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	02/10/2022

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview, and document review, the facility failed to ensure a do-no-resuscitate (DNR) order was accurately reflected throughout the medical record for 1 of 2 residents (R41) reviewed for advanced directives. This resulted in an immediate jeopardy (IJ) for R41 who would had received cardiopulmonary resuscitation (CPR), contrary to their wishes, in the absence of a pulse or respirations. The IJ began on [DATE], at 3:30 p.m. when R1's Provider Orders for Life-Sustaining Treatment (POLST) identified R41 had an active do-not-resuscitate order, however, the electronic health record (EHR) indicated R41's was to be administered CPR. The administrator was notified of the IJ at 3:30 p.m. on [DATE]. The IJ was removed on [DATE], at 10:56 a.m. but non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm. Findings include: R41's Admission Record printed [DATE], indicated R41 had diagnoses of heart failure, acute respiratory failure with hypoxia (low oxygen issues in the tissues), morbid obesity, cardiomyopathy (disease of the heart muscle), and obstructive sleep apnea. R41's significant change Minimum Data Set (MDS) dated [DATE], indicated R41 was cognitively intact. R41's physician orders reviewed on [DATE], at 4:10 p.m. included R41 was Full Code (CPR) dated [DATE]. R41's care plan dated [DATE], indicated R41 was Full Code, with a goal of Resident's Advanced Directives will be honored. Staff were directed to review R41's code status on a quarterly basis and as needed. R41's POLST signed by and R41 and the medical provider on [DATE], indicated DNR. R41's Care Conference Summary 1 - V2 dated [DATE] and [DATE], indicated R41's code status was Full Code. (continued on next page)

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

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R41's Social Service Note dated [DATE], at 3:43 p.m. identified R41's code status was Full Code. During interview on [DATE], at 2:15 p.m. registered nurse (RN)-A stated both the EHR and paper chart would be reviewed (in the event a resident did not have a pulse or respirations). If the information did not match CPR would be initiated. During interview on [DATE], at 2:17 p.m. licensed practical nurse (LPN)-A stated in the event of cardiac arrest, both the EHR and paper chart would be reviewed. If a discrepancy existed CPR would be initiated. During interview on [DATE], at 2:18 p.m. LPN-B stated in the event of cardiac arrest, both the EHR and paper chart would be reviewed. If a discrepancy existed CPR would be initiated. R41's EHR banner observed on [DATE], at 4:10 p.m. indicated R41 was Full Code; athough R41's POLST identiifed DNR. During interview on [DATE] at 4:13 p.m. R41 confirmed his code status was DNR and he had signed the appropriate forms. During interview on [DATE], at 4:14 p.m. RN-B stated he reviewed the both EHR banner and the signed POLST in the paper chart to determine whether to provide CPR. If there was a discrepancy, he would initiate CPR. RN-B confirmed R41's EHR banner indicated Full Code and R41's POLST indicated DNR. RN-B stated the electronic documentation should have been changed when R41's new POLST was completed, or staff would perform CPR on him when he did not want it. During interview on [DATE], at 4:39 p.m. director of nursing (DON) verified the EHR indicated R41 was identified as Full Code, however, the signed POLST in the paper chart indicated R41 was DNR. The DON stated the discrepancy existed for approximately three months and he would have treated R41 as a Full Code. He re-affirmed if there was any doubt he would save the life. During interview on [DATE], at 8:51 a.m. director of social services (DSS) stated if a resident wanted to change a POLST she would meet with the provider, a nurse, and the resident (or resident representative), fill out the POLST, and have the resident (or representative) sign it. Once completed she gave a copy to the resident and placed the document in the paper chart. She communicated any changes in code status verbally at a daily team meeting, and a nurse or a social worker changed the care plan. She did not change the banner or the physician order in the EHR but thought nursing staff would change it right away. If she noticed a conflict, she would check with the nurse manager, but expected staff would proceed with a Full Code. During interview on [DATE], at 9:14 a.m. social worker (SW)-A stated she typically was not involved in the POLST process, however, recalled reviewing the POLST with R41 and, after he signed it, she gave it to the DON. She stated if the code status in the paper chart and the EHR didn't match she anticipated staff would have performed CPR because of the lack of clarity, but it would have been against R41's wishes. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on [DATE], at 10:25 a.m. administrator stated when the POLST was completed the order should have been changed in the EHR and the banner updated. He stated he did not know why R41's code status was not updated in the EHR, but when the physician placed the order, it should had been changed. During interview on [DATE], at 11:49 a.m. physician (MD)-A stated code status must be addressed at each resident admission and re-admission, and he expected any change in status to be accurately communicated with staff. He stated the POLST must reflect the resident's choice, and staff must respect the resident's decision. He stated once a POLST was signed by the resident and the physician he gave it to the facility staff to put into the chart, and he considered the POLST a physician order. His expected staff to follow the orders on the paper copy of the POLST to ensure resident's wishes were respected. During interview on [DATE], at 1:38 p.m. R41 stated he changed his code status a few months ago after a visit with the provider, and the social worker at the time had him sign a form. He verified his understanding of DNR versus Full Code by stating DNR meant if your heart stops, they make no attempt to get it going again, and full code is when they do what they can to get you going. He further stated he changed his code status because he didn't want to have any chance of being brain damaged. The facility Advance Directives policy updated [DATE], indicated resident's code status would be obtained either verbally from the resident, hospital medical record or resident advanced directive documents. This information would be entered into the Electronic Medical Record for physician review and signature. Social Services reviews and updates the Advance Directives upon readmission and as needed but at least quarterly in conjunction with the plan of care. POLST information would be added to all resident charts upon admission. The policy Emergency Procedure - Cardiopulmonary Resuscitation revised ,d+[DATE], identified if the resident's DNR status was unclear, CPR would be initiated until it was determined that there was a DNR or a physician's order not to administer CPR. The IJ was removed on [DATE], at 10:56 a.m. when the facility developed and implemented a systemic removal plan which was verified by interview and document review. - All residents records were reviewed to ensure the electronic banner, physician orders, and advance directive care plans reflected the most current POLST and orders on [DATE]. - Seven LPNs and five RNs were educated on POLST completion, order entry and facility policy on [DATE], as evidenced by the Education Sign In Sheet. - A process was implemented to ensure all other nurses completed mandatory education prior to the start of their next shift on [DATE], which included notification of required mandatory education via signage at the time clock and via phone/text. - On [DATE], LPN-A, LPN-B, DON, and DSS were interviewed and verified they received education regarding POLST completion, order entry, and policy. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The policy for advanced directives was reviewed and updated to include the POLST will be reviewed upon admit, quarterly, and with change in condition by the IDT (interdisciplinary team) and matched against the medical record for accuracy.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43077 Based on observation, interview, and document review, the facility failed to comprehensively reassess and develop individualized interventions to address exhibited behaviors of dementia for 1 of 1 resident (R35) who had soiled nails and refused hygiene assistance. Findings include: R35's quarterly Minimum Data Set (MDS) dated [DATE], indicated R35 had a severe cognitive impairment, had no physical or verbal behaviors, and no refusal of cares. The MDS further indicated R35 required extensive assistance with personal hygiene and bathing. R35's diagnoses included Alzheimer's disease with early onset and dementia with behavioral disturbance. R35's care plan updated 1/19/22 indicated, R35 had behaviors of crawling/laying on the floor, self-transferring and disrobing in the bedroom/public places. Also, R35 was noted to smear stool on the walls and his clothing. R35 was noted to refuse cares, including, but not limited to, personal hygiene, nail care, repositioning, grooming, and bathing. Staff were to monitor behavioral episodes and attempt to determine underlying causes when considering the location, time of day, persons involved, and situations. Despite the facility having recognized R35 had ongoing refusals of care, R35's medical record lacked indication of a comprehensive reassessment and attempts to develop individualized dementia care interventions to promote hygiene. Review of R35's Weekly Skin Checks dated 1/9/22, 1/15/22, 1/22/22, and 2/5/22, included R35's fingernails and toenails needed trimming. On 2/7/22, at 5:36 p.m. R35 was observed lying in bed. R35's fingernails were long with a moderate amount of dried dark brown matter both underneath and on top of his nails. On 2/8/22, at 2:55 p.m. R35 was observed laying in bed. R25's fingernails remained long with a moderate amount of dried dark brown matter underneath and on top of his nails. During an interview on 2/8/22, at 4:08 p.m. R35's family member (FM)-A stated R35 dug in his soiled incontinence product which left his nails very dirty. FM-A stated she knew R35 did not like having his nails cut, but felt the facility could try other ways to address the situation rather than leaving his nails dirty. FM-B was also interviewed at this time and stated she felt the facility could try different intervention to attempt getting R35's nails clean. FM-B was not aware of any behavioral interventions attempted to assist R35 with nail care. During an interview on 2/9/22 at 8:43 a.m. hospice registered nurse, (RN)-D stated she was unaware of any behavioral interventions related to R35's nail care. RN-D observed R35's nails and stated, Those nails are gross. I think he is scratching himself. These need to be soaked. At 8:47 a.m. RN-D stated R35 refused to have his nails cut. RN-D stated she did not attempt any behavioral interventions, but added, If he was in a bathtub, they could soak. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/9/22, at 10:56 a.m. social worker (SW)-A stated she knew R35 had severely impaired cognition, but was unaware of any behaviors the resident displayed. SW-A was not aware R35 was resistive to care or assistance from staff. SW-A stated if R35 was resistive, staff could attempt to approach him in a different way. During an interview on 2/9/22, at 11:14 a.m. the director of nursing (DON) stated when a resident resisted care staff should re-approach. Staff should offer care in different ways, use calm words, and try to make the resident feel calm. The DON added it could be helpful to have a different staff member attempt to talk with a resident. If the interventions were not successful, the nurse should document in the medical record the care was refused and what interventions were attempted. If a resident had ongoing refusals of care, it should be reported to nursing supervisors to see how they could help with the situation. The DON was not aware of any ongoing refusals of care from R35, however, was aware R35 could be combative at times. When R35 was in a friendly mood, staff could be successful in completing his cares. Facility policy titled Dementia - Clinical Protocol revised 11/18, included, For the individual with confirmed dementia, the IDT [interdisciplinary team] with identify a resident-centered care plan to maximize remaining function and quality of life. The IDT will adjust interventions and the overall plan depending on the individual's response to those interventions, progression of dementia, development of new acute medical conditions, changes in resident or family wishes, and other relevant factors.