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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victory Health & Rehabilitation Center	512 49th Avenue North Minneapolis, MN 55430

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on interview and document review, the facility failed to notify the physician a resident was transferred to the hospital 1 of 4 residents (R29) reviewed for change of condition. Findings include: R29's significant change Minimum Data Set (MDS) dated [DATE], indicated R29 was cognitively intact and had diagnoses which included vertigo, hypotension (low blood pressure), and anxiety disorder. Review of R29's progress notes revealed the following: - 11/22/21, at 11:16 p.m. indicated R29 was hospitalized . - 11/26/21, at 9:64 a.m. indicated R29 was at the hospital on observation status. R29 had complaints of vision changes, was ruled out for a Clostridioides difficile infection (bacteria which causes severe diarrhea and inflammation of the colon) and had no new diagnoses. Review of R29's medical record lacked indication the physician was notified R29 was transferred to the hospital. During an interview on 12/1/21, at 3:18 p.m. social worker (SW)-A stated R29 was transferred to the emergency department on 11/22/21, and was placed on observation status at the hospital with a chief complaint of vertigo and failure to thrive. During an interview on 11/30/21, at 1:35 p.m. LPN-B stated R29 refused to take any medications on 11/22/21, and had notified the provider. R29 was not aware of any other concerns regarding R29 during their shift and verbalized they were not aware R29 was transferred to the hospital. During an interview on 11/30/21, at 2:50 p.m. licensed practical nurse (LPN)-A stated he observed R29 near the facility entrance on 11/30/21, at approximately 3:00 p.m. calling 911 when arriving for his shift. He was notified R29 had already left for the hospital when he started his shift, however, did not receive any detail regarding why R29 went to the hospital. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/1/21, at 10:59 a.m. physician assistant (PA)-A stated there were no call notes dictated on 11/22/21, indicating R29 was at the hospital, however there was a note LPN-B called to request R29 be rounded on as the resident, did not seem like themselves. PA-A stated they learned of R29's hospitalization during chart review on 11/26/21, or 11/29/21, when preparing for a visit. PA-A stated staff were expected to notify the provider, or call center, when a resident was transferred to the hospital and further verbalized the lack of notification was not an isolated incident for the facility. PA-A stated she did not know what lead to R29's hospitalization . During an interview on 12/2/21, at 10:10 a.m. the director of nursing (DON) stated she did not know why R29 was hospitalized or the events leading up to R29 going to the hospital. The DON verified R28's medical record lacked indication of why R29 was hospitalized or subsequent provider notification. The DON stated she expected staff to notify providers and document the notification. Facility policy titled A Change in a Resident's Condition or Status (undated), indicated the facility would promptly notify the physician of a resident's medical change or change in condition/status.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44657 Based on observation, interview, and document review, the facility failed to ensure assistance with hygiene was provided for 1 of 3 residents (R28) who was dependent upon staff for activities of daily living (ADL). Findings include: R28's Admission Record dated 12/2/21, indicated R28 had diagnoses which included rheumatoid arthritis (causes pain, swelling, stiffness, and loss of function in joints) and chronic pain syndrome. R28's quarterly Minimum Data Set (MDS) dated [DATE], indicated R28 was cognitively intact and had no documented rejection of care. R28 was totally dependent of two staff for bed mobility, transfers, toilet use, and personal hygiene. R28 had impairments of both upper and lower extremities and was always incontinent of bowel. R28's care plan dated 5/2/21, identified R28 had an ADL self-care deficit related to bilateral above knee amputations, a sacral wound (area where the spine connects to the lower half of the body), weakness, and rheumatoid arthritis. Staff were directed to provide assistance with all hygiene cares, assist with toileting, bathing, and dressing. Review of R28's ADL Task Record dated 11/30/21, indicated from 11/1/21, through 11/30/21, staff documented hygiene was completed for 16 of 87 opportunities. There were no documented refusals and R28 was hospitalized on [DATE]. Review of R28's ADL Task Record Record dated 12/2/21, indicated from 12/1/21, staff documented was completed for 1 of 3 opportunities. There were no documented refusals. During an observation on 11/29/21, at 9:00 a.m. R28 was observed laying in bed on her back with a pillow slightly under her right side. R28's fingernails were roughly two inches long and a brownish/black residue was noted under her fingernails. R28's skin was dry and flaking on her hands. R28's gums were noted to be red in color with breath had a noticeable odor. Further, R28's tongue was coated with a whitish/yellow colored thick film. During an observation on 11/30/21, at 9:41 a.m. R28 laying in bed and provided a bed bath by nursing assistant (NA)-A. NA-A did not offer nail care or oral care throughout the observation. NA-A stated the evening or night shift can provide oral cares and nail care. Further, R28's long nails needed to be cut or cleaned because of dirt underneath. During an interview on 11/30/21, at 2:28 p.m. licensed practical nurse (LPN)-C stated it was the responsibility of nursing assistants to provide ADL cares. She stated a resident's care plan directed staff of the care R28 required every day. LPN-C further stated she saw dirt build up under R28's nails. During an observation on 12/1/21, at 9:39 a.m. R28's fingernails remained roughly two inches long with browning/black residue underneath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/1/21, at 10:00 a.m. R28 stated no one had cleaned her fingernails or provided oral cares for many days; maybe sometime the previous week. R28 stated she previously brushed her teeth daily when she was able to do it on her own. R28 expressed she would like to have her nails cleaned and oral cares provided. During an interview on 12/1/21, at 1:45 p.m. the assistant director of nursing (ADON) stated she was unaware oral cares were not provided to R28. During an interview on 12/1/21, at 1:42 p.m. the director of nursing (DON) explained she had not heard of R28 refusing cares. The DON stated nursing assistants should provide daily personally hygiene care and document refusals. Her expectation was for personal hygiene cares to be completed every shift and as needed. The DON stated she felt there was enough staff to complete cares, but the facility culture was nurses did not always want to help nursing assistants. The DON confirmed she knew R28's fingernails were long. Facility policy titled Activities of Daily Living (ADL's) (undated) directed residents who were unable to carry out ADLs independently would receive services to maintain good nutrition, grooming, and personal and oral hygiene.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44657 Based on observation, interview, and document review, the facility failed to comprehensively reassess and implement interventions as ordered by the physician to promote healing and reduce the risk of complications of an existing pressure ulcer for 1 of 3 residents (R28) reviewed for pressure ulcers. The resulted in actual harm for R28 who had a worsening stage IV pressure ulcer. Findings include: Pressure Ulcer Definition: Stage IV Tissue loss with exposed bone, tendon, or muscle. Slough or eschar (Dead tissue that is hard or soft in texture, usually black, brown, or tan in color, and may appear scab-like. Eschar tissue is usually firmly adherent to the base of and wound and often the sides/edges of the wound), may be present. It often includes undermining (outwardly visible wound margins) and tunneling (passageways underneath the surface of the skin). R28's Admission Record dated 12/2/21, indicated R28's diagnoses included diabetes, pressure ulcer of sacral region (area where the spine connects to the lower half of the body), and absence of right and left leg above knee. R28's quarterly Minimum Data Set (MDS) dated [DATE], indicated R28 was cognitively intact and had no documented rejection of care. R28 was totally dependent of two staff with bed mobility, transfers, and toilet use. R28 had an impairment to both upper and lower extremities and was always incontinent of bowel. R28 had three documented stage IV pressure ulcers which were present upon admission. Several treatments were noted which included pressure reducing device for chair and bed. R28s Care Area Assessment (CAA) dated 5/7/21, indicated R28 was totally dependent of staff for bed mobility, dressing, toilet use, and personal hygiene. The CAA further indicated R28 required a total assist of two staff, with the use of hoyer lift to transfer Further, R28 required extensive assistance of two staff to turn and reposition in bed every two hours and as necessary. R28's care plan dated 9/19/21 indicated R28 had stage IV pressure ulcers on her sacrum right ischium (lower back part of the hip bone), and left ischium. The care plan further identified R28 had the potential to develop additional pressure ulcers related to incontinence, immobility, and weakness. R28's care plan included several interventions including to conduct weekly skin assessments and provide wound care per orders. R28's care plan was revised on 12/2/21, to include assisting R28 to sit up in tilt-in-space wheelchair with a pressure reducing cushion for mealtimes. R28 was not to exceed two hours of sitting to offload pressure. R28's Order Summary Report dated 12/2/21, indicated staff were to offload R28, per facility protocol, and maybe up in chair two hours per day and an additional one hour after a two-hour break in the morning and afternoon. Further, R28 was to be repositioned every two hours and have weekly skin checks completed every Tuesday morning. R28's wound care orders included: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Right/left ischium and sacrum wound care: Make sure all pieces of silver alginate (product used to promote wound healing) were removed from the wound bed. Saturate 4 x 4 gauze with Vashe (wound cleanser). The saturated gauze was then to be placed in R28's wound beds and undermining areas and allow to sit for five minutes. Remove (gauze) and place silver alginate. Place a foam boarder dressing in the morning. An Interdisciplinary team (IDT) progress note dated 12/1/21, at 7:17 p.m. indicated R28 was hospitalized from 10/1/21, to 10/20/21 due to severe sepsis secondary to a decubitus sacral wound abscess (collection of puss related to infection) and osteomyelitis. Additionally, R28 was under observation in the hospital on 11/24/21, related to chest pain. R28's Wound Physician Progress Note written by medical doctor (MD)-C dated 11/18/21, revealed the following: - R28's stage IV sacral pressure wound measured 3.5 centimeters (cm.) x 3.0 cm. x 2.0 cm. with undermining of 5.0 cm. at the three o'clock position. The wound had 80 percent granulation (new tissue), 20 percent muscle and fascia (thin casing of connective tissue which holds muscle in-place), and moderate serous exudate (clear, thin, and watery fluid). R28's stage IV pressure wound to her left ischium measured 1. 0 cm. x 1.0 cm. x 1.5 cm with abnormal granulation present within the wound margins. R28's stage IV pressure wound to her right ischium measured 0.8 cm. x 0.8 cm. x 1.0 cm with 100 percent granulation present. Recommendations included offloading the wound and repositioning per facility protocol. R28 may be up for two hours in their chair and one hour after a two-hour break. Review of R28's November 2021 Task Record, revealed no transferring/bed mobility was not documented for 46 of 87 opportunities. There were no documented refusals. Review of R28's December 2021 Task Record, revealed no transferring/bed mobility was not documented for 2 of 3 opportunities. There were no documented refusals. Review of R28's Weekly Skin Check Progress notes revealed: - 11/19/21, at 3:50 p.m. indicated R28 was on a turning and repositioning program and had a coccyx wound. The progress note lacked assessment of R28's wound. - No additional documentation was provided, when requested, for skin assessments on 11/1/21, 11/8/21, and 11/22/21. During a continuous observation conducted on 11/29/21, from 8:30 a.m. to 11:43 a.m. R28 was noted to be laying flat on her back, in bed, with a pillow to the right of her bed. R28's eyes were closed, and she was noted to be moaning and called out to staff for help. At 10:30 a.m., R28 was moaning, ouch. At 11:43 a.m., R28 called out for help and stated she had pain. At 11:44 a.m., licensed practical nurse (LPN)-C was approached and advised R28 had not been repositioned since the continuous observation began at 8:30 a. m. LPN-C stated she would notify a nursing assistant. Throughout the observation, no staff entered R28's room, nor responded to R28 who was calling out periodically. Three hours and 13 minutes had passed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation on 11/29/21, at 10:25 a.m. LPN-B provided wound care to R28. R28 reported she had pain and noted facial grimacing when repositioned to her left side and throughout wound care. R28's dressing was noted to be completely saturated with bloody red drainage which also soaked through to R28's incontinence product and the sheet below her. Further, R28 was also observed to have four [NAME] electrocardiogram (EKG) electrodes on her back which were removed by LPN-B. LPN-B stated the [NAME] electrodes must had been on R28's back since her emergency department visit on 11/24/21. LPN-B removed the old dressing from the sacral, right, and left ischium pressure wounds. LPN-B then poured a small amount of Vashe solution on gauze and placed the gauze on R28's sacral and right and left ischium pressure wounds. The gauze was not completely saturated with Vashe solution. After roughly five minutes, the gauze was removed and LPN-B applied silver alginate to R28's sacral, right, and left ischium pressure wounds. The piece silver alginate was cut round and roughly 1.5 inches in diameter and did not cover the entire wound bed of the sacral wound. LPN-B then covered R28's wounds with a foam dressings. Immediately following the dressing change LPN-B stated she was not aware the gauze needed to be saturated with Vashe solution or the silver alginate dressing needed to cover the entire wound bed. During an interview on 11/30/21, at 12:45 p.m. the assistant director of nursing (ADON) stated she started a performance improvement plan for wound care and assessments as she discovered concerns regarding how wounds were being assessed, staff roles and responsibilities, and providing wound care as directed by the medical provider. The ADON stated R28 had not been assessed by a wound provider for a few weeks as she fell off the list to be evaluated after being transferred to the emergency department on 11/24/21. During an observation on 12/1/21, at 10:00 a.m. the director of nursing (DON) and assistant director of nursing provided wound care to R28's sacral and right and left ischium pressure wounds. The ADON assisted R28 to reposition to her left side and removed an incontinence product. The DON removed the dressings which had a large copious amount of yellow/brown non-odorous drainage with blood which soaked through the dressing. The DON cleansed the outside of the sacral pressure wound and applied Vashe soaked gauze to R28's wound beds for five minutes. The DON then removed the gauze and inserted silver alginate into R28's wounds. The silver alginate did not cover the entire wound bed where undermining was located. The DON then applied a foam dressing. During an interview on 12/1/21, at 1:45 p.m. the director of nursing (DON) stated when she observed R28's dressing change on 11/30/21, it appeared wound care was not completed as ordered. She confirmed the silver alginate dressing did not cover R28's entire wound bed, as directed, and fluid had saturated through R28's dressing and onto R28's incontinence product. The DON described the drainage as bloody discharge and stated R28's wound bed lacked granulation upon her wound assessment today which was noted on previous assessments. The DON confirmed R28's wound had worsened and included several reasons which included weekly skin checks not being completed, lack of timely repositioning, and no consistent wound care. The DON also stated R28 had stool on her incontinent product and sheet when wound care was completed on 11/30/21, and staff needed to ensure R28 was kept clean. Further, the DON stated staff were not reporting to the nurse when bandages became soiled and needed to be changed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation on 12/2/21, at 12:00 p.m. MD-C, the ADON, and LPN-D provided wound care to R28. LPN-D assisted R28 reposition to her left side. R28 expressed pain to MD-C and had facial grimacing. The ADON removed R28's incontinence product and subsequently removed R28's old dressing located on the sacrum and right and left ischium pressure wounds. R28 had small amount of light brown colored stool noted on her incontinence product. Stool was also noted on R28's skin roughly three inches from the sacral wound. The ADON proceeded to cleanse the skin with wound cleanser. MD-C assessed R28's wounds and additional pieces of silver alginate were noted in the sacral wound. MD-C told the ADON and LPN-D to use a cotton tipped applicator to assess the wound and ensure all pieces of silver alginate were removed. MD-C inserted Vashe soaked gauze into R28's wound beds for five minutes. MD-C [NAME] removed the gauze and completely covered R28's pressure wounds with silver alginate. The wounds were then covered with a foam dressing. MD-C then stated to the ADON and LPN-D to ensure a full piece of alginate was used so it completed covered the entire wound bed to promote proper healing. MD-C also instructed staff to offload R28 completely. Immediately following the observation, MD-C was interviewed and stated R28's sacral wound had deteriorated from when she had assessed R28's wounds two weeks ago. R28's sacral pressure ulcer and measurements increased in length and the amount of tunneling. MD-C attributed worsening tunneling to not being fully repositioned or not being repositioned every two hours. MD-C stated the reasons for wound deterioration included: need to offload the wound, continuity of wound care, and incontinence care. MD-C stated during her visit today, R28 had stool in her incontinence product and staff left the stool on R28's skin when wound care was provided. MD-C stated she expected the facility to reposition R28 every two hours, provide R28 a wheelchair cushion, provide good incontinence care, and change dressings immediately if soiled. A subsequent Wound Physician Progress Note written by MD-C dated 12/2/21, revealed the following: - R28's stage IV sacral pressure wound measured 3.5 cm. x 4.0 cm. x 1.5 cm. Moderate serous excaudate was noted with 10 percent slough (dead tissue) and 90 percent granulation. Further, the wound had undermining which measured 5.5 cm at the three o'clock position, 4.5 cm. at the nine o'clock position, and 7. 5 cm. at the 12 o'clock position. R28's sacral wound had deteriorated since her last visit on 11/18/21. R28's wound was debrided of 1.4 cm. of devitalized tissue (non-viable) at a depth of 1.6 cm. Facility policy titled Pressure Injury Treatment (undated) directed to provide care of existing pressure injuries and the prevention of additional injuries. Staff were to review the residents care plan and assess for any special needs of the resident, pressure injury care, current support surfaces, and status of the injury.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44657 Based on interview and document review, the facility failed to ensure oxygen was administered in accordance with acceptable standards of practice to reduce the likelihood of potential accident hazards for 1 of 1 resident (R28) who was administered oxygen therapy. Findings include: R28's Admission Record dated 12/2/21, indicated R28's diagnoses included pneumonitis (inflammation of lung tissue) and chronic respiratory failure. R28's Order Summary Report dated 11/30/21, directed staff to apply a small amount of Vaseline into both of R28's nostrils twice daily for dryness. R28's care plan dated 9/17/21, indicated R28 received oxygen therapy related to ineffective gas exchange and directed staff to administer oxygen at l liter per minute (LPM). Review of R28's Treatment Administration Record (TAR) dated 11/30/21, indicated staff were to apply a small amount of Vaseline into both of R28's nostrils twice daily for dryness. Staff documented the intervention as completed, throughout November, with the exception of 11/24/21, in which R28 was noted to not be at the facility. During an interview on 11/30/21, at 4:25 p.m. the consultant pharmacist (CP) stated he recommended using a water-based lubricant over a petroleum-based lubricant. The CP stated potential problems of using a petroleum-based lubricant with liquid oxygen could cause burning when there was an open flame. Further, oxygen could react violently with oily substances and cause significant burns. During an interview on 12/1/21, at 1:20 p.m. the director of nursing (DON) stated she was surprised an order for petroleum jelly was to be used in the nostrils for R28. The DON confirmed R28 had an order for petroleum jelly to R28's nostrils and could cause burning if ignited by a spark or flame. The DON stated she would contact R28's primary physician regarding discontinuing the order. Facility policy titled Oxygen Administration (undated), directed staff to remove all potentially flammable items such as lotions, oils, alcohol, and smoking articles from the immediate areas where oxygen was to be administered.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44657 Based on observation, interview, and document review, the facility failed to ensure a tube feeding was administered as ordered for 1 of 2 residents (R28) who received a tube feeding. Findings include: R28's Admission Record dated 12/2/21, indicated R28's diagnoses included diabetes, rheumatoid arthritis (causes pain, swelling, stiffness, and loss of function in joints), and a pressure ulcer. R28's quarterly Minimum Data Set (MDS) dated [DATE], indicated R28 was cognitively intact. R28's MDS lacked indication R28 received a tube feeding. R28's admission care area assessment (CAA) dated 5/7/21, indicated R28 required tube feedings to meet her nutritional needs. R28's care plan dated 7/13/21, indicated R28 was at risk for impaired nutrition and hydration. R28 received a tube feeding to meet her nutritional needs due to a history of dysphasia (difficulty swallowing) and history of aspiration pneumonia. The care plan included several interventions including providing vitamin and mineral supplements, water flushes, and feedings. R28's Order Summary Report dated 11/30/21, directed staff to provide 100 milliliter (mL) water flushes every four hours through a j-tube (soft, plastic tube placed through the skin of the abdomen into the midsection of the small intestine) and Isosource (nutrition formula) 100 mL per hour for 12 hours per day, as tolerated. The tube feeding was to be started at 10:45 a.m. and turned off at 10:45 p.m. During an observation on 11/29/21, at 3:00 p.m. R28's Isosource tube feeding formula was hung on a pole and the feeding pump was shut off. The Isosource formula bottle had 700 mL of solution remaining in the bottle. The tubing connected to the Isosource formula was hung over the pole and not connected to R28. The Isosource formula and tubing lacked a date/time. During an observation on 11/30/21, at 7:25 a.m. R28 was observed sleeping in her bed. R28's bed was at a 25-to-30-degree angle, and she was not connected to the tube feeding at this time. The bottle of Isosource formula lacked a date/time. Dried formula was noted on the end of the tube feeding and 700 mL of formula was noted in the Isosource bottle. At 7:26 a.m. licensed practical nurse (LPN)-C was interviewed and stated she did not disconnect the tube feeding from R28. LPN-C stated it appeared evening shift did not connect R28 to the tube feeding. LPN-C confirmed the tubing connected to the Isosource formula had dried substance on the end. A progress note dated 11/30/21, at 11:07 a.m. indicated R28's physician was notified of the missed tube feeding (11/29/21) and an order was given to restart the tube feeding and follow a 12 hour on/off cycle. (continued on next page)

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	245544	A. Building B. Wing	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victory Health & Rehabilitation Center	512 49th Avenue North Minneapolis, MN 55430

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/30/21, at 2:25 p.m. R28 was laying in bed and awake. R28 was not connected to the tube feeding. At 2:28 p.m. LPN-C confirmed she did not complete R28's tube feeding during the shift as she was busy. During an observation on 11/30/21, at 4:00 p.m. R28 still was not connected to the tube feeding. During an interview on 11/30/21, at 9:30 a.m. medical doctor (MD)-B stated he assessed R28 and provided a verbal order, and later signed an order, to immediately resume R28's tube feeding and monitor for dehydration. MD-B stated there had been multiple occasions at the facility in which orders were not followed, or started, as directed. MD-B stated not starting R28's tube feeding could potentially cause harm and expected the facility to follow orders as given. During an interview on 12/1/21, at 1:43 p.m. the assistant director of nursing (ADON) stated R28's tube feeding did not get restarted until 10:45 p.m. on 11/30/21. The ADON stated she told LPN-C to immediately start R28's tube feeding and reported the incident to MD-B. During an interview on 12/1/21, at 1:45 p.m. the director of nursing (DON) stated she expected staff to follow orders provided by the physician and nursing supervisor. The DON stated LPN-C should had restarted R28's tube feeding when instructed to do so by the ADON on 11/30/21. The DON stated R28 went more than 24 hours without receiving nutrition. A progress note dated 12/1/21, at 6:41 p.m. indicated MD-B was notified R28 missed a tube feeding. Facility policy titled Enteral Feedings Safety Precautions (undated) directed all staff responsible for preparing, storing, and administering eternal nutrition formulas will be trained, qualified, and competent of responsibilities. Further, staff were directed to date, time, and initial the label when formula was hung and administered.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44657 Based on observation, interview, and document review, the facility failed to administer pain medication as ordered by the physician for 1 of 1 resident (R28) reviewed for pain. This resulted in actual harm for R28 who had verbal and physical signs of pain when extended-release narcotic pain medication was crushed and staff did not acknowledge or anticipate the need for pain intervention. Findings include: R28's Admission Record dated 12/2/21, indicated R28's diagnoses included diabetes, pressure ulcer of sacral region (area where the spine connects to the lower half of the body), and absence of right and left leg above knee. R28's quarterly Minimum Data Set (MDS) dated [DATE], indicated R28 was cognitively intact and had scheduled pain medications, as needed pain medications, and non-medication interventions. The MDS further indicated pain limited R28's daily activities and she rated her pain at 8 out of 10 (0 to ten scale). R28's Care Area Assessment (CAA) dated 5/13/21, indicated R28 had pain related to rheumatoid arthritis, cervical stenosis (narrowing of the spinal column) with chronic pain, peripheral vascular disease (decreased blood flow to limbs), and neuropathy (damage to the nerves which causes pain). The CAA further indicated R28 took opioids (narcotic pain medication) and staff were directed to administer medications as ordered. Pain impacted R28's ability to sleep at night and she experienced pain frequently. Staff were to administer pain medication 30 minutes prior to treatment and anticipate R28's need for pain relief. Additionally, staff were to respond immediately to complaints of pain and monitor for non-verbal signs of pain. R28 reported her pain was frequently 6 out of 10. R28's care plan dated 5/2/21, indicated R28 received pain medication related to her disease process. The care plan included several interventions and directed staff to administer analgesic medications, as ordered. Additionally, R28's care plan indicated R28 had chronic pain related to rheumatoid arthritis, diabetic neuropathy and directed staff to administer analgesia 30 minutes prior to treatments or cares and offer nonmedicinal forms of pain relief such as distraction, warm packs, cold packs, and gentle massage. A Physician's Progress Note dated 11/8/21, indicated R28 had diagnoses of chronic pain, cervical stenosis status post-fusion (surgery to permanently connect two or more vertebrae) and sacral pressure ulcer. The progress note also identified R28's chronic pain was related to cervical myopathy (compression of spinal cord), rheumatoid arthritis, sacral pressure ulcer, upper extremity contracture and immobility. R28's Order Summary Report printed 12/2/21, at 8:57 a.m. indicated R28 had a tube feeding, was ordered a dysphasia (difficulty swallowing) mechanical soft diet with nectar thick liquids. Staff may have medications crushed with applesauce for easy swallowing. Review of R28's November 2021 Medication Administration Record (MAR) identified R28 had the following medications ordered for pain: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	- Gabapentin Liquid 250 milligrams (mg) /5 milliliter (mL). Give 300 mg (6 mL) by mouth three times a day for neuropathic pain. The order was started on 11/15/21. - Morphine Sulfate Extended-Release (narcotic pain medication). Give 15 mg by mouth three times a day for chronic pain. - Acetaminophen (Tylenol) Solution 160mg/5mL. Give 650 mg via g-tube (tube feeding) every six hours as needed for pain. - Prednisone (steroid; reduces inflammation) 5 mg. Give one table via g-tube one time daily for pain. Further, the MAR lacked documentation R28 was administered Prednisone on 11/4/21, 11/5/21, 11/6/21, 11/7/21, 11/8/21, 11/11/21, 11/29/21, and 11/30/21, as the medication was not available. A Pain Management Progress Note dated 11/29/21, indicated R28 was frustrated with her pain and had pain all day. R28's reported pain in her buttock, leg, and had increased arm pain, which was described as sharp, achy, and sore. R28 received morphine and gabapentin for pain. Further, R28 should continue to work with physical and occupational therapy. R28's morphine sulfate extended release was increased to 15 mg three times a day. Staff was also to continue administering acetaminophen every six hours, as needed. Further, staff were to administer 6 mL of gabapentin 250 mg/5mL three times daily. During a continuous observation conducted on 11/29/21, from 8:30 a.m. to 11:43 a.m. R28 was noted to be lying flat on her back, in bed, with a pillow to the right of her bed. R28's eyes were closed, and she was noted to be moaning and called out to staff to help. At 10:30 a.m., R28 was moaning, ouch. At 11:43 a.m., R28 called out for help and stated she had pain. At 11:44 a.m., licensed practical nurse (LPN)-C was notified. Throughout the observation, no staff entered R28's room, nor responded to R28 who was calling out periodically. Three hours and 14 minutes had passed. LPN-C stated they would find a nursing assistant to assist R28. During an interview on 11/29/21, at 9:02 a.m. R28 stated she had a lot of pain and it seemed to never be under control. R28 verbalized she was so uncomfortable when staff moved her or provided cares. R28 reported her pain was 8 out of 10 and felt she would be able to manage if her pain was 3 out of 10. R28 stated she did not have a good quality of life because her pain was so bad. During an observation on 11/30/21, at 9:13 a.m. LPN-C crushed morphine sulfate extended release 15 mg tablet with a pill crusher and placed in a plastic medication cup. After crushing the medications, LPN-C entered R28's room and asked R28 if she had pain and R28 responded, Yes, I hurt all over. LPN-C proceeded to flush R28's G-tube and connected the syringe to the G-Tube to administer the medications. R28 stated to LPN-C, I hurt really bad. R28 had facial grimacing and was grunting. LPN-C proceeded to pour multiple medications together in a medication cup, added water in the medication cup, and dumped into the syringe. LPN-C finished medication administration and left the room. During observation LPN-C did not ask R28 to rate her pain or offer non-pharmacological methods of pain relief. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/30/21, at 9:20 a.m. LPN-C stated all of R28's medications could be crushed because there was an order. LPN-C stated all of R28's medications worked the same way whether crushed, given by mouth, or via tube feeding. LPN-C explained on days she passed medications to R28; she crushed all pills as there was an order from the physician. LPN-C stated she was not aware morphine sulfate extended release was not supposed to be crushed or impacted pain relief. LPN-C also confirmed she did not offer as needed acetaminophen to R28 or other methods of pain relief to keep R28 comfortable. Subsequent review of R28's November 2021 Medication Administration Record (MAR) indicated licensed practical nurse (LPN)-C administered extended-release morphine to R28 on 11/15/21, 11/16/21, 11/17/21, 11/19/21, 11/24/21, 11/25/21, 11/26/21, 11/29/21, and 11/30/21. For each of these administrations, R28's pain was rated from 3 to 5 out of 10 (using a 0 to 10 scale). During an observation on 11/30/21, at 9:41 a.m. R28 was observed lying in bed and was provided a bed bath by nursing assistant (NA)-A. R28 complained of pain when repositioned and when her right arm was moved. R28 also had noted facial grimacing when she received cares. During an interview on 11/30/21, at 9:50 a.m. NA-A stated R28 had a lot of pain and R28's pain was worse when staff attempted to perform cares such as incontinence cares or bathing. NA-A confirmed R28 yelled out in pain throughout the day and when her right arm was touched. During an interview on 11/30/21, at 1:55 p.m. medical doctor (MD)-A stated he was not aware R28's extended-release morphine was being crushed or given via a tube feeding. MD-A stated nursing staff should not crush extended-release morphine as all the medication would release all at once and not provide coverage for pain as it should. MD-A stated R28 could also receive too much morphine at once instead of receiving the medication slowly over time. This could cause serious breathing problems or relate to R28's concerns regarding poor pain control. MD-A stated they did not feel the facility provided appropriate pain control and management for R28. During an interview on 11/30/21, at 4:25 p.m., the consultant pharmacist (CP) stated crushing extended-release morphine possibly could not cover the length of time needed and caused R28 to not have complete coverage for her chronic pain. The CP stated the peak (highest level of a medication in the blood) for immediate release morphine was one hour and extended release was three hours. If extended-release morphine was crushed it would peak between one and three hours and not last the full 12 hours as intended and cause inadequate pain management. During an observation on 12/1/21, at 12:00 p.m. R28 was provided wound care to her stage IV pressure ulcers and moaned and complained of pain when repositioned. R28 was tearful and was noted to flinch and had facial grimacing when touched. R28 verbalized she had pain in her chest and arms. R28 was not observed to be offered pain medication prior to wound care. Subsequent review of R28's November 2021 and December 2021 MAR indicated R28 was administered as needed Acetaminophen Solution 160mg/5mL (650 mg) on 11/12/21, 11/14/21, 11/15/21, and 11/26/21. There was no indication Acetaminophen was consistently used prior to dressing changes or other times when R28 identified she was having pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/1/21, at 1:42 p.m. the director of nursing (DON) stated she was not aware R28's extended-release morphine was crushed. If crushed, may not provide pain relief as indicated or a resident could receive too much medication at once. The DON stated she expected staff to administer medication as ordered and follow-up with the physician if pain impacted a resident's quality of life. During an interview on 12/1/21, at 12:25 p.m. MD-C stated R28 had a lot of pain during wound care visits. MD-C stated she had given direction to staff to manage R28's pain so she could be repositioned every two hours, sit up in her wheelchair, and have less pain during wound care. MD-C stated during her visit today with R28, she had complained of pain. Facility policy titled Activities of Daily Living (ADLs) undated, directed to offer alternative interventions to minimize functional decline and include appropriate pain management.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43077 Based on observation, interview, and document review, the facility failed to provide comprehensive assistance with potential discharge planning for 1 of 1 resident (R500) who had ongoing allegations of sexually inappropriate behavior towards female residents (R501). Findings include: R500's quarterly Minimum Data Set (MDS) dated [DATE], identified R500 had a severe cognitive impairment and was independent with all activities of daily living (ADLs). R500's diagnoses included age-related cognitive decline and alcohol abuse. R500's care plan revised on 9/23/21, identified R500 was, At risk of abusing others r/t [related to] poor impulse control, alcohol induced dementia, level 1 sex offender. The care plan also included, On 8/27/21 resident accused of touch[ing] another resident inappropriately near south hall. On 9/23/21, accused of kissing. The care plan instructed staff to, Redirect away from female residents, Assist in looking [for] alternative placement, If staff hear [R500] making sexual gestures tell him to stop and redirect him back to his room, If staff see [R500] enter a female resident's room, remove resident immediately, [R500] is not to be in any other hall besides South hall without supervision, and [R500] will not enter north hall, will stay away from female resident related to allegations of inappropriate behavior. A Behavior Contract signed by R500 on 11/13/20, outlined, Boundaries related to allegations of inappropriate behavior: - Refrain from touching any female resident, even if they request a hug from you. - Refrain from entering female resident's rooms. - When in commons areas refrain from making sexual comments or gestures. A progress note dated 9/3/21, at 3:04 p.m. included, Met with resident, reviewed concerns with female residents. Reviewed recommendations for transition to another facility with males. A progress note dated 9/23/21, at 1:47 p.m. included, Spoke with resident and daughter, reviewed transition to another facility. Daughter expressed understanding and knowing it ws in his best interest. A Mental Health Provider Progress Note dated 9/24/21, included, A resident reported seeing [R500] kiss a female resident who he has previously shown interest in and who has stated she is not interested. Staff continue to work to find an all-male placement for [R500]. [R500] is ambivalent about this, but agreeable depending on the location. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/29/21, at 10:04 a.m. R501 stated that R500 wanted to be more physical with her and, I told him, no. I don't want to do that. R501 stated R500 liked to touch my boobs. I don't like that. I tell him, don't do that. Additionally, R500 stated R501 liked to kiss her and she did not want to kiss him. R500 stated, I don't feel good about it. During an interview on 11/29/21, at 11:39 a.m. R500 stated he thought R501 was a Nice lady and a friend. R500 denied touching or kissing R501 or any other female resident inappropriately. During an interview on 11/29/21, at 1:00 p.m. social worker (SW)-A stated she was aware R500 was a level 1 sex offender and there had been a couple of reports of R500 displaying sexually inappropriate behavior directed towards R501 during his stay at the nursing home. Due to the allegations, R500 was moved to a room in a different hallway than R501 and staff were educated R500 and R501 were not to touch each other. SW-A stated she attempted to find R500 placement in an all-male facility, but was unsuccessful. This included inquiring about placement at one alternative skilled nursing facility approximately two months ago, but the facility was unable to accept R500 due to his status as a sex offender. SW-A confirmed no additional inquiries were made for alternative placement. SW-A stated R500 was due for a care conference soon and she could talk to R500's daughter to see if they were open to considering transitioning to an assisted living facility or group home. During an interview on 11/30/21, at 4:07 p.m. the director of rehabilitation services stated it would be reasonable to consider R500 for transfer to an alternative level of care such as assisted living or a group home considering R500's independence with ADLs. During an interview on 12/2/21, at 10:50 a.m. with the administrator and assistant director of nursing (ADON) the administrator stated the facility had implemented interventions which included pursing alternative placement for R500 at an all-male facility. The ADON added the interdisciplinary team had agreed to this intervention to mitigate ongoing risk of inappropriate interaction with the facility's female residents. The administrator thought referrals to transfer R500 had been sent to multiple all-male care facilities, but had been declined at each facility due to being a registered sex offender. The ADON added it would be appropriate to assess R500's care needs to determine if he could transfer to an assisted living or group home. The administrator stated if SW-A was unsuccessful with implementing a behavior intervention he would expect the information to be shared with the interdisciplinary team for brainstorming. The facility Transfers and Discharges Policy dated 2001, included, Each resident will be permitted to remain in the facility, and not be transferred or discharged unless: . C. the safety of individuals in the facility is engaged due to the clinical or behavioral status of the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 44657 Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders and professional standards of practice for 1 of 2 residents (R28) observed to receive medication during the survey. This resulted in a facility medication administration error rate of 30% (percent). Findings include: R28's Admission Record dated 12/2/21, indicated R28's diagnoses included diabetes, pressure ulcer of sacral region (area where the spine connects to the lower half of the body), and absence of right and left leg above knee. A Physicians Order dated 7/26/21, indicated R28 may have their medication crushed and given with applesauce for easy swallowing. Review of R28's November 2021 Medication Administration Record (MAR), indicated staff were to administer the following medications by mouth: - Cefuroxime Axetil (antibiotic). Give one tablet by mouth two times a day for infection. - Doxycycline 100 milligram tablet. Give 100 milligrams by mouth every 12 hours for bone and joint infection. - Morphine sulfate (pain medication) extended-release tablet 15 mg. Give one tablet by mouth three times daily for chronic pain. - Famotidine 20 mg tablet (treats heartburn). Give 20 mg twice daily. - Gabapentin 6 mL 250mg/5mL. Give 300 mg (6 milliliters [mL]) by mouth two times daily for neuropathic pain. The November 2021 MAR further indicated the following medications were to be administered via g-tube (tube feeding): - Prednisone (steroid) 5 mg tablet. Give one tablet daily via g-tube for chronic pain. - Amlodipine 5 mg tablet. Give 1 tablet via g-tube daily for high blood pressure. - Duloxetine 20 mg tablet. Give 1 tablet via g-tube every Tuesday for depression. - Metoprolol Tartrate. Give 50 mg via g-tube two times daily for high blood pressure. On 11/30/21, at 9:13 a.m. licensed practical nurse (LPN)-C was observed preparing medications for R28 which included: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Cefuroxime Axetil - Amlodipine 5 mg - Duloxetine 20 mg - Doxycycline 100 mg - Morphine sulfate extended-release 15 mg - Famotidine 20 mg - Metoprolol Tartrate 50 mg - Gabapentin 6 mL 250mg/5mL give 300 mg - Prednisone 5 mg was not prepared as the medication was unavailable. On 11/30/21, at 9:13 a.m. LPN-C was observed to crush the above noted medications and placed them in medication cups. Additionally, LPN-C poured Gabapentin 250mg/5mL into a plastic medication cup with measurement lines on the cup (with measuring lines labeled 2.5, 5, 7.5 .). It was unable to be determined it 6 mL of Gabapentin was in the medication cup. LPN-C then gathered supplies and went into R28's room. LPN-C connected connected the syringe to R28's g-tube and pulled back. LPN-C then flushed the G-tube, using a syringe, with water. LPN-C then mixed four medications together with water and administered in G-tube with water flush. LPN-C next administered the liquid gabapentin medication and flushed with water. LPN-C then administered the last three crushed medication mixed together with water, gave in R28's G-tube, and flushed with water. During an interview on 11/30/21, at 9:13 a.m. LPN-C stated all medications could be crushed for R28 because there was an order. LPN-C also stated she was late with medication administration and confirmed Prednisone 5 mg tablets were not available. At 9:20 a.m. LPN-C confirmed she poured gabapentin into a plastic medication cup and had estimated 6 mL. LPN-C stated she should had used a syringe, but one was not available. LPN-C stated she could had given R28 too much gabapentin it not measured accurately. Further, she knew R28 had an order to crush medications, but was not aware to order was to place the medication in applesauce and give by mouth. LPN-C stated the physicians order should be followed and the physician should be asked if there were questions. LPN-C confirmed all oral medications were cocktailed and given via g-tube. During an interview on 11/30/21, at 1:55 p.m. medical doctor (MD)-A stated he expected staff to give medications as ordered to ensure proper absorption and relief of symptoms. During an interview on 12/1/21, at 9:00 a.m. the consulting pharmacist (CP) stated staff were expected to administer medication based on the physician order. The CP stated it was best practice to use a syringe when drawing up gabapentin to ensure the dose was correct. (continued on next page)

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/1/21, at 9:30 a.m. MD-B stated he expected the facility to follow medication orders as directed. If medications were ordered by mouth, then they should be given by mouth. If a resident had a change in condition, the physician should be notified and request a change or to review orders. MD-B stated the nurse should had clarified orders with the physician. During an interview on 12/1/21, at 1:42 p.m. the director of nursing (DON) stated she expected staff passing medication to check orders, check medication, and then check again. Further, she expected staff to ensure the right person, right dose, right medication, right route, and right time before medications were administered. If an individual had questions about an order, they should ask prior to administration. The DON stated medications which were crushed and given via a tube feeding, rather than by mouth, were considered a medication error. Further, LPN-C should not estimate a dose of gabapentin. The DON stated LPN-C would need to write up medication errors and she would provide staff education and guessed all staff made the same error. Facility policy titled Administering Oral Medications (undated) directed the individual administering medication to verify physician orders, review the care plan, and assess for special needs.