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	12/03/2025

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 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** Based on interview and document review the facility failed to communicate with a resident's emergency family contact when they were hospitalized and subsequently discharged from the facility for 1 of 2 residents (R1) reviewed for discharge process.Findings include:R1's electronic medical record (EMR) indicated R1 was admitted to the facility on [DATE] and discharged on 9/13/25.R1's progress note, dated 9/13/25, indicated R1 was not redirectable and walking towards traffic and sent to the emergency department (ED) due to safety concern to self.R1's EMR lacked any evidence the facility communicated with R1's family about any potential safety concerns, his hospitalization, and discharge from the facility. During an interview on 11/10/25 at 9:50 a.m., R1's emergency contact and family member (FM)-A stated she was not informed of any incidents regarding R1 walking outside in traffic and was never informed he was hospitalized . FM-A stated she arrived at the facility on a Wednesday or Thursday to bring R1 some tobacco, and when she could not find him at the facility, she was informed he had been sent to the hospital on Saturday. FM-A stated staff at the facility were not able to tell her what happened only that the paramedics took him. FM-A stated when R1 was ready to discharge from the hospital, the social worker (SW)-A at the hospital was having a hard time getting ahold of the facility. FM-A stated she stopped by the facility to discuss in person R1's plans to return to the facility and was told by the administrator that R1 had been discharged from the facility, and she was handed a box of R1's belongings to take with her. During an interview on 11/10/25 at 11:12 a.m., the facility social worker (SW)-B stated it was expected that family be informed when a resident discharged from the facility or was sent to the ED. SW-B stated he was not the SW for R1, that particular SW was no longer with the facility, however had heard that R1 was officially discharged from the facility when he was civilly committed at the hospital.During an interview on 11/10/25 at 11:19 a.m., the facility administrator stated R1 was discharged from the facility after he was civilly committed at the hospital as he was unsure if a [NAME] was also in place, stating if that was the case they would not be able to readmit R1. The administrator confirmed R1's EMR lacked any notes of communication with the family regarding R1 hospitalization and discharge, unable to confirm if family was contacted or not.During an interview on 11/10/25 at 12:01 p.m., R1's emergency contact and family member (FM)-B also confirmed she had not been informed of R1 hospitalization and discharge from the facility. FM-B stated R1's family had not been contacted about any potential safety concerns such as leaving the facility or wandering off in traffic.A facility policy on discharge was not received.

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
	245544	A. Building B. Wing	12/03/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure a written notice of transfer and bed hold was given to a resident and/or their family upon hospitalization for 1 of 2 residents (R1) reviewed for discharge. Findings include:R1's electronic medical record (EMR) indicated R1 was admitted to the facility on [DATE] and discharged on 9/13/25.R1's progress note, dated 9/13/25, indicated R1 was not redirectable and walking towards traffic and sent to the emergency department (ED) due to safety concern to self.R1's EMR lacked any evidence R1 and/or family had received a written notice of transfer and information on the facility's bed hold policy when R1 was hospitalized on [DATE].During an interview on 11/10/25 at 9:50 a.m., R1's emergency contact and family member (FM)-A stated she was not informed when R1 was sent to the hospital, did not received a written notice of transfer or any information on the facility bed hold policy.During an interview on 11/10/25 at 11:12 a.m., the facility social worker (SW)-B stated it would be expected that family be informed when a resident discharged from the facility or was sent to the ED. SW-B stated the facility would give a verbal notice of transfer and information on the bed hold policy which should be documented in a progress note. SW-B was unaware of any specific facility policy regarding a written notice of transfer.During an interview on 11/10/25 at 11:19 a.m., the facility administrator stated it would be expected that a written notice of transfer was uploaded in the resident's EMR when they are transferred to the hospital, along with the bed hold policy. The administrator confirmed these were not in place for R1.A bed hold and written notice of transfer policy was not received.