., R28 called out for help and stated she had pain. At 11:44 a.m., licensed practical nurse (LPN)-C was approached and advised R28 had not been repositioned since the continuous observation began at 8:30 a.m. LPN-C stated she would notify a nursing assistant. Throughout the observation, no staff entered R28's room, nor responded to R28 who was calling out periodically. Three hours and 13 minutes had passed. During an observation on 11/29/21, at 10:25 a.m. LPN-B provided wound care to R28. R28 reported she had pain and noted facial grimacing when repositioned to her left side and throughout wound care. R28's dressing was noted to be completely saturated with bloody red drainage which also soaked through to R28's incontinence product and the sheet below her. Further, R28 was also observed to have four Zoll electrocardiogram (EKG) electrodes on her back which were removed by LPN-B. LPN-B stated the Zoll electrodes must had been on R28's back since her emergency department visit on 11/24/21. LPN-B removed the old dressing from	2 900		

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2 900	Continued From page 14 the sacral, right, and left ischium pressure wounds. LPN-B then poured a small amount of Vashe solution on gauze and placed the gauze on R28's sacral and right and left ischium pressure wounds. The gauze was not completely saturated with Vashe solution. After roughly five minutes, the gauze was removed and LPN-B applied silver alginate to R28's sacral, right, and left ischium pressure wounds. The piece silver alginate was cut round and roughly 1.5 inches in diameter and did not cover the entire wound bed of the sacral wound. LPN-B then covered R28's wounds with a foam dressings. Immediately following the dressing change LPN-B stated she was not aware the gauze needed to be saturated with Vashe solution or the silver alginate dressing needed to cover the entire wound bed. During an interview on 11/30/21, at 12:45 p.m. the assistant director of nursing (ADON) stated she started a performance improvement plan for wound care and assessments as she discovered concerns regarding how wounds were being assessed, staff roles and responsibilities, and providing wound care as directed by the medical provider. The ADON stated R28 had not been assessed by a wound provider for a few weeks as she fell off the list to be evaluated after being transferred to the emergency department on 11/24/21. During an observation on 12/1/21, at 10:00 a.m. the director of nursing (DON) and assistant director of nursing provided wound care to R28's sacral and right and left ischium pressure wounds. The ADON assisted R28 to reposition to her left side and removed an incontinence product. The DON removed the dressings which had a large copious amount of yellow/brown non-odorous drainage with blood which soaked	2 900		

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2 900	Continued From page 15	2 900		

through the dressing. The DON cleansed the outside of the sacral pressure wound and applied Vashe soaked gauze to R28's wound beds for five minutes. The DON then removed the gauze and inserted silver alginate into R28's wounds. The silver alginate did not cover the entire wound bed where undermining was located. The DON then applied a foam dressing.

During an interview on 12/1/21, at 1:45 p.m. the director of nursing (DON) stated when she observed R28's dressing change on 11/30/21, it appeared wound care was not completed as ordered. She confirmed the silver alginate dressing did not cover R28's entire wound bed, as directed, and fluid had saturated through R28's dressing and onto R28's incontinence product. The DON described the drainage as bloody discharge and stated R28's wound bed lacked granulation upon her wound assessment today which was noted on previous assessments. The DON confirmed R28's wound had worsened and included several reasons which included weekly skin checks not being completed, lack of timely repositioning, and no consistent wound care. The DON also stated R28 had stool on her incontinent product and sheet when wound care was completed on 11/30/21, and staff needed to ensure R28 was kept clean. Further, the DON stated staff were not reporting to the nurse when bandages became soiled and needed to be changed.

During an observation on 12/2/21, at 12:00 p.m. MD-C, the ADON, and LPN-D provided wound care to R28. LPN-D assisted R28 reposition to her left side. R28 expressed pain to MD-C and had facial grimacing. The ADON removed R28's incontinence product and subsequently removed R28's old dressing located on the sacrum and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 16 right and left ischium pressure wounds. R28 had small amount of light brown colored stool noted on her incontinence product. Stool was also noted on R28's skin roughly three inches from the sacral wound. The ADON proceeded to cleanse the skin with wound cleanser. MD-C assessed R28's wounds and additional pieces of silver alginate were noted in the sacral wound. MD-C told the ADON and LPN-D to use a cotton tipped applicator to assess the wound and ensure all pieces of silver alginate were removed. MD-C inserted Vashe soaked gauze into R28's wound beds for five minutes. MD-C hen removed the gauze and completely covered R28's pressure wounds with silver alginate. The wounds were then covered with a foam dressing. MD-C then stated to the ADON and LPN-D to ensure a full piece of alginate was used so it completed covered the entire wound bed to promote proper healing. MD-C also instructed staff to offload R28 completely. Immediately following the observation, MD-C was interviewed and stated R28's sacral wound had deteriorated from when she had assessed R28's wounds two weeks ago. R28's sacral pressure ulcer and measurements increased in length and the amount of tunneling. MD-C attributed worsening tunneling to not being fully repositioned or not being repositioned every two hours. MD-C stated the reasons for wound deterioration included: need to offload the wound, continuity of wound care, and incontinence care. MD-C stated during her visit today, R28 had stool in her incontinence product and staff left the stool on R28's skin when wound care was provided. MD-C stated she expected the facility to reposition R28 every two hours, provide R28 a wheelchair cushion, provide good incontinence care, and change dressings immediately if soiled.	2 900		

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2 900	Continued From page 17 A subsequent Wound Physician Progress Note written by MD-C dated 12/2/21, revealed the following: - R28's stage IV sacral pressure wound measured 3.5 cm. x 4.0 cm. x 1.5 cm. Moderate serous excaudate was noted with 10 percent slough (dead tissue) and 90 percent granulation. Further, the wound had undermining which measured 5.5 cm at the three o'clock position, 4.5 cm. at the nine o'clock position, and 7.5 cm. at the 12 o'clock position. R28's sacral wound had "deteriorated" since her last visit on 11/18/21. R28's wound was debrided of 1.4 cm. of devitalized tissue (non-viable) at a depth of 1.6 cm. Facility policy titled Pressure Injury Treatment (undated) directed to provide care of existing pressure injuries and the prevention of additional injuries. Staff were to review the residents care plan and assess for any special needs of the resident, pressure injury care, current support surfaces, and status of the injury. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise policies on pressure ulcer prevention and treatment. The DON, or designee, could then educate staff on the facility's policies and procedures. A system for evaluating and monitoring consistent implementation could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

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2 920	Continued From page 18	2 920		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assistance with hygiene was provided for 1 of 3 residents (R28) who was dependent upon staff for activities of daily living (ADL). Findings include: R28's Admission Record dated 12/2/21, indicated R28 had diagnoses which included rheumatoid arthritis (causes pain, swelling, stiffness, and loss of function in joints) and chronic pain syndrome. R28's quarterly Minimum Data Set (MDS) dated 10/27/21, indicated R28 was cognitively intact and had no documented rejection of care. R28 was totally dependent of two staff for bed mobility, transfers, toilet use, and personal hygiene. R28 had impairments of both upper and lower extremities and was always incontinent of bowel. R28's care plan dated 5/2/21, identified R28 had an ADL self-care deficit related to bilateral above knee amputations, a sacral wound (area where the spine connects to the lower half of the body), weakness, and rheumatoid arthritis. Staff were directed to provide assistance with all hygiene	2 920	Corrected	1/10/22

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2 920	Continued From page 19 cares, assist with toileting, bathing, and dressing. Review of R28's ADL Task Record dated 11/30/21, indicated from 11/1/21, through 11/30/21, staff documented hygiene was completed for 16 of 87 opportunities. There were no documented refusals and R28 was hospitalized on 11/24/21. Review of R28's ADL Task Record Record dated 12/2/21, indicated from 12/1/21, staff documented was completed for 1 of 3 opportunities. There were no documented refusals. During an observation on 11/29/21, at 9:00 a.m. R28 was observed laying in bed on her back with a pillow slightly under her right side. R28's fingernails were roughly two inches long and a brownish/black residue was noted under her fingernails. R28's skin was dry and flaking on her hands. R28's gums were noted to be red in color with breath had a noticeable odor. Further, R28's tongue was coated with a whitish/yellow colored thick film. During an observation on 11/30/21, at 9:41 a.m. R28 laying in bed and provided a bed bath by nursing assistant (NA)-A. NA-A did not offer nail care or oral care throughout the observation. NA-A stated the evening or night shift can provide oral cares and nail care. Further, R28's long nails needed to be cut or cleaned because of dirt underneath. During an interview on 11/30/21, at 2:28 p.m. licensed practical nurse (LPN)-C stated it was the responsibility of nursing assistants to provide ADL cares. She stated a resident's care plan directed staff of the care R28 required every day. LPN-C further stated she saw dirt build up under R28's	2 920		

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2 920	Continued From page 20 nails. During an observation on 12/1/21, at 9:39 a.m. R28's fingernails remained roughly two inches long with browning/black residue underneath. During an interview on 12/1/21, at 10:00 a.m. R28 stated no one had cleaned her fingernails or provided oral cares for many days; maybe sometime the previous week. R28 stated she previously brushed her teeth daily when she was able to do it on her own. R28 expressed she would like to have her nails cleaned and oral cares provided. During an interview on 12/1/21, at 1:45 p.m. the assistant director of nursing (ADON) stated she was unaware oral cares 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 refusing cares. The DON stated nursing assistants should provide daily personally hygiene care and document refusals. Her expectation was for personal hygiene cares to be completed every shift and as needed. The DON stated she felt there was enough staff to complete cares, but the facility culture was nurses did not always want to help nursing assistants. The DON confirmed she knew R28's fingernails were long. Facility policy titled Activities of Daily Living (ADL's) (undated) directed residents who were unable to carry out ADLs independently would receive services to maintain good nutrition, grooming, and personal and oral hygiene. SUGGESTED METHOD OF CORRECTION: The	2 920		

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2 920	Continued From page 21 director of nursing (DON), or designee, could review applicable procedures and policies to ensure residents are provided oral care and nail care with personal hygiene/grooming in a timely manner; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a tube feeding was administered as ordered for 1 of 2 residents (R28) who received a tube feeding. Findings include: R28's Admission Record dated 12/2/21, indicated	2 930	Corrected	1/10/22

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2 930	Continued From page 22 R28's diagnoses included diabetes, rheumatoid arthritis (causes pain, swelling, stiffness, and loss of function in joints), and a pressure ulcer. R28's quarterly Minimum Data Set (MDS) dated 10/27/21, indicated R28 was cognitively intact. R28's MDS lacked indication R28 received a tube feeding. R28's admission care area assessment (CAA) dated 5/7/21, indicated R28 required tube feedings to meet her nutritional needs. R28's care plan dated 7/13/21, indicated R28 was at risk for impaired nutrition and hydration. R28 received a tube feeding to meet her nutritional needs due to a history of dysphasia (difficulty swallowing) and history of aspiration pneumonia. The care plan included several interventions including providing vitamin and mineral supplements, water flushes, and feedings. R28's Order Summary Report dated 11/30/21, directed staff to provide 100 milliliter (mL) water flushes every four hours through a j-tube (soft, plastic tube placed through the skin of the abdomen into the midsection of the small intestine) and Isosource (nutrition formula) 100 mL per hour for 12 hours per day, as tolerated. The tube feeding was to be started at 10:45 a.m. and turned off at 10:45 p.m. During an observation on 11/29/21, at 3:00 p.m. R28's Isosource tube feeding formula was hung on a pole and the feeding pump was shut off. The Isosource formula bottle had 700 mL of solution remaining in the bottle. The tubing connected to the Isosource formula was hung over the pole and not connected to R28. The Isosource formula and tubing lacked a date/time.	2 930		

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2 930	Continued From page 23 During an observation on 11/30/21, at 7:25 a.m. R28 was observed sleeping in her bed. R28's bed was at a 25-to-30-degree angle, and she was not connected to the tube feeding at this time. The bottle of Isosource formula lacked a date/time. Dried formula was noted on the end of the tube feeding and 700 mL of formula was noted in the Isosource bottle. At 7:26 a.m. licensed practical nurse (LPN)-C was interviewed and stated she did not disconnect the tube feeding from R28. LPN-C stated it appeared evening shift did not connect R28 to the tube feeding. LPN-C confirmed the tubing connected to the Isosource formula had dried substance on the end. A progress note dated 11/30/21, at 11:07 a.m. indicated R28's physician was notified of the missed tube feeding (11/29/21) and an order was given to restart the tube feeding and follow a 12 hour on/off cycle. During an observation on 11/30/21, at 2:25 p.m. R28 was laying in bed and awake. R28 was not connected to the tube feeding. At 2:28 p.m. LPN-C confirmed she did not complete R28's tube feeding during the shift as she was busy. During an observation on 11/30/21, at 4:00 p.m. R28 still was not connected to the tube feeding. During an interview on 11/30/21, at 9:30 a.m. medical doctor (MD)-B stated he assessed R28 and provided a verbal order, and later signed an order, to immediately resume R28's tube feeding and monitor for dehydration. MD-B stated there had been multiple occasions at the facility in which orders were not followed, or started, as directed. MD-B stated not starting R28's tube feeding could potentially cause harm and	2 930		

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2 930	Continued From page 24 expected the facility to follow orders as given. During an interview on 12/1/21, at 1:43 p.m. the assistant director of nursing (ADON) stated R28's tube feeding did not get restarted until 10:45 p.m. on 11/30/21. The ADON stated she told LPN-C to immediately start R28's tube feeding and reported the incident to MD-B. During an interview on 12/1/21, at 1:45 p.m. the director of nursing (DON) stated she expected staff to follow orders provided by the physician and nursing supervisor. The DON stated LPN-C should had restarted R28's tube feeding when instructed to do so by the ADON on 11/30/21. The DON stated R28 went more than 24 hours without receiving nutrition. A progress note dated 12/1/21, at 6:41 p.m. indicated MD-B was notified R28 missed a tube feeding. Facility policy titled Enteral Feedings Safety Precautions (undated) directed all staff responsible for preparing, storing, and administering eternal nutrition formulas will be trained, qualified, and competent of responsibilities. Further, staff were directed to date, time, and initial the label when formula was hung and administered. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable procedures and policies to ensure residents are receiving tube feedings as ordered. The DON, or designee, could then educate staff and implement a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 930		

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2 930	Continued From page 25 (21) days.	2 930		
21475	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide comprehensive assistance with potential discharge planning for 1 of 1 resident (R500) who had ongoing allegations of sexually inappropriate behavior towards female residents (R501). Findings include: R500's quarterly Minimum Data Set (MDS) dated 11/12/21, identified R500 had a severe cognitive impairment and was independent with all activities of daily living (ADLs). R500's diagnoses included age-related cognitive decline and alcohol abuse. R500's care plan revised on 9/23/21, identified R500 was, "At risk of abusing others r/t [related to] poor impulse control, alcohol induced dementia, level 1 sex offender." The care plan also included, "On 8/27/21 resident accused of touch[ing] another resident inappropriately near	21475	Corrected	1/10/22

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21475	Continued From page 26	21475		

south hall." On 9/23/21, "accused of kissing." The care plan instructed staff to, "Redirect away from female residents," "Assist in looking [for] alternative placement," If staff hear [R500] making sexual gestures tell him to stop and redirect him back to his room," "If staff see [R500] enter a female resident's room, remove resident immediately," [R500] is not to be in any other hall besides South hall without supervision," and "[R500] will not enter north hall, will stay away from female resident" related to allegations of inappropriate behavior.

A Behavior Contract signed by R500 on 11/13/20, outlined, "Boundaries related to allegations of inappropriate behavior:
- Refrain from touching any female resident, even if they request a hug from you.
- Refrain from entering female resident's rooms.
- When in commons areas refrain from making sexual comments or gestures.

A progress note dated 9/3/21, at 3:04 p.m. included, "Met with resident, reviewed concerns with female residents. Reviewed recommendations for transition to another facility with males."

A progress note dated 9/23/21, at 1:47 p.m. included, "Spoke with resident and daughter, reviewed transition to another facility. Daughter expressed understanding and knowing it ws in his best interest."

A Mental Health Provider Progress Note dated 9/24/21, included, "A resident reported seeing [R500] kiss a female resident who he has previously shown interest in and who has stated she is not interested." "Staff continue to work to find an all-male placement for [R500]. [R500] is

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21475	Continued From page 27 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 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 facility or group home.	21475		

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21475	Continued From page 28 During an interview on 11/30/21, at 4:07 p.m. the director of rehabilitation services stated it would "be reasonable" to consider R500 for transfer to an alternative level of care such as assisted living or a group home considering R500's independence with ADLs. During an interview on 12/2/21, at 10:50 a.m. with the administrator and assistant director of nursing (ADON) the administrator stated the facility had implemented interventions which included pursing alternative placement for R500 at an all-male facility. The ADON added the interdisciplinary team had agreed to this intervention to mitigate ongoing risk of inappropriate interaction with the facility's female residents. The administrator thought referrals to transfer R500 had been sent to multiple all-male care facilities, but had been declined at each facility due to being a registered sex offender. The ADON added it would be appropriate to assess R500's care needs to determine if he could transfer to an assisted living or group home. The administrator stated if SW-A was unsuccessful with implementing a behavior intervention he would expect the information to be shared with the interdisciplinary team for brainstorming. The facility Transfers and Discharges Policy dated 2001, included, "Each resident will be permitted to remain in the facility, and not be transferred or discharged unless: ... C. the safety of individuals in the facility is engaged due to the clinical or behavioral status of the resident." SUGGESTED METHOD FOR CORRECTION: The administrator, or designee, could review and/or revise policies and procedures related to social services and educate all staff. The	21475		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21475	Continued From page 29 administrator, or designee, could then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21475		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the	21545		1/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	C 12/02/2021

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21545	Continued From page 30 physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders and professional standards of practice for 1 of 2 residents (R28) observed to receive medication during the survey. This resulted in a facility medication administration error rate of 30% (percent). Findings include: R28's Admission Record dated 12/2/21, indicated R28's diagnoses included diabetes, pressure ulcer of sacral region (area where the spine connects to the lower half of the body), and absence of right and left leg above knee. A Physicians Order dated 7/26/21, indicated R28 may have their medication crushed and given with applesauce for easy swallowing. Review of R28's November 2021 Medication	21545	Corrected	

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21545	Continued From page 31 Administration Record (MAR), indicated staff were to administer the following medications by mouth: - Cefuroxime Axetil (antibiotic). Give one tablet by mouth two times a day for infection. - Doxycycline 100 milligram tablet. Give 100 milligrams by mouth every 12 hours for bone and joint infection. - Morphine sulfate (pain medication) extended-release tablet 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 2021 MAR further indicated the following medications were to be administered via g-tube (tube feeding): - Prednisone (steroid) 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 pressure. - Duloxetine 20 mg tablet. Give 1 tablet via g-tube every Tuesday for depression. - Metoprolol Tartrate. Give 50 mg via g-tube two times daily for high blood pressure. On 11/30/21, at 9:13 a.m. licensed practical nurse (LPN)-C was observed preparing medications for R28 which included: - Cefuroxime Axetil - Amlodipine 5 mg - Duloxetine 20 mg - Doxycycline 100 mg - Morphine sulfate extended-release 15 mg - Famotidine 20 mg - Metoprolol Tartrate 50 mg - Gabapentin 6 mL 250mg/5mL give 300 mg	21545		

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21545	Continued From page 32 - 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. During an interview on 11/30/21, at 9:13 a.m. LPN-C stated all medications could be crushed for R28 because there was an order. LPN-C also stated she was late with medication administration and confirmed Prednisone 5 mg tablets were not available. At 9:20 a.m. LPN-C confirmed she poured gabapentin into a plastic medication cup and had estimated 6 mL. LPN-C stated she should had used a syringe, but one was not available. LPN-C stated she could had given R28 too much gabapentin it not measured accurately. Further, she knew R28 had an order to crush medications, but was not aware to order was to place the medication in applesauce and give by mouth. LPN-C stated the physicians order should be followed and the physician should be asked if there were questions. LPN-C confirmed	21545		

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21545	Continued From page 33 all oral medications were cocktailed and given via g-tube. During an interview on 11/30/21, at 1:55 p.m. medical doctor (MD)-A stated he expected staff to give medications as ordered to ensure proper absorption and relief of symptoms. During an interview on 12/1/21, at 9:00 a.m. the consulting pharmacist (CP) stated staff were expected to administer medication based on the physician order. The CP stated it was best practice to use a syringe when drawing up gabapentin to ensure the dose was correct. During an interview on 12/1/21, at 9:30 a.m. MD-B stated he expected the facility to follow medication orders as directed. If medications were ordered by mouth, then they should be given by mouth. If a resident had a change in condition, the physician should be notified and request a change or to review orders. MD-B stated the nurse should had clarified orders with the physician. During an interview on 12/1/21, at 1:42 p.m. the director of nursing (DON) stated she expected staff passing medication to check orders, check medication, and then check again. Further, she expected staff to ensure the right person, right dose, right medication, right route, and right time before medications were administered. If an individual had questions about an order, they should ask prior to administration. The DON stated medications which were crushed and given via a tube feeding, rather than by mouth, were considered a medication error. Further, LPN-C should not estimate a dose of gabapentin. The DON stated LPN-C would need to write up medication errors and she would provide staff	21545		

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21545	Continued From page 34 education and guessed all staff made the same error. Facility policy titled Administering Oral Medications (undated) directed the individual administering medication to verify physician orders, review the care plan, and assess for special needs. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and/or revise policies related to medication administration. The DON, or designee, could then educate staff and develop a monitoring system to ensure medication were correctly administered as ordered by the physician. The quality assurance committee could monitor these measures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21545		