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	12/27/2021

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32982 Based on observation, interview, and document review, the facility failed to ensure a call light was within reach to enable calling for assistance for 1 of 2 residents (R2) reviewed for call light accessibility. Findings include: R2 diagnoses included unspecified dementia without behavioral disturbance, bilateral amputee above the knee, anxiety and osteoporosis obtained from the admission record dated 12/27/21. R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 had intact cognition and required total dependence of one to two staff assistance with all activities of daily living. R2's care plan dated 12/15/21, identified resident was at a moderate risk for falls related to bilateral amputee, psychotropic medications, weakness and dementia. The care plan directed staff to Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. R2's falls Care Area assessment dated [DATE], indicated staff was to anticipate and meet the resident's needs and they were to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. In addition, the staff was to respond to resident needs and requests for assistance promptly. On 12/22/21, at 3:35 p.m. during the facility tour the call lights in rooms 100, 103, 104 and 106 were observed to be on outside the room in the hallway and were audible at the nursing station. A resident was observed seated on the toilet calling Help me I need help to get off the toilet. At the same time R2 who was this resident's roommate was observed lying on the bed calling out for assistance as surveyor went past the room. When approached R2 stated one of the nursing assistants (NA's) had been to her room and put the call light on top of the bedside table which she was not able to reach to call for assistance. R2's roommate stated she was not able to get assistance for R2 because she needed assistance to get off the toilet to do so. R2 stated she needed assistance to turn the fan on and clip her call light to her night gown. R2 further stated she had been calling out for an hour but nobody had come. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 3:40 p.m. surveyor summoned NA-B to R2's room. NA-B then went to the bathroom and stated to R2's roommate, let me help you before you fall. NA-B then was observed assist the roommate with pericare then cued her to keep standing as she adjusted the roommates clothing and as she left the room, NA-B told R2 she was going to return to assist her. -At 3:44 p.m. NA-B came back to R2's room and was observed moving the soft touch call light which was on top of R2's bedside table and set it on R2's chest. NA-B acknowledged the call light was not at reach for R2. NA-B also stated R2 was not able to call for assistance using the call light and due to R2's limitations R2 was not able to reach for the call light where it was and staff was to ensure R2 had the call light on at all times. On 12/23/21, at 2:52 p.m. the director of nursing (DON) reviewed the care plan for R2 and stated the staff were supposed to make sure all resident's call lights were within reach and staff was supposed to answer call lights promptly at all times. The facility Answering the Call Light policy reviewed 8/5/21, directed staff to ensure the call light was at reach at all times, staff was to answer the call lights as soon as possible and for resident who were not able to use the call lights the staff was to check on them frequently.

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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 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** 32982 Based on interview and document review, the facility failed to ensure the physician and resident representative was notified of skin injury concerns for 1 of 3 residents (R1) reviewed for notification of change. Findings include: R1's diagnoses included altered mental status, dementia with behavioral disturbance, transient alteration of awareness and convulsions obtained from the significant Minimum Data Set (MDS) dated [DATE]. The MDS indicated R1 required extensive physical assistance with bed mobility, transfers, toilet use and personal hygiene. In addition, the MDS indicated R1 had severely impaired cognition and it was important for family or significant other to be involved in R1's care discussions per the staff assessment completed. A Minnesota Adult Abuse Reporting Center (MAARC) report dated 12/19/21, indicated R1 was observed with multiple bruises on both legs, arms, old bruise on right cheek by the eye, and there was a bandage with a date of 12/19/21, on the left arm and under the bandage was a three and a half inch laceration. During review of R1's medical record the following was revealed: -Weekly Skin Check assessment dated [DATE], identified R1 had a skin tear the size of a nickel on the left lower leg. -Weekly Skin Check assessment dated [DATE], indicated R1 had a scab on the right medial wrist which measured 0.3 centimeter (cm) by 0.2 cm by 0.0 cm and a small scratch measuring 2.2 cm superior to the scab. -Weekly Skin Check assessment dated [DATE], indicated R1 did not have any skin concerns. -12/11/21, at 4:10 p.m. nursing note indicated R1 had crawled from the bed to the floor and had sustained injury to the arm. The writer indicated he had applied a dressing but R1 had removed the dressing. The note did not indicated which arm and did not indicated if the family representative and physician were notified of the change in skin condition. -12/17/21, at 12:15 p.m. an incident note indicated R1 had rolled out of her bed unto a mattress laid by her bed while trying to eat her lunch. In the process R1 had scraped her left arm against the bed frame thereby bruising the old scar which bleed slightly. The writer cleansed the area and apply bacitracin ointment over the affected area. The note did not indicated if the physician and resident representative had been notified of the injury. In addition, the note did not indicated the measurement and assessment of the injury. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/18/21, at 6:57 a.m. an incident note indicated it was reported to writer that resident had an abrasion on the left forearm when she scraped her arm on the bed, as noted and assessed, the abrasion was about 7 inches long and 5 inches wide, was dry and no bleeding noted. The writer cleansed the area during the shift and had applied Vaseline gauze, bacitracin and wrapped the forearm with two staff assistance. The note did not indicated if the physician and resident representative had been notified of the injury. During interview on 12/23/21, at 7:31 a.m. family member (FM)-A stated after R1 was transferred to the hospital the nurse had assisted her to look at R1's body and she had observed R1 had multiple bruises on both legs, arms, old bruise on right cheek by the eye, and there was a bandage with a date of 12/19/21, on the left arm and under the bandage was a three and a half inch skin tear which appeared infected. FM-A stated she was not aware of the bruises including the skin tear on the left arm. FM-A further stated she had reached out to the facility social service director recently and had asked for staff to send her pictures of R1's body which was after a staff had called her to inform her R1 had slipped out of bed and had bruised. FM-A stated the director of social service told her she needed to communicate with the director of nursing (DON) but was never assisted to facilitate that. During interview on 12/23/21, at 2:28 p.m. DON reviewed R1's medical record and verified R1 had sustained a skin tear on the left arm. The DON reviewed the hospital provided pictures dated 12/19/21, and verified multiple skin alterations were not all documented in R1's medical record and there was no documentation of the physician and family representative being notified. The DON stated when there was a skin alteration in any resident skin, the nurses were supposed to call the provider to see if there was a treatment for the wound, the family/responsible party was to be notified and the nurse was supposed to complete a risk management assessment. The DON further stated when R1 had sustained the skin tear to the left arm registered nurse (RN)-B night nurse had notified her. The facility Skin Tears--Abrasion, Bruising and Minor Breaks, Care of policy updated 4/13/21, directed the staff that notifying the responsible family member and physician were routine (that is, non-immediate) if the abrasion is uncomplicated or not associated with significant trauma . The policy directed staff to assess skin alterations, complete in-house investigation of causation, generate non-pressure form, document the family and physician being notified in the medical record, if the resident refused treatament, if the explanation was provided for refusal and staff was to complete a Report of Incident/Accident with the measurements of the alterations and interventions put in place.

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32982 Based on interview and document review, the facility failed to ensure the resident or resident's representative was informed of the bed hold notice at the time of hospitalization for 1 of 3 residents (R1) reviewed for hospitalization . Findings include: R1's diagnoses included altered mental status, dementia with behavioral disturbance, transient alteration of awareness and convulsions obtained from the significant Minimum Data Set (MDS) dated [DATE]. In addition, the MDS indicated R1 had severely impaired cognition and it was important for family or significant other to be involved in R1's care discussions per the staff assessment. During a review of the interdisciplinary notes, it was revealed on 12/19/21, at 4:08 p.m. the nurse had been called by family member (FM)-A to R1's room to evaluate R1. The nurse indicated R1 was non-verbal and could not respond to nurse or FM-A. The nurse then indicated he had decided to do a rapid Covid test which R1 tested positive for Covid-19. As the nurse was in the process of evaluating the R1, FM-A called 911 and the ambulance with paramedics arrived within 10 minutes and R1 was transferred to the hospital. R1's medical record was reviewed, and lacked documentation that bed hold information was offered to R1, sent to the hospital for R1, given to FM-A at the time of transfer or attempts to contact FM-A to offer the bed hold policy. During interview on 12/27/21, at 8:55 a.m. registered nurse (RN)-A stated he was supposed to provide the bed hold when residents were sent to the hospital however he had not documented he had discussed the bed hold with the R1's family member (FM)-A at the time. On 12/27/21, at 10:44 a.m. during the exit conference with the interim administrator, and the infection control nurse (ICN), the interim administrator stated he expected the the staff sending the resident to the hospital to issue the bed hold at the time of the transfer to the hospital and for emergency transfers the staff should have made a call to the hospital to discuss the bed hold policy. The facility Transfer or Discharge Notice reviewed 12/22/21, directed the staff to provide a resident and/or the resident's representative (sponsor) with a thirty day written notice of the impending transfer or discharge. The policy lacked documentation on bed hold notices for residents when being transferred to a hospital/acute care setting.

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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** 32982 Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R1) who was dependent on staff for meeting activities of daily living (ADLs) had trimmed toenails. Findings Include: R1's diagnoses included altered mental status, dementia with behavioral disturbance, transient alteration of awareness and convulsions obtained from the significant Minimum Data Set (MDS) dated [DATE]. The MDS indicated R1 required extensive physical assistance with personal hygiene. R1's care plan dated 11/21/21, identified resident had an ADL self-care performance deficit related to dependency on staff to complete ADL. The care plan directed staff for personal hygiene set up assistance and at times assist of one with personal hygiene and oral care. A Minnesota Adult Abuse Reporting Center (MAARC) report dated 12/19/21, indicated R1 was observed lying in bed without a incontinent brief on and there was dried urine on sheets. In addition, R1's toenails were long and curled over toes. During a review of hospital provided pictures dated 12/19/21, it was revealed R1 had long toenails which were approximately 2 inches long and curled over R1's toes and around the nail bed the skin was purple. During interview on 12/23/21, at 7:31 a.m. family member (FM)-A stated she had come to visit R1 as she had been told it was okay to visit R1. FM-A stated when she entered R1's room, R1 was lying in a fatal position and R1 had a single sheet covering her. FM-A then stated she observed the night gown had dried bowel movement smears and urine stains. FM-A also stated at the hospital the nurse had assisted her to look at R1's body and she had observed R1's toenails on both feet were long approximately 2 inches and the toenails were curled over the toes. During interview on 12/23/21, at 2:28 p.m. the director of nursing (DON) reviewed R1's medical record and verified for six weeks R1 had been at the facility Weekly Skin Checks had been completed three times on 11/21/21, 12/3/21 and 12/8/21. The DON reviewed the hospital provided pictures dated 12/19/21, and the facility Weekly Skin Checks assessments completed on 12/3/21 and 12/8/21 and acknowledged although the toenails had been marked trimmed, the documentation was not accurate they would have to have a podiatrist trim those they are at least 2 inches long and curled. The DON stated both toenail and fingernail care should be done with showers and if the staff are not able to do it they were to let the nurse know. The DON also stated the staff was to attempt or re-approach the resident the next shift. On 12/27/21, at 10:44 a.m. during the exit conference with the interim administrator, and the infection control nurse (ICN), the interim administrator stated he would not have expected a nurse to trim R1's toenails but should be seen by a podiatrist, he further stated he was not sure about the contracted podiatrist schedule cycle. The interim administrator added, [R1] had came to us with those toenails but was not sure if R1 had been scheduled for podiatry as R1 had signed the consent for services at admission. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Activities of Daily Living (ADL's), Supporting policy reviewed 12/7/21, directed staff for resident who were unable to carry out ADL's independently the staff was to ensure they received the services necessary to main good nutrition, grooming, 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32982 Based on observation, interview and document review, the facility failed to investigate bruising for 1 of 1 residents (R1) reviewed for non-pressure related skin concerns. Findings include: R1's diagnoses included altered mental status, dementia with behavioral disturbance, transient alteration of awareness and convulsions obtained from the significant Minimum Data Set (MDS) dated [DATE]. The MDS indicated R1 required extensive physical assistance with bed mobility, transfers, toilet use and personal hygiene. A Minnesota Adult Abuse Reporting Center (MAARC) report dated 12/19/21, indicated R1 was observed with multiple bruises on both legs, arms, old bruise on right cheek by the eye, and there was a bandage with a date of 12/19/21, on the left arm and under the bandage was a three and a half inch laceration. During review of R1's medical record the following was revealed: -Weekly Skin Check assessment dated [DATE], identified R1 had a skin tear the size of a nickel on the left lower leg. -Weekly Skin Check assessment dated [DATE], indicated R1 had a scab on the right medial wrist which measured 0.3 centimeter (cm) by 0.2 cm by 0.0 cm and a small scratch measuring 2.2 cm superior to the scab. -Weekly Skin Check assessment dated [DATE], indicated R1 did not have any skin concerns. -12/11/21, at 4:10 p.m. nursing note indicated R1 had crawled from the bed to the floor and had sustained injury to the arm. The writer indicated he had applied a dressing but R1 had removed the dressing. The note did not indicated which arm. -12/17/21, at 12:15 p.m. an incident note indicated R1 had rolled out of her bed unto a mattress laid by her bed while trying to eat her lunch. In the process R1 had scraped her left arm against the bed frame thereby bruising the old scar which bleed slightly. The writer cleansed the area and apply bacitracin ointment over the affected area. In addition, the note did not indicated the measurement and assessment of the injury. -12/18/21, at 6:57 a.m. an incident note indicated it was reported to writer that resident had an abrasion on the left forearm when she scraped her arm on the bed, as noted and assessed, the abrasion was about 7 inches long and 5 inches wide, was dry and no bleeding noted. The writer cleansed the area during the shift and had applied Vaseline gauze, bacitracin and wrapped the forearm with two staff assistance. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 12/23/21, at 7:31 a.m. family member (FM)-A stated after R1 was transferred to the hospital the nurse had assisted her to look at R1's body and she had observed R1 had multiple bruises on both legs, arms, old bruise on right cheek by the eye, and there was a bandage with a date of 12/19/21, on the left arm and under the bandage was a three and a half inch skin tear which appeared infected. FM-A further stated she had reached out to the facility social service director recently and had asked for staff to send her pictures of R1's body which was after a staff had called her to inform her R1 had slipped out of bed and had bruised. FM-A stated the director of social service told her she needed to communicate with the director of nursing (DON) but was never assisted to facilitate that. During interview on 12/23/21, at 2:28 p.m. DON reviewed the hospital provided pictures dated 12/19/21, and verified multiple skin alterations were not all documented in R1's medical record. The DON stated the nurses were supposed to complete a risk management assessment and documentation for all skin alterations. The facility Skin Tears--Abrasion, Bruising and Minor Breaks, Care of policy updated 4/13/21, directed the staff that notifying the responsible family member and physician were routine (that is, non-immediate) if the abrasion is uncomplicated or not associated with significant trauma . The policy directed staff to assess skin alterations, complete in-house investigation of causation, generate non-pressure form, document the family and physician being notified in the medical record, if the resident refused treatament, if the explanation was provided for refusal and staff was to complete a Report of Incident/Accident with the measurements of the alterations and interventions put in place.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44652 Based on observation, interview and document review, the facility failed to ensure Centers for Disease Control (CDC) guidelines were followed to prevent or minimize the transmission of COVID-19 for 1 of 5 residents (R4) who were placed on quarantine, though not enforced, following exposure to a COVID-19 positive roommate. This had the potential to affect 54 of 59 residents who had the potential to be exposed to R4 while accessing the communal areas of the facilities. The IJ began on [DATE], at 5:42 a.m. licensed practical nurse (LPN)-A wrote a progress note that she observed R4 in the hallway of the facility. LPN-A explained to R4 that she was on quarantine and should be in her room due to exposure to COVID-19 from a positive roommate. The progress note read; R4 told the nurse she was not going to stay in her room. The facility administrator and director of nursing (DON) were notified of the IJ on [DATE] at 4:57 p.m. The IJ was removed on [DATE], at 10:23 a.m. but remained at a lower scope and severity of F, no actual harm with potential for more than minimal harm that is not immediate jeopardy, widespread. Findings include: R4's quarterly Minimum Data Set (MDS) dated [DATE], noted R4 had intact cognition and was independent with most activities of daily living (ADL's). R4's face sheet accessed on [DATE], noted R4's diagnoses included: paranoid schizophrenia, anemia, hypokalemia, heart disease and tobacco use. The facility provided a listing of COVID-19 positive residents during routine testing on [DATE]. During review of the infection control binder provided by the infection control preventionist, it was revealed the facility had been in outbreak status since [DATE], with a total of four positive staff members and 15 positive residents and one COVID-19 related death on [DATE], due to exposure to a positive roommate. The facility documented that R4 refused the COVID-19 vaccination when offered under the immunization tab of R4's electronic health record (EHR). During continuous observation on [DATE], beginning at 9:13 a.m. R4 approached this surveyor in the south hall without a mask on. R4 was concerned about housekeeping cleaning her room. At 9:22 a.m. R4 was seen outside smoking with several other unmasked residents, the smoking aide assisted R4 to the smoking area. At 9:31 a.m. R4 was in the dining room near the smoking area exit, unmasked and was within 6 feet of other unmasked residents. At 9:36 a.m. R4 was again observed outside smoking with other unmasked residents. At 10:03 a.m. R4 was near the nursing station and continued to self-propel her wheelchair to the north hall and approached a staff member. At 10:08 a.m. R4 was unmasked and in the dining room pouring coffee near other unmasked residents. At 10:21 a.m. R4 was still unmasked and in the dining room near the exit to the smoking area among other unmasked residents. At 10:24 a.m. the smoking aide placed a smoking apron on R4 and she went back outside to smoke. At 10:34 a.m. R4 re-entered the dining room, unmasked and within six feet of other unmasked residents. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	When interviewed on [DATE], at 9:23 a.m. trained medication aide (TMA)-A stated she was unsure if quarantine residents had to remain in their room or if they are limited to certain areas of the facility. When interviewed on [DATE] at 9:41 a.m. licensed practical nurse (LPN)-A stated a resident on quarantine should be observed for symptoms, they should limit their interaction with other residents however, they cannot stop the resident from going out to smoke when they want to. When interviewed on [DATE], at 10:45 a.m. nursing assistant (NA)-A stated if a resident is on quarantine they should remain in their room. NA-A further stated she was not aware of any residents on quarantine. When interviewed on [DATE], at 11:17 a.m. the infection preventionist (IP) stated R4 was put on quarantine status the evening of [DATE], after her roommate tested positive for COVID-19. Further, the IP stated residents that are on quarantine are required to stay in their rooms and if they are non-compliant with staying in their rooms, the interdisciplinary team will meet to come up with a solution. The IP stated R4 was not compliant with quarantining in her room, but there had not been an interdisciplinary meeting and one had not been scheduled at that time. When interviewed on [DATE], at 11:17 a.m. the infection preventionist (IP) stated she was made aware of R4's roommate testing positive on the evening of [DATE]. The IP stated she then called the facility and notified staff that R4's roommate tested positive for COVID-19 and was moved to the COVID-19 isolation wing in the facility and that R4 should be placed on quarantine. When interviewed on [DATE], at 11:31 a.m. the acting administrator (AA) stated there were designated smoking times for residents that are on quarantine. The AA further stated they currently don't have any quarantined residents that go out to smoke. On [DATE], at 12:18 p.m. social services (SS)-A and the IP stated they conducted a meeting and have developed interventions for keeping R4 in her room during her quarantine. When interviewed on [DATE], at 2:01 p.m. an activities assistant (AA)-A stated R4 disliked wearing masks and would tell staff she would put mask on when she was damn good and ready. Resident refused interview on [DATE], at 2:06 p.m. When interviewed on [DATE], at 2:18 p.m. the director of nursing (DON) stated quarantine residents must be in their rooms. The DON further stated she was unaware R4 was out of her room, self-propelling her wheelchair throughout the facility unmasked. The DON stated that should not have happened. When interviewed on [DATE], at 3:58 p.m. the IC nurse stated R4 refused to be tested during the facility wide outbreak testing on [DATE]. Further, the IC was not sure the last time R4 agreed to testing and referred to a three-ring binder for the information. (continued on next page)

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	12/27/2021

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE], at 1:30 p.m. during the first attempted removal visit R4 was observed wearing a mask and was being wheeled down the hallway by the activities assistant (AA), they went past the nursing station and as they went past the employee break room, R4 asked AA to stop outside the employee breakroom. R4 then removed her mask and was observed talking to the staff who sat in the room. AA then redirected R4 to leave the mask on. R4 re-applied the mask and AA then wheeled R4 through the dining room to the entrance of the smoking area where R4 joined other residents in the smoking area. -At 1:35 p.m. to 1:37 p.m. R4 was observed being assisted from the smoking area by staff and back into the dining room. At 1:38 p.m. R4 was observed return into the building from the smoking area and as she went past the door threshold AA cued her to wear her mask. At 1:40 p.m. R4 asked AA for a cup of coffee to drink in the dining room. -At 1:41 p.m. AA approached R4 with a cup with coffee and was overheard telling R4 she was supposed to always have the mask on when out of the room except when eating, drinking or smoking. At 1:43 p.m. to 1:49 p.m. R4 was observed drinking coffee in the dining room. At 1:50 p.m. R4 was observed go over to the door again asked to go outside to smoke. As she approached the table with smoking supplies R4 was assisted by the staff to the smoking area however she did not have a mask on as she went past two residents who sat and stood by the door. At 1:57 p.m. R4 returned to the dining room and sat at the table by the wall as she continued to drink the coffee and not wearing a mask. At this same time AA and kitchen staff was observed setting up the dining room for the resident Christmas party and residents were independently coming into the dining room and being seated. At 2:06 p.m. to 2:29 p.m. R4 remained at the table seated not drinking or eating and was not wearing a mask. At 2:11 p.m. the DON came into the dining room and stood by R4 but never redirected R4 to go back to her room or wear a mask. -At 2:13 p.m. the DON re-directed R4 to wear the mask and R4 asked how about the test results. R4 then asked the DON to stop standing by her and still did not put the mask on. The DON continued to stand by R4 and at this time the dining room had 15 residents seated waiting to be served food. At 2:29 p.m. as AA brought R4 food to eat in the dining room, the surveyor intervened, and the DON stated R4 was not supposed to be in the dining room because she was supposed to be quarantined in her room due to the exposure. The DON stated R4 was supposed to have been brought back to the room after smoking but AA was assisting with the Christmas party. -At 2:31 p.m. DON wheeled R4 out of the dining room down the hallway to her room. During interview on [DATE], at 2:39 p.m. the activities assistant stated she did not know that R4 was not supposed to participate in communal activities. The activities assistant stated she thought if R4 had her mask on and maintained 6 feet this was appropriate. AA stated she had told R4 if she was not eating and drinking, she was supposed to have her mask on and she did not know why other staff did not re-direct R4 to put the mask on as she was busy assisting with the activity. During interview on [DATE], at 3:04 p.m. the DON stated the facility was going to revised the training for the staff to include -unvaccinated residents can only go to smoke then back into their rooms and she of the infection control nurse would communicate to the staff the vaccination status of a residents when this situations came up and this would be implemented immediately in IJ the removal staff training. (continued on next page)

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