



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 23, 2024

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

RE: CCN: 245544
Cycle Start Date: June 13, 2024

Dear Administrator:

On July 1, 2024, we notified you a remedy was imposed. On July 17, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 15, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 16, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 1, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 16, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 15, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 23, 2024

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

Re: Reinspection Results
Event ID: 9BSQ12

Dear Administrator:

On July 17, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 13, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

*****THIS LETTER IS TO REPLACE THE LETTER ORIGINALLY POSTED TO EPOC ON 6/27/24.
PLEASE DISREGARD PREVIOUS LETTER.*****

Electronically delivered
July 1, 2024

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

RE: CCN: 245544
Cycle Start Date: June 13, 2024

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 June 13, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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 location for imposition. The CMS location 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 July 16, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 16, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 16, 2024.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 \$12,924; 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 July 16, 2024, 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 July 16, 2024. 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:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 December 13, 2024 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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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://forms.web.health.state.mn.us/form/NHDisputeResolution>

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Melissa Poepping". The signature is fluid and cursive, with the first name "Melissa" and last name "Poepping" clearly distinguishable.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 27, 2024

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

RE: CCN: 245544
Cycle Start Date: June 13, 2024

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 June 13, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient

practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by September 13, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 13, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

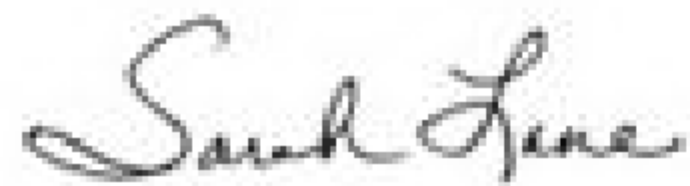
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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

PRINTED: 07/03/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/13/2024
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 6/10/24-6/13/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 6/10/24-6/13/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H55444301C (MN00101928/MN101363), H55444262C (MN00100643), H55444249C (MN00100953), H55444263C (MN00102856/MN00102833), H55444283C (MN00099283) AND The following complaint was reviewed: H55444248C (MN00100086) with a deficiency cited at F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/02/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/13/2024
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	Continued From page 1 form. Your electronic submission of the POC will be used as verification of compliance.	F 000			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)-	F 656			7/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/13/2024
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page 2 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to include individualized approaches for care, including non-pharmacological interventions to aid in the management of behavior, in the comprehensive care plan for 2 of 5 residents (R1, R6) reviewed for unnecessary medications. Findings include: R1's significant change Minimum Data Set (MDS) dated 5/9/24, included R1 was moderately cognitively impaired, had diagnoses of dementia, depression, and psychotic disorder (other than schizophrenia). R1 took antidepressant and antipsychotic medications on a routine basis. R1's Mood State Care Area Assessment (CAA) was not triggered. R1's Psychotropic Drug Use Care Area	F 656	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent informal dispute resolution session, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F 656 R 1 and R 3 medication orders were reviewed for diagnosis and indication for use. In addition, R 1 and R 3 will meet with the social services director to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/13/2024	
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F 656	Continued From page 3 Assessment (CAA) indicated R1 took antipsychotic medications, was at risk for adverse reactions from the medications, and had no noted side effects. R1's Order Summary Report dated 6/5/24, included: *Aripiprazole tablet 5 milligrams (mg) one time per day for psychosis starting 6/1/24. *Sertraline HCl (hydrochloride) tablet, 150 mg one time per day for major depressive disorder starting 1/6/24. *Trazodone HCl tablet 100 mg (an antidepressant), one time per day at bedtime for insomnia starting 10/23/23. R1's care plan dated 10/30/23, indicated the resident had anxiety and included the following interventions: *Adhere to resident's stated choice of routine/activity pattern. *Allow resident to express concerns--validate/offer TLC (tender loving care) as appropriate. *Allow the resident time to answer questions and to verbalize feelings perceptions, and fears. *Assess placement needs as needed/appropriate. *Be attentive to resident's need--observe for any s/s of discomfort, anxiety, being overwhelmed, etc. *Consult with: Pastoral care, Social services, Psychology services *Educate resident and/or family regarding discharge planning needs. *Encourage participation in activities/decisions from resident who depends on others to make own decisions.			F 656	thoroughly review their care plans, update trauma assessments as needed and add target behavior and non-pharmalogical interventions. All current residents who currently are medicated with antidepressants and antipsychotics, their medication orders and care plans were reviewed for target behaviors and non-pharmalogical interventions and were updated as needed. Future residents who admit to the facility and their comprehensive care plan indicate mood or behavior care planning, their care plans will be initiated and will include target behavior and non-pharmalogical interventions per facility policy. IDT, licensed nurses and social services will be in-serviced on the Care Plan Comprehensive Policy. Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior and how the staff will observe for effectiveness of the interventions. Director of Nursing and/or designee is responsible for compliance. Audits on behavioral care plan intervention with target behavior and individualized non-pharmalogical interventions and effectiveness of interventions will begin weekly x4 weeks, monthly x 3 months then quarterly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for		

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F 656	Continued From page 4 The care plan also included R1 had a mood problem dated 10/30/23, and included interventions of: *Administer medications as ordered. Monitor/document for side effects and effectiveness. *Behavioral health consults as needed psycho-geriatric team, psychiatrist etc. *Educate the resident/family/caregivers regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance. *Monitor/document/report PRN (as needed) any risk for harm to self: suicidal plan, past attempt at suicide, risky actions stockpiling pills, saying goodbye to family, giving away possessions or writing a note, intentionally harmed, or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment, or safety awareness. *Monitor/record mood to determine if problems seem to be related to external causes, i.e., medications, treatments, concern over diagnosis. *Monitor/record/report to MD (medical doctor) prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills *Monitor/record/report to MD prn mood patterns s/sx (signs/symptoms) of depression, anxiety, sad mood as per facility behavior monitoring protocols. In addition, R1 had depression and took an antidepressant medication, and the care plan dated 11/2/23, instructed staff to:	F 656	review and recommendation.		

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F 656	Continued From page 5 *Administer medications as ordered. Monitor/document for side effects and effectiveness. *Arrange for psych consult, follow up as indicated. *Discuss with the resident/family/caregivers any concerns, fears, issues regarding health or other subjects *Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment, or safety awareness. *Monitor/document/report PRN any s/sx of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness. *Monitor/record/report to MD prn risk for harming others: increased anger, labile mood, or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons *Pharmacy review monthly or per protocol. *The resident needs time to talk. Encourage the resident to express feelings. *The resident needs adequate rest periods. The resident prefers to rest. *Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness *Educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms of anti-depressant drugs being given). *Monitor/document/report PRN adverse reactions	F 656			

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F 656	Continued From page 6 to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, n/v (nauseas/vomiting), dry mouth, dry eyes R1 used psychotropic medications and the care plan dated 10/24/23, included the following interventions: *The resident will reduce the use of psychotropic medication through the review date. *Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness. *Consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly. *Discuss with MD, family re ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. *Monitor/document/report PRN any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (extrapyramidal side effects caused by psychotropic medications, such as shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. The care plan lacked evidence of	F 656			

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F 656	Continued From page 7 non-pharmacological, resident-specific interventions. During observation on 6/10/24 at 1:28 p.m., R1 was heard crying in their room, stating numerous times, "I feel like shit, I feel like shit" while staff were in the room attempting to assist R1. R1 continued to verbalize negative comments, many unintelligible. Staff placed R1 in their bed and left the room. R1 was noted to be sleeping in bed at 2:20 p.m., and 5:18 p.m. During interview on 6/12/24, at 7:42 a.m., registered nurse (RN)-A stated mental health and behavioral interventions should be in the care plan and be specific for each resident based upon the cause of the behavior or situation. Once potential causes were assessed and interventions were identified, staff would know how best to help. During interview on 6/12/24 at 8:57 a.m., trained medication aide (TMA)-A stated if a resident demonstrated they were in distress, either by words or behaviors, they would ask what they needed and try to fix it, and/or let the nurse know to possibly give medication. They were unaware of any resident-specific interventions for R1 and addressed each resident in the same manner. During interview on 6/12/24 at 10:01b a.m., licensed practical nurse (LPN)-C stated if there was a behavioral or mental health concerns, they talked with the resident to figure out why they were acting out and tried to address it. LPN-C indicated R1 a history of suicidal ideation and anxiety, and made comments including "nobody cares", or "let me lay down", however there were no resident-specific interventions in R1's care	F 656			

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F 656	Continued From page 8 plan. During interview on 6/12/24 at 10:12 a.m., director of nursing (DON) stated interventions should be individualized and in the care plan, and any behaviors and successful interventions documented so staff could use what was known to be helpful before trying other things. DON reviewed R1's medical record and care plan and verified there were no resident-specific interventions related to their depression, anxiety, and mental health in general, however it was important to identify a list of things which could be helpful since everyone reacts differently in varying situations. It was important to learn what was helpful and spread the word to make the resident feel better.	F 656			
F 684 SS=E	The Antipsychotic Medication Use Policy dated 12/2016, included antipsychotic medications will be considered if behavioral interventions have been attempted and included in the plan of care, except in emergency. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 684			7/15/24
			F 684		

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F 684	Continued From page 9 review the facility failed to ensure coordination of scheduled and/or follow up appointments was completed for 2 of 3 residents (R38, R47) who required services from outside medical providers, and failed to ensure monitoring for edema (condition where fluid builds up in the body) for 1 of 1 residents (R19) reviewed for edema. Furthermore, the facility failed to ensure medications were administered following standard practice for 1 of 1 resident (R58) reviewed for tube feeding. Findings include: coordination of appointments R38's significant change Minimum Data Set (MDS) dated 5/7/24, indicated R38 had cognitive impairment and diagnoses of glioblastoma (aggressive type of brain cancer) and schizophrenia. R38's clinical appointment list dated 6/12/24, indicated R38 did not show up/had rescheduled appointments for 12/1/23, 12/15/23, 1/3/24, and 1/16/24. R38's neurosurgery clinic call documentation note dated 11/28/23 at 9:01 a.m., indicated the clinic called the facility about a tentative appointment for follow up scheduled on 12/1/24. The note indicated a call back was requested from the facility to confirm. R38's neurosurgery clinic call documentation note dated 11/29/23 at 9:44 a.m., indicated the clinic called the facility to confirm R38's appointment on 12/1/23.			F 684	Resident Appointments R 38 MD will be made aware that R 38 missed several appointments. The MD response will be recorded in the electronic medical record. R 47 has an eye appointment scheduled for 7-31-24. R 38 and R 47 will have a risk management incident initiated and a root cause identified, and interventions initiated. All current resident who has outside medical providers, their follow-up paperwork was reviewed from survey exit until present and appointments were scheduled as needed. Future resident appointments and transportation needs will be coordinated through the Health Unit Coordinator. Licensed nurses, Health Unit Coordinator and Social Services Director will be in-serviced on the Referral and Transportation Services Policy and procedure with emphasis that facility Health Unit Coordinator is responsible for coordination of appointments and transportation for facility residents. Health Unit Coordinator and/or designee is responsible for compliance. Audits on resident return appointments, transportation arrangements and resident refusals of appointment with physician notification will begin 2x week for 4 weeks, weekly x 4 week then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Edema		

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F 684	Continued From page 10 R38's provider order dated 11/29/23, directed staff to note neurosurgery follow up appointment on 12/1/23 and ensure transportation was set up. R38's medical record lacked indication R38 had attended the neurosurgery follow up appointment on 12/1/24 and had seen neurosurgery on 12/4/23. R38's neurosurgery after visit summary dated 12/4/23, indicated R38 required a referral to see a radiation oncologist. R38's nursing progress note dated 12/27/23 at 11:38 a.m., the facility was notified by the radiation oncology clinic of R38's appointment scheduled on 1/3/24. R38's oncology clinic call documentation dated 1/4/24 at 11:43 a.m., indicated the clinic called the facility to inquire about R38 not showing for a clinic visit on 1/3/24. R38's clinic visit was rescheduled for 1/16/24. R38's oncology clinic call documentation dated 1/19/24 at 2:07 p.m., indicated health unit coordinator (HUC) was called to ensure R38 made it to the follow up appointments on 1/25/24. The note further indicated R38 had not showed for the prior 4 appointments. The HUC indicated she was unaware of the prior appointments. R38's medical record lacked indication R38 had attended their scheduled appointments on 12/1/23 or 12/15/23, 1/3/24, and 1/16/24. When interviewed on 6/11/24 at 2:55 p.m., HUC stated when residents were admitted or returned from an appointment the paperwork was given			F 684	R 19s MD will be notified that resident edema was not monitored, vital sign order parameters were not being followed and no notification of weight gain took place. The physician's response will be recorded in the resident record. All current resident orders for weight were reviewed and physician notification for weight parameters were updated as needed. Future resident admission, resident physician parameter orders and acute changes in condition, the physician will be notified per facility policy. Licensed nurses will be in-serviced on the Acute Change in Condition Policy with emphasis on promptly notifying the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status and on the Medication Order policy that vital sign monitoring must have time frames and parameters established. These results will be recorded in the electronic medical record. The MD will be contacted per parameter order and a progress note will be created. Director of Nursing and/or designee is responsible for compliance. Audits on physician parameter and MD notification along with review of resident change in condition with physician notification will begin daily x 5 days, weekly x 4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for		

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F 684	Continued From page 11 either to them or the nursing staff for review. The HUC stated she was responsible for coordinating the appointments and rides if needed. Once the appointment was made, HUC placed the appointment in the electronic medical record as well as their appointment book. Closer to the appointment date, transportation would be arraigned, and an envelope created for the resident to take to the appointment to foster communication with the outside provider. HUC verified R38 had missed appointments and further stated the facility wasn't aware of them. The HUC further stated there wasn't any communication with the facility from the outside providers about the appointments initially. The HUC stated she called and received an appointment list from them at the end of January and R38 had been going to the appointments since then. When interviewed on 3/13/24 at 9:12 a.m., the radiation clinic coordinator CC verified R38's missed appointments. She was not sure why the appointments were missed and verified clinic staff did contact the facility to coordinate appointments, but something got missed along the way. CC further stated typically residents came with a form to complete and send back with follow up information. CC further stated if a form was sent it was completed. When interviewed on 6/13/24 at 10:01 p.m., licensed practical nurse (LPN)-A stated when a resident has orders for an appointment or already has an appointment scheduled, the order was signed off and scanned into the chart. If the appointment needed to be made or transportation set, the HUC would receive the information. The HUC then placed appointment information into			F 684	review and recommendation. Feeding Tube R 58s physician was notified that the resident medications were administered as a cocktail and not separately. The MDs response will be recorded in the resident record. R 58s medication order obtained to cocktailed. All current residents who receive medication via gastrostomy, their flush order after each medication administration was reviewed and updated as needed. Licensed nurses will be in-serviced on the Administering Medications via Enteral Tube with emphasis on administering each medication separately unless order obtained and if theres more than one medication being administered, 15ml must be flushed in between medication doses. Director of Nursing and/or designee is responsible for compliance. Audits on enteral medication administration with 15ml flush after each medication administration will begin 2x week x 3 weeks, weekly x 4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 7/10/2024 F 758 R 1 and R 27 medication orders were reviewed for diagnosis and indication for use. In addition, R 1 and R 27 will meet		

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F 684	Continued From page 12 the EMR in the dashboard. This lets everyone know when residents had appointments scheduled. LPN-A further stated when a resident returned from an appointment, the paperwork was given either to her or the HUC. The HUC was then responsible for coordinating new appointments while nursing took care of any new orders. LPN-A stated R38 had some missed appointments and sated she wasn't sure why they were missed. During a follow up interview on 6/13/24 at 9:55 p.m., HUC stated not all residents returned with paperwork or they may return it to the nurse. HUC stated sometimes a phone call was made to the clinic to know if further appointments were needed, however verified the phone call was not routinely documented. R47's significant change Minimum Data Set (MDS) dated 3/28/24, indicated R47 was understood and able to understand others. R47's vision was adequate; he was able to see fine detail and regular print in newspapers and books. Corrective lenses were not required. Review of R47's medical record indicated R47 was seen for his vision on 11/15/23. At that time R47 reported, "wavy vision at a distance," as well as, "blurry vision," primarily in his left eye. It was noted these symptom were reported by R47 for approximately three years. At the time of this appointment, R47 felt the symptoms had improved. Also on this report, it was noted R47 had a history of remarkable retinal detachment of the right eye and eye surgery consisted of cataract surgery. A provider note dated 2/20/24, indicated R47			F 684	with the social services director to thoroughly review their care plans, update trauma assessments as needed and add target behavior and non-pharmalogical interventions. All current residents who currently are medicated with antidepressants and antipsychotics, their medication orders and care plans were reviewed for target behaviors and non-pharmalogical interventions and were updated as needed. Future residents who admit to the facility and their comprehensive care plan indicate mood or behavior care planning, their care plans will be initiated and will include target behavior and non-pharmalogical interventions per facility policy. IDT team, licensed nurses and social services will be in-serviced on the Care Plan Comprehensive Policy with emphasis on item areas of concern will be evaluated before interventions are added to the care plan and on the Behavior Assessment and Monitoring policy that Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior and how the staff will observe for effectiveness of the interventions. Director of Nursing and/or designee is responsible for compliance. Audits on behavioral care plan intervention with target behavior and individualized non-pharmalogical interventions and effectiveness of interventions will begin weekly x4 weeks,		

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F 684	Continued From page 13 received a referral for an eye specialist exam. During interview on 6/10/24 at 12:50 p.m., R47 stated he was waiting for an update regarding a vision appointment. He had requested this previously but felt facility was not being helpful. R47 reported his left was, "much worse." During interview on 6/11/24 at 10:05 a.m., health unit coordinator (HUC) stated R47 declined the appointment for the eye specialist when discussed in 2/2024. HUC stated she placed a call on this day (6/11/24) to schedule an appointment with another eye provider, but had not received a call back. During interview on 6/13/24 at 11:38 a.m., director of nursing (DON) stated there is a, "huge communication gap for appointments." No documentation process was currently in place for attempts to make appointments but there was a dashboard. DON noted R47 was not listed on the dashboard. DON stated there was no follow up being done for appointments. DON expected those responsible for reviewing appointment notes were checking the notes for follow up appointments needed, to set up those appointments and to document attempts. A facility procedure/policy for coordination of appointments was requested however was not provided. edema monitoring R19's admission MDS dated 5/17/24, indicated R19 was cognitively intact and had diagnoses of liver failure with ascites (fluid that can accumulate			F 684	monthly x 3 months then quarterly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 7/10/2024 F 812 The dishwasher was serviced on (INSERT DATE). There were no ill effects experienced by residents or staff for this deficient practice. Future temperature wash and rinse cycles not meeting appropriate levels, the dietary department will utilize paper products and follow the manual cleaning of dishes facility policy. The entire dietary department will be in-serviced on the Cleaning Dish/Dish Machine Policy with emphasis on monitoring the dish cycle throughout the procedure to ensure proper temperatures are maintained and for dish machine malfunctions, the dietary staff will follow the policy on Manual Cleaning of Dishes with emphasis on wash rinse and sanitize procedures and utilizing test stripes to ensure sanitation solution levels are maintained. Dietary Manager and/or designee is responsible for compliance. Audits on dish cycle monitoring and cycle temperatures will begin daily x 14 days, weekly x 2 weeks then monthly to ensure sustained compliance. All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendation. Compliance: 7/10/2024		

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F 684	Continued From page 14 in the abdomen) and was taking medication to help reduce edema. R19's admission assessment dated 5/17/24, indicated R19 had edema and used a diuretic medication. R19's provider and nursing order summary indicated the following: -lacked indication R19 required monitoring for edema. -a provider order dated 5/10/24, directed staff to obtain weekly weights for 4 weeks and then monthly. - a provider order dated 5/11/24, indicated R19 required spironolactone 50 milligrams (mg) in the morning for edema A review of R19's weights showed the following: -5/10/24, 270 pounds -5/23/24, 290.2 pounds -6/7/24 318.2 pounds R19's weights indicated a 48.2-pound weight gain between 5/10/24 and 6/7/24. R19's care plan dated 5/17/24, lacked indication R19 required monitoring for edema. R19's progress note dated 6/7/24 at indicated R19 had gained 28 pounds since previous weight 2 weeks ago. Resident was assessed with no edema or swelling noted. R19's provider was notified and as aware of R19's dietary habits. A dietary consult placed. When interviewed on 6/10/24 at 2:08 p.m., R19 was sitting up on her bed with a lunch tray. A second tray was on her bedside table with 2 wrapped sandwiches. R19 stated they "just keep	F 684	F 880 R 56 and R 58 physicians were made aware that proper hand hygiene was not performed during resident care. The physician's response will be recorded in the resident electronic medical record. There were no ill effects experienced for this deficient practice. All current residents who are in enhanced barrier precautions, their care was observed and any deficient practices their MD was noted as needed. Future residents who are placed in enhanced precautions, their care will be delivered utilizing the proper hand hygiene per facility policy. Facility nurses and nurse aides will be in-serviced on the enhanced barrier precaution policy that gowns and gloves are to be worn during high contact resident activities and on the Hand Hygiene policy with emphasis on item #8 that before and after handling an invasive device hand hygiene must be performed. Director of Nursing and Infection Preventionist is responsible for compliance. Audits on resident cares observing proper hand hygiene before and after high contact resident activities will begin 3x week x2 weeks, weekly x 4 weeks, then monthly to ensure sustained compliance. All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendation.		

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F 684	Continued From page 15 swelling up". R19 stated she had liver failure and kidney problems that caused swelling. R19 was worried that her legs would start to weep soon as that had happened before when the swelling had gotten bad. R19 further stated she had told staff about the swelling but wasn't sure if anything was done to help. When interviewed on 6/11/24 at 11:09 a.m., registered nurse (RN)-A stated residents with edema would have assessments done of their extremities and lung sounds. If there were significant changes in swelling or trouble breathing the provider would be notified. RN-A stated R19 had some concerns off and on about edema, but really had no changes. RN-A verified R19's orders and care plan lacked monitoring or interventions to prevent increased edema. RN-A verified R19's weight gain and gaps in weight checks. RN-A stated the provider was aware of the weight gain and R19 usually ordered double or triple portions during meals and the weight gain was attributed to that. Furthermore, RN-A stated it was challenging to assess R19's edema as her legs were large due to obesity. At 11:16 a.m., RN-A entered R19's room assess R19 for edema. R19's was lying in bed and RN-A assisted to remove R19's socks. The tops of the socks were tight and had left marks on both of R19's ankles. RN-A stated R19 had plus one pitting edema to both feet/ankle areas. R19 further stated he felt this was baseline but was not sure as there wasn't much documentation of the edema. When interviewed on 6/12/24 at 12:25 p.m., the interim Director of Nursing (DON) DON stated R19 was on a diuretic medication and a history of needing paracentesis (procedure to remove fluid			F 684			

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F 684	Continued From page 16 from the abdomen) due to liver failure. DON expected staff to be monitoring and documenting residents with edema for signs or symptoms of increased edema and the care plan should include interventions. A facility policy for assessments for edema/fluids was requested however was not received. Feeding tube med admin R58's admission MDS dated 6/4/24, indicated R58's diagnoses include stroke, hypertension, hemiplegia (paralysis of one side of the body), and depression. R58 required use of a feeding tube for nutrition. During observation on 6/11/24 at 9:16 a.m., registered nurse (RN)-A was observed entering R58 room while holding two cups of liquid and a syringe of dilute, brown liquid with particles present in the liquid. RN-A disconnected R58 feeding tube from infusion, flushed the tube to check for placement, instilled the contents of the syringe into R58 feeding tube, followed by another flush of water. During interview on 6/11/24 at 11:55 a.m., RN-A confirmed the dilute, brown liquid with particles in the syringe contained R58 medications which include: " Amlodipine besylate (for hypertension) 10mg (milligrams) tablet- crushed " Fluoxetine (for depression) 20mg/5mL (milliliters) 2.5mL " Lisinopril (for hypertension) 40mg tablet- crushed " Modafinil 200mg (to promote wakefulness) 200mg tablet- crushed			F 684			

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F 684	Continued From page 17 " Multivitamin 15mL " Polyethylene glycol 3350 (for constipation) 17GM (grams) powder " Acetaminophen 160mg/5mL- 20.3mL R58 medication profile did not include an order to cocktail (crush medications and mix with powered and liquid medications for administration at the same time) medications. RN-A verified there was no order to cocktail R58 medications. RN-A stated he used his nursing knowledge to determine if there was a contraindication to cocktail any residents' medications that were given through their feeding tube. During interview on 6/13/24 at 8:53 a.m., DON stated she expected a minimal flush with water of 15mL between each medication administered in a feeding tube. Each medication, crushed, powder or liquid should be in a separate cup, dissolved in at least 10-15mL of water. DON expected an order in the resident's chart if the medications could be cocktailed.	F 684			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758			7/15/24

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F 758	Continued From page 18 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to identify individualized approaches for care, including non-pharmacological interventions to aid in the			F 758	F 758 R 1 and R 27 medication orders were reviewed for diagnosis and indication for		

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F 758	Continued From page 19 management of mood and behavior, for 2 of 5 residents (R1, R27) reviewed for unnecessary medications. Findings include: R1's significant change Minimum Data Set (MDS) dated 5/9/24, included R1 was moderately cognitively impaired, had diagnoses of dementia, depression, and psychotic disorder (other than schizophrenia). R1 took antidepressant and antipsychotic medications on a routine basis. R1's Mood State Care Area Assessment (CAA) was not triggered. R1's Psychotropic Drug Use Care Area Assessment (CAA) indicated R1 took antipsychotic medications, was at risk for adverse reactions from the medications, and had no noted side effects. R1's Order Summary Report dated 6/5/24, included: *Aripiprazole tablet 5 milligrams (mg) one time per day for psychosis starting 6/1/24. *Sertraline HCl (hydrochloride) tablet, 150 mg one time per day for major depressive disorder starting 1/6/24. *Trazodone HCl tablet 100 mg (an antidepressant), one time per day at bedtime for insomnia starting 10/23/23. R1's care plan dated 10/30/23, indicated the resident had anxiety and included the following interventions: *Adhere to resident's stated choice of routine/activity pattern. *Allow resident to express			F 758	use. In addition, R 1 and R 27 will meet with the social services director to thoroughly review their care plans, update trauma assessments as needed and add target behavior and non-pharmalogical interventions. All current residents who currently are medicated with antidepressants and antipsychotics, their medication orders and care plans were reviewed for target behaviors and non-pharmalogical interventions and were updated as needed. Future residents who admit to the facility and their comprehensive care plan indicate mood or behavior care planning, their care plans will be initiated and will include target behavior and non-pharmalogical interventions per facility policy. IDT team, licensed nurses and social services will be in-serviced on the Care Plan Comprehensive Policy with emphasis on item areas of concern will be evaluated before interventions are added to the care plan and on the Behavior Assessment and Monitoring policy that Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior and how the staff will observe for effectiveness of the interventions. Director of Nursing and/or designee is responsible for compliance. Audits on behavioral care plan intervention with target behavior and individualized non-pharmalogical interventions and effectiveness of		

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F 758	Continued From page 20 concerns--validate/offer TLC (tender loving care) as appropriate. *Allow the resident time to answer questions and to verbalize feelings perceptions, and fears. *Assess placement needs as needed/appropriate. *Be attentive to resident's need--observe for any s/s of discomfort, anxiety, being overwhelmed, etc. *Consult with: Pastoral care, Social services, Psychology services *Educate resident and/or family regarding discharge planning needs. *Encourage participation in activities/decisions from resident who depends on others to make own decisions. The care plan also included R1 had a mood problem dated 10/30/23, and included interventions of: *Administer medications as ordered. Monitor/document for side effects and effectiveness. *Behavioral health consults as needed psycho-geriatric team, psychiatrist etc. *Educate the resident/family/caregivers regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance. *Monitor/document/report PRN (as needed) any risk for harm to self: suicidal plan, past attempt at suicide, risky actions stockpiling pills, saying goodbye to family, giving away possessions or writing a note, intentionally harmed, or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment, or safety awareness. *Monitor/record mood to determine if problems	F 758	interventions will begin weekly x4 weeks, monthly x 3 months then quarterly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation.		

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F 758	Continued From page 21 seem to be related to external causes, i.e., medications, treatments, concern over diagnosis. *Monitor/record/report to MD (medical doctor) prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills *Monitor/record/report to MD prn mood patterns s/sx (signs/symptoms) of depression, anxiety, sad mood as per facility behavior monitoring protocols. In addition, R1 had depression and took an antidepressant medication, and the care plan dated 11/2/23, instructed staff to: *Administer medications as ordered. Monitor/document for side effects and effectiveness. *Arrange for psych consult, follow up as indicated. *Discuss with the resident/family/caregivers any concerns, fears, issues regarding health or other subjects *Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment, or safety awareness. *Monitor/document/report PRN any s/sx of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness.	F 758			

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F 758	Continued From page 22 *Monitor/record/report to MD prn risk for harming others: increased anger, labile mood, or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons *Pharmacy review monthly or per protocol. *The resident needs time to talk. Encourage the resident to express feelings. *The resident needs adequate rest periods. The resident prefers to rest. *Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness *Educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms of anti-depressant drugs being given). *Monitor/document/report PRN adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, n/v (nausea/vomiting), dry mouth, dry eyes R1 used psychotropic medications and the care plan dated 10/24/23, included the following interventions: *The resident will reduce the use of psychotropic medication through the review date. *Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness. *Consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly.			F 758			

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F 758	Continued From page 23 *Discuss with MD, family re ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. *Monitor/document/report PRN any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (extrapyramidal side effects caused by psychotropic medications, such as shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. The care plan lacked evidence of non-pharmacological, resident-specific interventions. During observation on 6/10/24 at 1:28 p.m., R1 was heard crying in their room, stating numerous times, "I feel like shit, I feel like shit" while staff were in the room attempting to assist R1. R1 continued to verbalize negative comments, many unintelligible. Staff placed R1 in their bed and left the room. R1 was noted to be sleeping in bed at 2:20 p.m., and 5:18 p.m. During interview on 6/12/24, at 7:42 a.m., registered nurse (RN)-A stated mental health and behavioral interventions should be in the care plan and be specific for each resident based upon the cause of the behavior or situation. Once potential causes were assessed and interventions were identified, staff would know how best to help. During observation on 6/12/24 at 8:45 a.m., R1			F 758			

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F 758	Continued From page 24 was being pushed in their wheelchair by a staff member and repeatedly stated they wanted to go to bed. While staff was transferring R12 to bed, R1 cried out "AH" in a loud, fearful voice. After being placed in bed staff left the room and R1 remained quiet. During interview on 6/12/24 at 8:57 a.m., trained medication aide (TMA)-A stated if a resident demonstrated they were in distress, either by words or behaviors, they would ask what they needed and try to fix it, and/or let the nurse know to possibly give medication. They were unaware of any resident-specific interventions for R1 and addressed each resident in the same manner. During interview on 6/12/24 at 10:01 a.m., licensed practical nurse (LPN)-C stated if there was a behavioral or mental health concerns, they talked with the resident to figure out why they were acting out and tried to address it. LPN-C indicated R1 a history of suicidal ideation and anxiety, and made comments including "nobody cares", or "let me lay down", however there were no resident-specific interventions outlined for each resident, including R1. During interview on 6/12/24 at 10:08 a.m., nursing assistant (NA)-A stated if a resident had dementia or behaviors, they spoke to them politely in a way they would understand. They indicated R1 had behaviors and would sometimes yell at the staff, and NA-A spoke calmly to de-escalate, but there were no resident-specific interventions identified for R1 and they knew what worked by getting to know the residents over time. During interview on 6/12/24 at 10:12 a.m.,	F 758			

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F 758	Continued From page 25 director of nursing (DON) stated interventions should be individualized and in the care plan, and any behaviors and successful interventions documented so staff could use what was known to be helpful before trying other things. DON reviewed R1's medical record and care plan and verified there were no resident-specific interventions related to their depression, anxiety, and mental health in general, however it was important to identify a list of things which could be helpful since everyone reacts differently in varying situations. It was important to learn what was helpful and spread the word to make the resident feel better. Findings include: R27's quarterly Minimum Data Set (MDS) dated 5/31/24, indicated moderately impaired cognition and diagnoses of mood disorder and major depressive disorder with recurrent, severe, psychotic symptoms. R27 was dependent on staff for all activities of daily living (ADL), mobility, and received an antipsychotic medication on a routine basis. R27's physicians orders dated 5/10/24, indicated Quetiapine Fumarate (Seroquel) oral tablet. Give 12.5 milligram (mg) tablet by mouth at bedtime related to mood disorder due to known physiological condition with depressive features. R27's care plan indicated R27 had mood problem with interventions to: -administer medications as ordered, - monitor/document for side effects and effectiveness. -behavioral health consults as needed	F 758			

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F 758	Continued From page 26 psycho-geriatric team, psychiatrist etc. -monitor/document/report (as needed) any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. -monitor/record mood to determine if problems seem to be related to external causes. medications, treatments, concern over diagnosis. -monitor/record/report to MD prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills -monitor/record/report to MD prn mood patterns s/sx of depression, anxiety, sad mood as per facility behaviour monitoring protocols. -Monitor/record/report to medical doctor as needed risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons -The resident needs time to talk. Encourage the resident to express feelings. R27's care plan dated // indicated R27 used psychotropic medications Seroquel related to behavior management/depression with interventions to: -administer psychotropic medications as ordered by physician. -monitor for side effects and effectiveness every shift (1. akathisia (restlessness/pacing/inability to	F 758			

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F 758	Continued From page 27 sit still), 2. excessive sedation, 3. tremors, 4. tardive dyskinesia, 5. stiffness of neck, 6. hypotension, 7).urinary retention, 8. dry mouth, 9. blurred vision, 10. confusion, 11. constipation, 12. tachycardia, 13. weight gain, 14 .profuse drooling, 15. falls / dizziness, 16. none) -consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly. -discuss with medical doctor and family regarding the ongoing need for use of medication. -review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. -educate the Dale/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of Seroquel -monitor/document/report as needed any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. -monitor/record occurrence of for target behavior symptoms: inappropriate response to verbal communication, violence/aggression towards staff/others- yelling at staff and document per facility protocol. -psychotropic behavior monitoring:: 1. agitation, 2. isolation in room 3. weight gain 4. decreased appetite 5. increased depression 6. lethargy 7. none R27's care plan lacked evidence of non-pharmacological, resident-specific			F 758			

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F 758	Continued From page 28 interventions.			F 758			
F 812 SS=F	The Antipsychotic Medication Use Policy dated 12/2016, included antipsychotic medications will be considered if behavioral interventions have been attempted and included in the plan of care, except in emergency. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper sanitization of dishware used for meal preparation and resident service when 1 of 1 low-temperature chemical sanitizing commercial dishwashers was identified as not reaching adequate wash and rinse temperatures. This had potential to affect all			F 812			7/15/24
					F 812 The dishwasher was serviced on 6/13/2024. There were no ill effects experienced by residents or staff for this deficient practice. Future temperature wash and rinse cycles not meeting appropriate levels, the dietary department		

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F 812	Continued From page 29 62 residents within the facility, staff, and visitors who consumed food from the main production kitchen. Findings include: During observation and interview on 6/11/24 at 12:04 p.m., dietary manager (DM) stated staff used chlorine test strips to determine if the chemical sanitizer concentration was adequate for sanitization by dipping the strip into the bottom reservoir of the dish machine and comparing the color to the key on the test strip label container. They indicated it must read between 100-200 parts per million (ppm). DM demonstrated the process, and the solution tested at 100 ppm. DM loaded a tray of pans, placed it in the dish machine, and closed the door to start the unit. The water temperature gauge read 113 degrees Fahrenheit (°F). DM verified the temperature reading, and stated the pans were sanitized because it was a low temperature dishwasher, so the water temperature did not matter. The dish machine was identified as an Ecolab ES2000. During observation and interview on 6/12/24 at 11:17 a.m., dietary aide (DA)-A demonstrated the use of the facility dish machine. They loaded a rack with nine plates and two bowls, placed the rack in the dishwasher, and closed the door to start the unit, allowing it to run until the cycle was complete. When asked about the water temperature requirements for dish sanitization, DA-A demonstrated the facility testing method by placing an indicator strip in the refuse drain trap underneath the dish machine where the soiled water was ejected from the machine. The strip read 50 ppm. DA-A stated it should read 100-200, obtained another test strip, and inserted it into the			F 812	will utilize paper products and follow the manual cleaning of dishes facility policy. The entire dietary department will be in-serviced on the Cleaning Dish/Dish Machine Policy with emphasis on monitoring the dish cycle throughout the procedure to ensure proper temperatures are maintained and for dish machine malfunctions, the dietary staff will follow the policy on Manual Cleaning of Dishes with emphasis on wash rinse and sanitize procedures and utilizing test stripes to ensure sanitation solution levels are maintained. Dietary Manager and/or designee is responsible for compliance. Audits on dish cycle monitoring and cycle temperatures will begin daily x 14 days, weekly x 2 weeks then monthly to ensure sustained compliance. All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendation. Compliance: 7/10/2024 F 880 R 56 and R 58 physicians were made aware that proper hand hygiene was not performed during resident care. The physician's response will be recorded in the resident electronic medical record. There were no ill effects experienced for this deficient practice. All current residents who are in enhanced barrier precautions, their care was observed and any deficient practices their MD was noted as needed. Future residents who are placed in enhanced precautions, their care will be delivered utilizing the proper		

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F 812	Continued From page 30 water at the bottom of the inside of the machine where it read 100 ppm. DA-A stated the strip indicated the "water temperature", but the process was "confusing" to them. They then stated the water temperature did not matter, and it "will temp how it's supposed to be". They indicated they recorded the temperature on the log hanging on the wall, which should be between 120-150°F, which was the reading on the test strip, and then indicated they thought it was a measure of the water "pressure" but did not know. DA-A ran a load of dishes and verified the temperature reached 112°F. A second load was run and reached 114°F. They indicated the water "pressure" was not reaching 150°F and told the dietary manager (DM). DM stated the water temperature was set to 120°F, and if they set it any higher the laundry had issues. DA-A wrote 150°F in the breakfast and lunch "DM TEMP" columns on the temperature log. The Sanitizer Solution Logs for 3/24, 4/24, 5/24, and 6/24, indicated the water temperature for each meal, every day, was exactly 120°F, except for breakfast and lunch on 6/12/24, which were recorded as 150°F. During observation and interview on 6/12/24 at 12:12 p.m., DM stated the dishwasher was on the same line as the laundry, so if they turned the temperature up too high in the laundry, the water in the dishwasher didn't get hot, however the dishwasher used chemicals to sanitize. DM stated staff measured the sanitizer concentration using a test strip indicator each shift, which should read between 100 ppm and 200 ppm, and recorded it on the log. They stated if it was below 100 ppm they called the service technician to come out to adjust it. Regardless of the water	F 812	hand hygiene per facility policy. Facility nurses and nurse aides will be in-serviced on the enhanced barrier precaution policy that gowns and gloves are to be worn during high contact resident activities and on the Hand Hygiene policy with emphasis on item #8 that before and after handling an invasive device hand hygiene must be performed. Director of Nursing and Infection Preventionist is responsible for compliance. Audits on resident cares observing proper hand hygiene before and after high contact resident activities will begin 3x week x2 weeks, weekly x 4 weeks, then monthly to ensure sustained compliance. All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendation.		

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F 812	Continued From page 31 temperature, DM considered dishware sanitized if the test strips were within acceptable range. A rack of dishware was sent through the machine, where the water temperature reached 113°F. DM stated they were going to call maintenance, to look at it, and indicated dishware needed to be sanitized to kill bacteria. During observation and interview on 6/12/24 at 1:39 p.m., maintenance staff stated the dishwasher temperature reached 120°F during the rinse cycle when it was running. Two loads of dishes were washed, the first reached 112°F, the second reached 118°F. Maintenance stated if there was an issue with the dishwasher, they called the service company, however they were unaware of the inadequate temperature and the service company had not been called. During interview on 6/12/24 at 1:55 p.m., administrator stated they did not have a user manual for the dish machine and was unsure how often the water temperature was checked or documented. They suggested speaking with DM and the dietician to obtain accurate information; however, they assumed the chemical sanitizer was working based upon the results of the test strips. The indicated proper sanitization was important to protect the residents. The dietician was unavailable for interview. During interview on 6/12/24 at 2:40 p.m., dishwasher service representative stated low-temperature dishwashers using chemical sanitizing required a heat temperature at or above 120°F, and the rinse could be between 120°F and 160°F if the sanitizer concentration was within appropriate parameters according to			F 812			

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F 812	Continued From page 32 the test strips. They stated they had not been contacted by the facility to service the dishwashing unit but would come out the following day to assess. During observation on 6/13/24 at 8:57 a.m., dietary staff placed seven plates, one tray, two ceramic bowls, and two plastic bowls into a rack, placed the rack in the machine, and ran the cycle. The temperature on the gauge reached 112°F. A second rack containing six lids, one divided plate, one carafe, one ceramic bowl, one plastic bowl, and three trays was placed into the dishwasher for sanitization. The temperature again reached 112°F. In an email dated 6/13/24, dishwasher service representative indicated they went to the facility to service the machine that afternoon and determined it used the building's hot water supply which was not reaching the required temperature for proper sanitization. The Ecolab Regular Service Call summary dated 6/13/24, identified the dish machine chemical levels were in compliance, however the water temperature was identified as 115°F and included, "Monitor wash temp for compliance to protect guests, reputations, and machine efficiency". The ES Series Door Type, Chemical Sanitizing, Single and Dual Rack Dishmachines Installation and Operation Manual dated 12/5/2007, indicated the machine required a minimum water temperature of 120°F during the wash and rinse cycles. The Dishwashing Machine Use policy dated			F 812			

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F 812	Continued From page 33 3/2010, included food service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation. The policy lacked information relating to water temperature requirements during chemical sanitation.	F 812			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880			7/15/24

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F 880	Continued From page 34 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880			

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F 880	Continued From page 35 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure appropriate hand hygiene practices were performed following personal cares and catheter care for 1 of 1 resident (R58) observed during cares. In addition the facility failed to ensure enhanced barrier precautions (EBP) were utilized for 1 of 1 resident (R56) reviewed who received dialysis. Findings include: R58's admission Minimum Data Set (MDS) dated 6/4/24, identified R58 had moderately impaired cognition and required physical assist from another person for activities of daily living (ADLs) including toileting hygiene, bathing, upper and lower body dressing and personal hygiene. Diagnoses included stroke, hemiplegia (one-sided paralysis), and cataracts. R58 had an indwelling catheter. R58 care plan dated 5/29/24 noted R58 was on enhanced barrier precautions related to an indwelling catheter and tube feeding. During observation on 6/11/24 at 9:38 a.m., nursing assistants (NA)-B and NA-C we observed wearing isolation gowns and gloves during cares. NA-B completed catheter care, then without doffing gloves, performing hand hygiene and donning clean gloves brought the wash basin to the bathroom, opened the bathroom door, emptied the basin, turned on warm water, filled the basin, turned of the water and returned to R58's bedside. NA-B completed perineal care from the head of the penis, to the meatus then	F 880	F 880 R 56 and R 58 physicians were made aware that proper hand hygiene was not performed during resident care. The physician's response will be recorded in the resident electronic medical record. There were no ill effects experienced for this deficient practice. All current residents who are in enhanced barrier precautions, their care was observed and any deficient practices their MD was noted as needed. Future residents who are placed in enhanced precautions, their care will be delivered utilizing the proper hand hygiene per facility policy. Facility nurses and nurse aides will be in-serviced on the enhanced barrier precaution policy that gowns and gloves are to be worn during high contact resident activities and on the Hand Hygiene policy with emphasis on item #8 that before and after handling an invasive device hand hygiene must be performed. Director of Nursing and Infection Preventionist is responsible for compliance. Audits on resident cares observing proper hand hygiene before and after high contact resident activities will begin 3x week x2 weeks, weekly x 4 weeks, then monthly to ensure sustained compliance. All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendation.		

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NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 36 down the catheter. R58 was positioned on his side and buttocks was washed with soap and water, this included an open on his buttocks. Following cares, NA-B , without doffing gloves, performing hand hygiene and donning clean gloves, changed bed linens which also included clean pillow cases. NA-B handed R58 his call light and television remote. Bed controls were used to return R58's bed to the low position while still wearing the same gloves. During interview on 6/11/24 at 10:00 a.m., NA-B accurately explained gloves were changed between cares and hand hygiene performed when transitioning from a dirty area to a clean area. NA-B confirmed she did not change her gloves or perform hand hygiene after completing catheter care and perineal care prior to touching the bathroom door handle, the bathroom door, sink faucet, R58's dresser, changing bed linens, handing R58 his call light and television remote. During interview on 6/12/24 at 10:38 a.m., infection preventionist (RN)-D stated hand washing was the first defense, it was the key to everything. RN-D expected handwashing was completed before donning gloves and after doffing gloves. Gloves should be changed during cares, when moving from a clean area to a dirty area. A facility policy related to hand hygiene and donning/doffing of gloves was requested but was not received. R56's admission MDS dated 5/17/24, indicated R56 had severe cognitive impairment and	F 880			

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

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F 880	Continued From page 37 diagnoses of kidney failure, stroke, and was dependent on dialysis. R56's nursing admission assessment dated 5/7/24, indicated R56 had a dialysis port in the right chest. R56's provider order dated 5/9/24, directed staff to auscultate the vascular access site to R56's right chest to detect a bruit or swishing sound that indicates patency every evening shift after dialysis on Tuesday, Thursday, and Saturday. R56's electronic medical record lacked indication R56 required EBP. An observation on 6/11/24 at 3:46 p.m., R56's door had a sign indicating Enhanced Barrier Precautions and directed staff to wear a gown and gloves when providing close contact cares that include hygiene, dressing, transfers, or device care. Licensed practical nurse (LPN)-B performed hand hygiene and obtained gloves from the personal protective storage on R56's door and walked into R56's room with a blood pressure machine. R56 was seated at the edge of his bed. LPN-B placed the gloves on the bedside table. Without donning a gown or the gloves, LPN-B assisted R56 to remove a flannel shirt from their arm to obtain a blood pressure. LPN-B then obtained the blood pressure. Still without gloves or a gown, LPN-B assisted R56 to lift the long-sleeved shirt up so R56's right dialysis line was visualized. Without touching the line, LPN-B verified the line dressing was intact and had no drainage. LPN-B then assisted with pulling down R56's shirt and placing the left arm back into the flannel shirt. LPN-B then assisted R56 to stand, turn and sit in the wheelchair so he			F 880			

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F 880	Continued From page 38 could be brought to the shower room for a weight. LPN-B then placed the gloves on R56's table and took a sanitizing wipe from the basket of the blood pressure machine to wipe down the machine before removing it from the room. LPN-B then removed gloves and performed hand hygiene before pushing R56 to the shower room. On the shower room door was the same Enhanced Barrier Precautions sign. Under the sign was another sign that directed staff to use personal protective equipment inside room for those on EBP. LPN-B wheeled R56 into the shower room and placed the wheelchair next to the scale. LPN-B did not don a gown or gloves before assisting R56 to stand and take a few steps onto the scale. The weight was obtained and then LPN-B assisted R56 back into his chair and out of the shower room. LPN-B then performed hand hygiene. When interviewed on 6/11/24 at 4:03 p.m., LPN-B stated EBP was not needed for R56, and the sign on the door was intended for R56's roommate. LPN-B further stated if R56 was on EBP, a gown and gloves had to be worn with the assessments and transfers that were just completed. When interviewed on 6/11/24 at 4:03 p.m., registered nurse (RN)-B stated EBP were required for R56 because R56 had an indwelling dialysis line. RN-B further stated any resident with the Enhanced Barrier Precaution sign on the door needed gown and gloves with any close contact cares such as dressing, transferring, and bathing. RN-B further stated those with EBP were typically roomed together, so the signs were for both residents in the room. When interviewed on 6/12/24 at 12:33 p.m., the	F 880			

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F 880	Continued From page 39 interim Director of Nursing (DON) expected EBP to be utilized with those with indwelling lines, such as R56's dialysis line. DON stated some residents were roomed with those who did not require EBP. If a sign was posted on the door, a small sticker was next to the resident's name indicating to staff which resident required EBP. DON acknowledged initially R56 had not been in EBP but should have been due to the line. A facility policy titled Enhanced Barrier Precautions revised 10/18/2022, directed staff to wear gown and gloves during high contact resident care activities such as dressing, transferring, and device care. Furthermore, the policy directed EBP were indicated for residents with wounds and indwelling medical devices regardless of multi-drug resistant organism colonization.	F 880			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/13/2024. At the time of this survey, Victory Health and Rehabilitation Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000			

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

Electronically Signed

TITLE

(X6) DATE

07/02/2024

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

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Victory Health & Rehab Center is a 2-story building with a partial basement that was built in 1990 and was determined to be of Type II(222) construction. This facility is divided into three separate smoke compartments. This facility is fully protected throughout by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in the corridors and	K 000			

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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 9BSQ21 Facility ID: 00166 If continuation sheet Page 3 of 8

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K 321	Continued From page 3 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage room doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, and 19.3.2.1.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/13/2024 between 9:00 and 11:00 AM, it was revealed by observation that room 190 had combustible storage in it and did not have self-closing door hardware. An interview with the Administrator verified this deficient finding at the time of discovery.	K 321	This Plan of Correction and the responses to each K-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the K-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent informal dispute resolution session, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. Room 190 combustionable concerns have been removed. Room 190 remains a banked resident room. All rooms have reviewed to ensure compliance. Maintenance staff educated on defeincy and compliance by the Administrator. Administrator will round facility once weekly regarding stated compliance for 30 days to ensure compliance with plan of correction. Results of findings will be forwarded to the		

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K 321	Continued From page 4	K 321	QAPI Committee for on going compliance review/recommendations.	7/15/24	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA				

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K 918	Continued From page 5 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.9, 8.4.9.1, 8.4.9.2, and 8.4.9.5.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/13/2024 between 9:00 and 11:00 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing a four (4) hour load bank test has been completed within the last 36 months for the generator. An interview with the Administrator verified this deficient finding at the time of discovery.	K 918	K 918 A generator test was performed by 7/15/24. A load bank test is scheduled by Cummings. Monthly, the generator test will be completed per policy and an annual load test will be performed yearly per facility policy. There were no ill effects experienced from this deficient practice. The Maintenance Director will be in-serviced on the NFPA 110 Generator TELS Masters procedure for performing and recording monthly generator testing. A load bank test will be performed annually, and results of this test will be placed in the maintenance log. The Maintenance Director and/or designee is responsible for compliance. Audits on monthly generator testing will begin monthly x 3 months to ensure compliance. Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation.		
K 923 SS=D	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates	K 923			7/15/24

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K 923	Continued From page 6 outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain storage of an oxygen tank per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.2.3 (11), and 11.6.5.2. This deficient finding could have an isolated impact on the patients within the facility. Findings include:			K 923	The full and empty oxygen tanks have been stored properly per regulation. Both full and empty tanks segregated and tip resistance storage. Staff have been educated on proper storage of oxygen including the deficient practice.		

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K 923	Continued From page 7 On 06/13/2024 between 9:00 and 11:00 AM, it was revealed by observation in oxygen storage room there were 3 oxygen tanks that were not secured for tip resistance, and empty and full cylinders were not properly segregated from each other. An interview with the Administrator verified this deficient finding at the time of discovery.			K 923	Audits will occur for 2 times a week for the duration of one month. Results of findings will be forwarded to the QAPI Committee for on going compliance review/recommendations.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 27, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 9BSQ11

Dear Administrator:

The above facility was surveyed on June 10, 2024 through June 13, 2024 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.

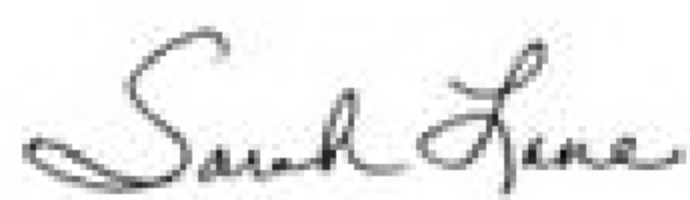
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/13/2024
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
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 6/10/24-6/13/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

07/02/24

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H55444301C (MN00101928/MN00101363), H55444262C (MN00100643), H55444249C (MN00100953), H55444263C (MN00102856/MN00102833), H55444283C (MN00099283), H55444248C (MN00100086) no licensing orders were issued. 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 surveyors 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic	2 000			

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2 000	Continued From page 2 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to include individualized approaches for care, including non-pharmacological interventions to aid in the management of behavior, in the comprehensive care plan for 2 of 5 residents (R1, R6) reviewed for unnecessary medications. Findings include:	2 565			7/15/24
			This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any		

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2 565	Continued From page 3 R1's significant change Minimum Data Set (MDS) dated 5/9/24, included R1 was moderately cognitively impaired, had diagnoses of dementia, depression, and psychotic disorder (other than schizophrenia). R1 took antidepressant and antipsychotic medications on a routine basis. R1's Mood State Care Area Assessment (CAA) was not triggered. R1's Psychotropic Drug Use Care Area Assessment (CAA) indicated R1 took antipsychotic medications, was at risk for adverse reactions from the medications, and had no noted side effects. R1's Order Summary Report dated 6/5/24, included: *Aripiprazole tablet 5 milligrams (mg) one time per day for psychosis starting 6/1/24. *Sertraline HCl (hydrochloride) tablet, 150 mg one time per day for major depressive disorder starting 1/6/24. *Trazodone HCl tablet 100 mg (an antidepressant), one time per day at bedtime for insomnia starting 10/23/23. R1's care plan dated 10/30/23, indicated the resident had anxiety and included the following interventions: *Adhere to resident's stated choice of routine/activity pattern. *Allow resident to express concerns--validate/offer TLC (tender loving care) as appropriate. *Allow the resident time to answer questions and to verbalize feelings perceptions, and fears. *Assess placement needs as needed/appropriate. *Be attentive to resident's need--observe for any	2 565	appropriate forum, including in an independent informal dispute resolution session, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. Corrected		

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2 565	Continued From page 4 s/s of discomfort, anxiety, being overwhelmed, etc. *Consult with: Pastoral care, Social services, Psychology services *Educate resident and/or family regarding discharge planning needs. *Encourage participation in activities/decisions from resident who depends on others to make own decisions. The care plan also included R1 had a mood problem dated 10/30/23, and included interventions of: *Administer medications as ordered. Monitor/document for side effects and effectiveness. *Behavioral health consults as needed psycho-geriatric team, psychiatrist etc. *Educate the resident/family/caregivers regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance. *Monitor/document/report PRN (as needed) any risk for harm to self: suicidal plan, past attempt at suicide, risky actions stockpiling pills, saying goodbye to family, giving away possessions or writing a note, intentionally harmed, or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment, or safety awareness. *Monitor/record mood to determine if problems seem to be related to external causes, i.e., medications, treatments, concern over diagnosis. *Monitor/record/report to MD (medical doctor) prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor	2 565			

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2 565	Continued From page 5 skills *Monitor/record/report to MD prn mood patterns s/sx (signs/symptoms) of depression, anxiety, sad mood as per facility behavior monitoring protocols. In addition, R1 had depression and took an antidepressant medication, and the care plan dated 11/2/23, instructed staff to: *Administer medications as ordered. Monitor/document for side effects and effectiveness. *Arrange for psych consult, follow up as indicated. *Discuss with the resident/family/caregivers any concerns, fears, issues regarding health or other subjects *Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment, or safety awareness. *Monitor/document/report PRN any s/sx of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness. *Monitor/record/report to MD prn risk for harming others: increased anger, labile mood, or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons *Pharmacy review monthly or per protocol. *The resident needs time to talk. Encourage the resident to express feelings. *The resident needs adequate rest periods. The	2 565			

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2 565	Continued From page 6 resident prefers to rest. *Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness *Educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms of anti-depressant drugs being given). *Monitor/document/report PRN adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, n/v (nauseas/vomiting), dry mouth, dry eyes R1 used psychotropic medications and the care plan dated 10/24/23, included the following interventions: *The resident will reduce the use of psychotropic medication through the review date. *Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness. *Consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly. *Discuss with MD, family re ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. *Monitor/document/report PRN any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (extrapyramidal side effects caused by psychotropic medications, such as shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry	2 565			

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2 565	Continued From page 7 mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. The care plan lacked evidence of non-pharmacological, resident-specific interventions. During observation on 6/10/24 at 1:28 p.m., R1 was heard crying in their room, stating numerous times, "I feel like shit, I feel like shit" while staff were in the room attempting to assist R1. R1 continued to verbalize negative comments, many unintelligible. Staff placed R1 in their bed and left the room. R1 was noted to be sleeping in bed at 2:20 p.m., and 5:18 p.m. During interview on 6/12/24, at 7:42 a.m., registered nurse (RN)-A stated mental health and behavioral interventions should be in the care plan and be specific for each resident based upon the cause of the behavior or situation. Once potential causes were assessed and interventions were identified, staff would know how best to help. During interview on 6/12/24 at 8:57 a.m., trained medication aide (TMA)-A stated if a resident demonstrated they were in distress, either by words or behaviors, they would ask what they needed and try to fix it, and/or let the nurse know to possibly give medication. They were unaware of any resident-specific interventions for R1 and addressed each resident in the same manner. During interview on 6/12/24 at 10:01b a.m., licensed practical nurse (LPN)-C stated if there was a behavioral or mental health concerns, they	2 565			

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2 565	Continued From page 8 talked with the resident to figure out why they were acting out and tried to address it. LPN-C indicated R1 a history of suicidal ideation and anxiety, and made comments including "nobody cares", or "let me lay down", however there were no resident-specific interventions in R1's care plan. During interview on 6/12/24 at 10:12 a.m., director of nursing (DON) stated interventions should be individualized and in the care plan, and any behaviors and successful interventions documented so staff could use what was known to be helpful before trying other things. DON reviewed R1's medical record and care plan and verified there were no resident-specific interventions related to their depression, anxiety, and mental health in general, however it was important to identify a list of things which could be helpful since everyone reacts differently in varying situations. It was important to learn what was helpful and spread the word to make the resident feel better. The Antipsychotic Medication Use Policy dated 12/2016, included antipsychotic medications will be considered if behavioral interventions have been attempted and included in the plan of care, except in emergency. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating and implementing a comprehensive individualized care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created	2 565			

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2 565	Continued From page 9 and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565			
21155	MN Rule 4658.0675 Subp. 5 Mechanical Cleaning and Sanitizing; Chemical Subp. 5. Chemical sanitization. Single-tank machines, stationary-rack machines, door-type machines, and spray-type glass washers using chemicals for sanitization may be used, provided that: A. wash water temperatures, addition of chemicals, rinse water temperatures, and chemical sanitizers used are in conformance with NSF International Standard No. 3, incorporated by reference in subpart 2, and Standard No. 29, Detergent and Chemical Feeders for Commercial Spray-Type Dishwashing Machines, issued by NSF International, November 1992. These standards are incorporated by reference. They are available through the Minitex interlibrary loan system. They are not subject to frequent change; B. a test kit or other device that accurately measures the parts per million concentration of the sanitizing solution must be available and be used, and a log of the test results must be maintained for the previous three months; C. containers for storing the sanitizing agent must be installed in such a manner as to ensure that operators maintain an adequate supply of sanitizing compound; and D. a visual or audible warning device must be provided for the operator to easily verify when the	21155			7/15/24

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21155	Continued From page 10 sanitizing agent is depleted. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper sanitization of dishware used for meal preparation and resident service when 1 of 1 low-temperature chemical sanitizing commercial dishwashers was identified as not reaching adequate wash and rinse temperatures. This had potential to affect all 62 residents within the facility, staff, and visitors who consumed food from the main production kitchen. Findings include: During observation and interview on 6/11/24 at 12:04 p.m., dietary manager (DM) stated staff used chlorine test strips to determine if the chemical sanitizer concentration was adequate for sanitization by dipping the strip into the bottom reservoir of the dish machine and comparing the color to the key on the test strip label container. They indicated it must read between 100-200 parts per million (ppm). DM demonstrated the process, and the solution tested at 100 ppm. DM loaded a tray of pans, placed it in the dish machine, and closed the door to start the unit. The water temperature gauge read 113 degrees Fahrenheit (°F). DM verified the temperature reading, and stated the pans were sanitized because it was a low temperature dishwasher, so the water temperature did not matter. The dish machine was identified as an Ecolab ES2000. During observation and interview on 6/12/24 at 11:17 a.m., dietary aide (DA)-A demonstrated the use of the facility dish machine. They loaded a	21155	Corrected		

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21155	Continued From page 11 rack with nine plates and two bowls, placed the rack in the dishwasher, and closed the door to start the unit, allowing it to run until the cycle was complete. When asked about the water temperature requirements for dish sanitization, DA-A demonstrated the facility testing method by placing an indicator strip in the refuse drain trap underneath the dish machine where the soiled water was ejected from the machine. The strip read 50 ppm. DA-A stated it should read 100-200, obtained another test strip, and inserted it into the water at the bottom of the inside of the machine where it read 100 ppm. DA-A stated the strip indicated the "water temperature", but the process was "confusing" to them. They then stated the water temperature did not matter, and it "will temp how it's supposed to be". They indicated they recorded the temperature on the log hanging on the wall, which should be between 120-150°F, which was the reading on the test strip, and then indicated they thought it was a measure of the water "pressure" but did not know. DA-A ran a load of dishes and verified the temperature reached 112°F. A second load was run and reached 114°F. They indicated the water "pressure" was not reaching 150°F and told the dietary manager (DM). DM stated the water temperature was set to 120°F, and if they set it any higher the laundry had issues. DA-A wrote 150°F in the breakfast and lunch "DM TEMP" columns on the temperature log. The Sanitizer Solution Logs for 3/24, 4/24, 5/24, and 6/24, indicated the water temperature for each meal, every day, was exactly 120°F, except for breakfast and lunch on 6/12/24, which were recorded as 150°F. During observation and interview on 6/12/24 at 12:12 p.m., DM stated the dishwasher was on the	21155			

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21155	Continued From page 12 same line as the laundry, so if they turned the temperature up too high in the laundry, the water in the dishwasher didn't get hot, however the dishwasher used chemicals to sanitize. DM stated staff measured the sanitizer concentration using a test strip indicator each shift, which should read between 100 ppm and 200 ppm, and recorded it on the log. They stated if it was below 100 ppm they called the service technician to come out to adjust it. Regardless of the water temperature, DM considered dishware sanitized if the test strips were within acceptable range. A rack of dishware was sent through the machine, where the water temperature reached 113°F. DM stated they were going to call maintenance, to look at it, and indicated dishware needed to be sanitized to kill bacteria. During observation and interview on 6/12/24 at 1:39 p.m., maintenance staff stated the dishwasher temperature reached 120°F during the rinse cycle when it was running. Two loads of dishes were washed, the first reached 112°F, the second reached 118°F. Maintenance stated if there was an issue with the dishwasher, they called the service company, however they were unaware of the inadequate temperature and the service company had not been called. During interview on 6/12/24 at 1:55 p.m., administrator stated they did not have a user manual for the dish machine and was unsure how often the water temperature was checked or documented. They suggested speaking with DM and the dietician to obtain accurate information; however, they assumed the chemical sanitizer was working based upon the results of the test strips. The indicated proper sanitization was important to protect the residents.	21155			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/13/2024
NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21155	Continued From page 13 The dietician was unavailable for interview. During interview on 6/12/24 at 2:40 p.m., dishwasher service representative stated low-temperature dishwashers using chemical sanitizing required a heat temperature at or above 120°F, and the rinse could be between 120°F and 160°F if the sanitizer concentration was within appropriate parameters according to the test strips. They stated they had not been contacted by the facility to service the dishwashing unit but would come out the following day to assess. During observation on 6/13/24 at 8:57 a.m., dietary staff placed seven plates, one tray, two ceramic bowls, and two plastic bowls into a rack, placed the rack in the machine, and ran the cycle. The temperature on the gauge reached 112°F. A second rack containing six lids, one divided plate, one carafe, one ceramic bowl, one plastic bowl, and three trays was placed into the dishwasher for sanitization. The temperature again reached 112°F. In an email dated 6/13/24, dishwasher service representative indicated they went to the facility to service the machine that afternoon and determined it used the building's hot water supply which was not reaching the required temperature for proper sanitization. The Ecolab Regular Service Call summary dated 6/13/24, identified the dish machine chemical levels were in compliance, however the water temperature was identified as 115°F and included, "Monitor wash temp for compliance to protect guests, reputations, and machine efficiency".	21155			

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21155	Continued From page 14 The ES Series Door Type, Chemical Sanitizing, Single and Dual Rack Dishmachines Installation and Operation Manual dated 12/5/2007, indicated the machine required a minimum water temperature of 120°F during the wash and rinse cycles. The Dishwashing Machine Use policy dated 3/2010, included food service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation. The policy lacked information relating to water temperature requirements during chemical sanitation. The Sanitization policy (undated), indicated low-temperature dishwashing machines must be operated using a wash temperature of 120°F. SUGGESTED METHOD OF CORRECTION: The facility could review their policy and procedures pertaining to dishwasher sanitization. The facility could educate staff on dishwasher sanitization. The facility could then develop an auditing system to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21155			
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375			7/15/24

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21375	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure appropriate hand hygiene practices were performed following personal cares and catheter care for 1 of 1 resident (R58) observed during cares. In addition the facility failed to ensure enhanced barrier precautions (EBP) were utilized for 1 of 1 resident (R56) reviewed who received dialysis. Findings include: R58's admission Minimum Data Set (MDS) dated 6/4/24, identified R58 had moderately impaired cognition and required physical assist from another person for activities of daily living (ADLs) including toileting hygiene, bathing, upper and lower body dressing and personal hygiene. Diagnoses included stroke, hemiplegia (one-sided paralysis), and cataracts. R58 had an indwelling catheter. R58 care plan dated 5/29/24 noted R58 was on enhanced barrier precautions related to an indwelling catheter and tube feeding. During observation on 6/11/24 at 9:38 a.m., nursing assistants (NA)-B and NA-C we observed wearing isolation gowns and gloves during cares. NA-B completed catheter care, then without doffing gloves, performing hand hygiene and donning clean gloves brought the wash basin to the bathroom, opened the bathroom door, emptied the basin, turned on warm water, filled the basin, turned of the water and returned to R58's bedside. NA-B completed perineal care from the head of the penis, to the meatus then down the catheter. R58 was positioned on his	21375	Corrected		

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21375	Continued From page 17 5/7/24, indicated R56 had a dialysis port in the right chest. R56's provider order dated 5/9/24, directed staff to auscultate the vascular access site to R56's right chest to detect a bruit or swishing sound that indicates patency every evening shift after dialysis on Tuesday, Thursday, and Saturday. R56's electronic medical record lacked indication R56 required EBP. An observation on 6/11/24 at 3:46 p.m., R56's door had a sign indicating Enhanced Barrier Precautions and directed staff to wear a gown and gloves when providing close contact cares that include hygiene, dressing, transfers, or device care. Licensed practical nurse (LPN)-B performed hand hygiene and obtained gloves from the personal protective storage on R56's door and walked into R56's room with a blood pressure machine. R56 was seated at the edge of his bed. LPN-B placed the gloves on the bedside table. Without donning a gown or the gloves, LPN-B assisted R56 to remove a flannel shirt from their arm to obtain a blood pressure. LPN-B then obtained the blood pressure. Still without gloves or a gown, LPN-B assisted R56 to lift the long-sleeved shirt up so R56's right dialysis line was visualized. Without touching the line, LPN-B verified the line dressing was intact and had no drainage. LPN-B then assisted with pulling down R56's shirt and placing the left arm back into the flannel shirt. LPN-B then assisted R56 to stand, turn and sit in the wheelchair so he could be brought to the shower room for a weight. LPN-B then placed the gloves on R56's table and took a sanitizing wipe from the basket of the blood pressure machine to wipe down the machine before removing it from the room.	21375			

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21375	Continued From page 18 LPN-B then removed gloves and performed hand hygiene before pushing R56 to the shower room. On the shower room door was the same Enhanced Barrier Precautions sign. Under the sign was another sign that directed staff to use personal protective equipment inside room for those on EBP. LPN-B wheeled R56 into the shower room and placed the wheelchair next to the scale. LPN-B did not don a gown or gloves before assisting R56 to stand and take a few steps onto the scale. The weight was obtained and then LPN-B assisted R56 back into his chair and out of the shower room. LPN-B then performed hand hygiene. When interviewed on 6/11/24 at 4:03 p.m., LPN-B stated EBP was not needed for R56, and the sign on the door was intended for R56's roommate. LPN-B further stated if R56 was on EBP, a gown and gloves had to be worn with the assessments and transfers that were just completed. When interviewed on 6/11/24 at 4:03 p.m., registered nurse (RN)-B stated EBP were required for R56 because R56 had an indwelling dialysis line. RN-B further stated any resident with the Enhanced Barrier Precaution sign on the door needed gown and gloves with any close contact cares such as dressing, transferring, and bathing. RN-B further stated those with EBP were typically roomed together, so the signs were for both residents in the room. When interviewed on 6/12/24 at 12:33 p.m., the interim Director of Nursing (DON) expected EBP to be utilized with those with indwelling lines, such as R56's dialysis line. DON stated some residents were roomed with those who did not require EBP. If a sign was posted on the door, a small sticker was next to the resident's name	21375			

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