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	12/02/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure a self-administration of medications assessment was completed for 1 of 1 resident (R2) observed with medication at their bedside.Findings include:R2's quarterly minimum data set (MDS) dated [DATE] indicated intact cognition with diagnoses included morbid obesity and asthma.R2's self-administration of medications assessment dated [DATE] indicated R2 did not want to self-administer any medicationsR2's current provider orders on 10/21/25 included albuterol sulfate inhalation solution. 1 puff inhale orally every 4 hours as needed for shortness of breath due to asthma. R2's care plan dated 9/8/25 did not identify R2 did not identify a focus and/or interventions for self-administration of medication. During an observation and interview on 10/21/25 at 12:41 p.m., an inhaler was observed in a bowl on R2's bedside table. R2 stated he kept the inhaler next to his bed so he could use it as needed a couple of times a week. R2 did not tell staff when he used the inhaler.During an interview on 10/21/25 at 1:24 p.m., licensed practical nurse (LPN)-B confirmed R2 had an albuterol inhaler at his bedside. LPN-B stated when a nurse saw a medication in a resident room, the medication should be placed in the nurse's cart then an assessment needed to be completed. If the resident was deemed safe to self-administer the medication, an order needed to be obtained from the provider. LPN-B confirmed R2 had an order for an albuterol inhaler but did not have a self-administration order for the inhaler. During an interview on 10/21/25 at 11:29 a.m., the director of nursing (DON) stated if a resident asked to self-administer a medication the nurse needed to complete an assessment and if the resident was deemed safe, a provider order was obtained. The assessment was important to confirm the resident was capable and safe to self-administer the medication.During an interview on 10/21/25 at 12:13 p.m., the medical director stated if a resident requested to keep an inhaler at their bedside, the nurse should assess if the resident could use the inhaler properly, recognize when to use the inhaler, and how often they could use it. If the resident was deemed safe to self-administer, a provider order to keep the medication at the bedside should be obtained. The assessment was important to confirm the resident used the inhaler appropriately.The Self-administration of Medications policy dated 2/2021 instructed the interdisciplinary team to assess each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate. If the resident is deemed safe and appropriate to self-administer medications, this would be documented in the medical record and the care plan.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and document review, the facility failed to accommodate resident needs by ensuring call light buttons were within reach for 1 of 2 (R3) residents reviewed for call light usage.Findings include:R3 quarterly minimum date set (MDS) date 7/31/25 indicated severe cognitive impairment with diagnoses included schizoaffective disorder, bipolar type and catatonic schizophrenia.R3's care plan dated 9/8/25 instructed to be sure resident's call light is within reach and encourage resident to use it.During an observation and interview on 10/20/2025 at 2:41 p.m., R3 was lying in her bed. A cord was coming out of the wall near the head of the bed, but no call button was observed. R3 stated she did not have a call button. If she needed help, she would wave at staff as they walked by or would say help me. During an observation and interview on 10/20/2025 at 2:51 p.m. licensed practical nurse (LPN)-A confirmed R3's call light was lying on the floor under her bed. LPN-A stated the call light should have been attached to R3's bed where she could reach it. Resident's call lights needed to be within reach so the resident could receive help when needed.During an interview on 10/20/2025 at 2:57 p.m. nursing assistant (NA)-A stated before leaving a resident room, a staff person should make sure the resident has their call light and other needed items within their reach.During an interview 10/21/2025 at 11:29 a.m., director of nursing stated staff member need to be sure a resident has their call light within reach before leaving a resident's room. The call light is the resident's tool to communicate with staff.The Answering the Call Light policy dated 9/2022 instructed staff to ensure the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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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. Based on interview and document review the facility failed to monitor temperature and intravenous access (IV) site for 1 of 1 resident (R3) following electroconvulsive therapy (ECT).Findings include:ECT is a procedure done under general anesthesia. During this procedure, small electric currents pass through the brain, intentionally causing a brief seizure. ECT seems to change brain chemistry, and these changes can quickly improve symptoms of certain mental health conditions. Electroconvulsive therapy (ECT) - Mayo Clinic R3 quarterly minimum date set (MDS) date 7/31/25 indicated severe cognitive impairment with diagnoses included schizoaffective disorder, bipolar type, and catatonic schizophrenia.R3's care plan dated 9/8/25 indicated R3 had ECT treatment 2 times a week on Tuesday and Thursday. Following treatment R3 should be monitored for extreme headache, nausea, vomiting, confusion, temperature greater than 100.5, redness, swelling, and drainage or pain at the IV site lasting more than 24 hours.R3's ECT discharge orders and information dated 10/2/25, 10/7/25, 10/9/25, 10/14/25, and 10/16/2025 instructed what to report after ECT: Extreme headache, nausea, vomiting, confusion, Temperature greater than 100.5, Redness, swelling, and drainage or pain at the IV site lasting more than 24 hours, Major increase in depression or mania. R3's electronic physician orders included the aforementioned orders however did not include monitoring for temperature greater than 100.5 and redness, swelling, and drainage or pain at the IV site lasting more than 24 hours after ECT. The orders transcribed into the record included the following. -Physician order dated 5/14/24 instructed to monitor behaviors after ECT every shift on Tuesdays and Thursdays.-Physician order dated 7/31/25 instructed to monitor resident for extreme headache, nausea, vomiting, and confusion every shift on Tuesdays and Thursdays.-Physician order dated 7/16/24 instructed to complete vital signs every 4 weeks on Tuesday.R3's provider orders lack indication of R3's October treatment administration record (TAR) indicated R3 had ECT on 10/2, 10/7, 10/9, 10/14, and 10/16/2025. R3's temperature was checked on 10/7/25 and documented under the monthly vital sign check order. R3's TAR lacked temperature monitoring for 10/2, 10/9, 10/14, and 10/16/25.R3's nurse's notes for the month of October 2025 indicate R3's vital signs were checked one time on 10/14/25. R3's notes lack documentation of temperature monitoring on 10/2, 10/9 and 10/16. R3's notes lack documentation of IV site monitoring on 10/2, 10/7, 10/9, 10/14, and 10/16/2025. During an interview on 10/20/25 at 2:51 p.m., licensed practical nurse (LPN)-A stated if a resident needed additional monitoring an order would pop up in the TAR. Vital signs were supposed to be monitored as ordered in the TAR or if a resident was not feeling well. R3 had additional monitoring for behaviors, headache, and vomiting after ECT. Her vital signs were checked monthly.During an interview on 10/21/25 LPN-B stated all special monitoring for a resident was documented on the TAR. Resident's vital signs were checked according to provider orders, usually once a month and as needed if a resident was not feeling well. LPN-B confirmed R3's monitoring following ECT included behaviors and extreme headache, nausea, vomiting, and confusion. LPN-B could not find an order to monitor for temperature greater than 100.5 and redness, swelling, and drainage or pain at the IV site lasting more than 24 hours after ECT.During an interview on 10/21/25 at 11:29 p.m., director of nursing (DON) stated the symptoms nurses should be monitoring would be placed in the TAR. DON confirmed R3 had ECT 5 times in October 2025. Her temperature was taken 1 time and there was no documentation of IV site monitoring. It is important to monitor a resident so if they start feeling unwell staff can intervene timely.During an interview on 10/21/25 at 12:13 p.m., the medical director (MD) stated nurses should follow the patient instructions for monitoring sent with the resident following ECT treatment. Staff need to be monitoring for increased temperature and headache. Temperature should be taken when the resident returns from ECT. Monitoring should be completed to catch any problems early.The Behavioral Assessment, Intervention and Monitoring policy dated 3/2019 instructed if the resident is being treated for altered behavior or mood, the interdisciplinary team (IDT) will see and document any improvements or worsening in the individual's behavior, mood, and function.