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	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victory Health and 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and document review, the facility failed to perform complete and thorough investigations of allegations of abuse for 3 of 3 residents (R1, R2, R3) who were involved in resident-to-resident altercations. Findings include:A Nursing Home Incident Report (NHIR) dated 5/26/26 at 8:20 p.m., indicated at approximately 6:25 p.m., when R2 and R3 were both in the dining room, R2 struck R3 in the chest and face. Facility initiated 15-minute safety checks. The incident was witnessed by activity staff. A NHIR dated 5/26/26 at 10:30 p.m., indicated at 7:39 p.m., R2 and R1 were involved in a physical altercation in which R2 hit and scratched R1. Staff intervened and separated the residents, and staff performed monitoring and safety checks. Review of the investigative files on 6/1/26 of each of the two incidents revealed the investigations did not include interviews with other residents to ensure the other residents did not also have allegations of abuse by R2. During an interview on 6/2/26 at 12:09 p.m., the director of nursing (DON) stated during an investigation for abuse, other residents other than those involved in the incident, should be interviewed to determine if other residents had also been abused and acknowledged that had not occurred for either incident. A policy for abuse investigations was requested but not provided.

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

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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** Based on interview and document review the facility failed to ensure a safe environment was maintained and monitoring was implemented as indicated in the medical record for 2 of 3 residents (R1, R3), and as ordered for 1 of 3 residents (R2) after resident-to-resident altercations.Additionally, the facility failed to ensure ongoing assessment and monitoring for 2 of 2 residents (R1, R3) after R1 was hit and scratched by R2, and R3 was hit in the torso and slapped by R2, which had the potential to result in unmonitored decline for R1 and R3.Findings include:A Nursing Home Incident Report (NHIR) dated 5/26/26 at 8:20 p.m., indicated at approximately 6:25 p.m., when R2 and R3 were both in the dining room, R2 struck R3 in the chest and face. Facility initiated 15-minute checks. The incident was witnessed by activity staff. A NHIR dated 5/26/26 at 10:30 p.m., indicated at 7:39 p.m., R2 and R1 were involved in a physical altercation in which R2 hit (did not indicate where) and scratched R1. Staff intervened and separated the residents, and staff performed monitoring and safety checks. R1R1's annual Minimum Data Set (MDS) dated [DATE], indicated intact cognition, no behaviors, and diagnoses that included anxiety, depression, and Post Traumatic Stress Disorder (PTSD). R1's care plan indicated the following:5/19/25- safety- [R1] is at risk for potential abuse due to chemical dependency, mental illness, and intrusive thoughts. Intervention included to not have R1 near residents who disturb him and remove from potentially dangerous situations. 7/28/25- vulnerable adult due to mental health, cognition, physical impairment and nursing facility placement. The diagnoses list on the care plan indicated alcohol dependence and other stimulant use.R1's progress notes indicated the following:5/26/26 at 10:25 a.m., R1's bath audit was completed with no skin concerns noted. 5/26/26 at 8:01 p.m., activity staff informed the licensed practical nurse (LPN)-B R1 was involved in a physical altercation with R2; R2 hit and scratched R1. R1 was noted to have scratches on the chest, abdominal area, and arm following the incident. Staff performed monitoring and safety checks. 5/27/26 at 7:19 a.m., 15-minute checks continued. The progress notes lacked a comprehensive assessment of the scratches, their length, depth, and width, description of the color, shape, and margins, and if there was any drainage from the wounds. Also, the progress note lacked mention of the treatment provided, a pain assessment, and indication of ongoing monitoring of R1's injuries. R1's Incident Audit Report dated 5/26/26 at 9:38 p.m., indicated the LPN-B was informed by activity staff, R1 and R2 were involved in a physical altercation, R2 hit and scratched R1 over a money conflict. Male resident [R1] noted with scratches to chest, abdominal area, and arm following the incident. The residents [R1 and R2] were separated, and safety checks were initiated. The director of nursing (DON), administrator, provider, police, and psychologist were notified. R1's care plan was reviewed and updated, first aid care was performed for R1's scratches, and a PTSD screen and Vulnerable Adult assessment were completed. Referrals were sent to R1's psychology clinic for onsite evaluation and to the onsite substance abuse counselor. Monitoring and safety checks continued. R1's 15-Minute Check Sheet indicated 15-minute checks were implemented on 5/26/26 at 8:30 a.m., and continued through 5/28/26 at 7:00 a.m. The Check Sheet further indicated the 15-minute checks were omitted during the following time frames:5/27/26 from 12:15 a.m., through 6:15 a.m.5/28/26 from 8:15 a.m., through 2:15 p.m.5/28/26 from 7:15 a.m., through the end of the 72-hour monitoring periodR1's orders lacked mention of 15-minute checks. During an interview on 6/1/26 at 2:18 p.m., R1 stated he did not remember the incident with R2, but he had scratches on his arms and chest and was kicked by R2; staff told him about the incident. R1 stated he was not on safety checks, and the only time his VS were checked was twice daily when he had been drinking. R2R2's quarterly MDS dated [DATE], indicated intact cognition, no behaviors, and diagnoses that included traumatic brain injury, depression, anxiety, and PTSD. R2's care plan indicated the following:1/13/26- at risk for abuse due to being a vulnerable adult with an intervention dated 1/16/26 to not allow R2 to be near other residents who disturbed her.3/19/26, updated 5/27/26- (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Impaired thought process related to substance abuse and dependence of alcohol dated, with an intervention dated 5/27/26 to initiate the facility alcohol and substance abuse policy.5/27/26- potential to be physically aggressive after a resident to resident altercation with interventions to monitor and document for increase in behavior, specifically ( ), The care plan lacked indication of the behaviors the staff were supposed to monitor and was left blank.), and monitor, document, and report as needed (PRN) any signs and symptoms posing danger to self and others. The diagnoses list on the care plan indicated current alcohol use. R2's progress notes indicated the following:5/26/26 at 4:17 p.m., social worker (SW)-A went outside to schedule Care conference with another resident and R2 was passing a jug of liquor around to other residents. Staff asked to take the bottle, but R2 would not give up the bottle. Staff let nursing staff know the resident was drinking.5/26/26 at 7:35 p.m., at approximately 6:30 p.m., activity staff informed LPN-A that R2 attempted to hit R3, and R2 initially stopped, but when activity staff turned to assist another resident R2 struck R3 in the chest and face. 15-minute safety checks were initiated. The police, DON, and administrator were notified. 5/26/26 at 9:04 p.m., R2 continued to exhibit signs of intoxication, including slurred speech and mood changes, medication on hold, and her medical provider was notified. The progress notes lacked mention of R2's second altercation, between R2 and R1, on 5/26/26 at 7:39 p.m. R2's 15-Minute Check Sheet indicated 15-minute checks were implemented on 5/26/26 at 6:30 p.m., and further indicated the 15-minute checks were omitted during the following time frames:5/27/26 from 2:45 p.m., to 5/28/26 12:00 a.m.5/28/26 from 6:30 a.m,. to 5/28/26 8:00 a.m.5/28/26 from 1:15 p.m., through the 72-hour monitoring periodR2's provider orders dated 5/27/26, indicated 15-minute safety checks every shift, fill out the paper form. The provider order did not have an end date and was not entered until the day after the safety checks were implemented. During an interview on 6/1/26 at 3:46 p.m., R2 stated R3 called her a racist name and, a bitch. R2 told R3 to stop, but R3 didn't. R2 didn't recall the incident with R1, only that something happened. R2 stated she is able to hide from staff and staff couldn't keep up with her to check on her. During an interview on 6/1/26 at 3:00 p.m., the LPN-B stated both R1 and R2 were on 15-minute checks after the incident, which were completed on paper forms, usually for 72 hours after an altercation. The LPN-B stated she did not see R1's wounds up close but when R1 went outside, she saw them, and they were, not gushing blood. R1 was angry and the LPN-B was afraid to approach him to assess the wounds more closely. The LPN-B stated staff should have continued to monitor and check on the wounds for signs of infection and was unsure is staff had. R3R3's quarterly MDS dated [DATE], indicated severe cognitive impairment, no behaviors, and diagnoses that included malnutrition and visual problems. R3's care plan indicated the following:10/10/24- no cultural preference. The care plan lacked interventions for known racism/racist comments. 5/13/25- impaired thought processes with an intervention dated 10/8/21, closely supervise activities and interactions with others. 11/5/25- safety- was at risk with a potential for abuse due to cognition and physical impairment with an intervention dated 10/24/25 to ensure safety around others who may take advantage of R3, and an intervention dated 3/7/23, do not allow R3 to be around others who disturbed her. The diagnoses list on the care plan indicated symptoms and signs involving cognitive functions and awareness, depression, and adjustment disorder with anxiety. R3's progress notes indicated:5/26/26 at 7:24 p.m., indicated R3 was hit in the face by another resident, and the nurse conducted a head-to-toe assessment and found no swollen or open areas. VS were taken, and within normal range. Resident was placed in 15-minute checks. The progress note lacked values of the VS. 5/27/26 at 11:47 a.m., indicated the LPN-C was notified by other residents, R3 was slapped by R2. The LPN-C performed a head-to-toe assessment, VS were taken and were within normal range, the resident denied pain or discomfort, and R3 was placed on 15-minute checks. The provider and R3's FM were updated. 5/28/26 at 11:47 a.m., indicated the progress note created on 5/27/26 at 11:47 a.m., was not indicative of a new incident, but was instead a follow up note from the incident that was noted on 5/26/26. R3 remained stable and maintained on 15-minute checks. The progress notes lacked the VS values after the incident and lacked ongoing (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment after R3 was struck in the face by another resident. R3's Incident Report Audit dated 5/27/26 at 11:02 a.m., indicated an incident occurred 5/26/26 at 5:50 p.m., between R2 and R3. The Report indicated R2 slapped R3 in the face and a head-to-toe assessment was completed. Resident placed on 15-minute checks. The assessment lacked indication of VS values. R3's care plan was reviewed and updated, and a PTSD screen and VA assessment were completed. R3 was referred to on the onsite psychologist. R3's 15-Minute Check Sheet indicated 15-minute checks were implemented on 5/26/26 at 6:30 a.m., and continued through 5/30/26 at 8:00 a.m. The Check Sheet further indicated the 15-minute checks were omitted during the following time frames:5/27/26 from 12:15 a.m., through 6:15 a.m.5/28/26 from 8:15 a.m., through 2:15 p.m.R3's orders lacked mention of 15-minute checks.During an interview on 6/1/26 at 3:20 p.m., the activity aide (AA)-A stated she noticed on 5/26/26 after 6:00 p.m., R1 was shirtless, looked agitated, and had bloody scratches on his chest, a bloody handprint on his left arm, and the knuckles on both hands were bleeding. R1 walked towards his room but stopped where R2 was talking to another resident in front of R1's door and talked about how R1 went to the store for them, and came back with no money and no merchandise. R1 went into his room and walked out with a razor and threatened the other resident with it, and the AA-A hollered down the hallway for help. The AA-A asked R1 for the razor, but R1 walked outside instead. R2 picked up her walker and tried to hit R1 with it, but the AA-A redirected R2. The AA-A was discussing the incident with nursing staff (the AA-A didn't recall which nursing staff) and then walked outside to observe and saw R1 and R2 were hugging and appeared to be friendly again. Further, the AA-A stated she saw R2 hit R3 in the chest because R3 called R2 a racist name, and the AA-A hadn't heard the name-calling but the AA-A redirected R2 to keep her hands off R3. The AA-A stated she went to help someone else and came back and saw R2 had slapped R3's glasses off, and R3 said ow, that hurt. The AA-A stated she reported the incidents to a nurse, but didn't recall who, but the AA-A reported R2 first punched R3 in the chest and later slapped R3 on the face. During an interview on 8/2/26 at 8:56 a.m., the LPN-C stated 15-minute checks required an order, the checks were typically completed for 72 hours, and if the order did not have an end date, the checks should continue. The LPN-C acknowledged the 15-minute check order for R2 was still active, and the checks should have continued but did not and further acknowledged the 15-minute checks for R1, R2, and R3 were not completed fully. The LPN-C stated a change in condition could occur and if staff were not performing checks, staff would not know about the change in condition. During an interview on 6/2/26 at 9:34 a.m., the LPN-D stated R2 had two incidents on 5/26/26 when R2 was intoxicated with alcohol. The LPN-D stated she expected to see more of an assessment for R1's scratches, if they were old or new, if they required treatment, and if they were cleansed. The LPN-D stated she did not see any follow-up in the medical record about the scratches later but should have to ensure they were healing. The LPN-D acknowledged 15-minute checks were not completed fully for R1, R2, and R3., and if the checks were not completed, further incidents could occur. The checks were used to know the location of the residents, know they were safe, and to keep residents who had altercations away from each other while they are still upset. If the checks were not completed, staff would not know if the residents were in a safe situation. During an interview on 6/2/26 at 10:37 a.m., the nursing assistant (NA)-A stated staff were doing some15-minute checks on R3, but acknowledged staff did not do all the checks they were supposed to do, every 15 minutes for 72 hours. During an interview on 6/2/26 at 10:55 a.m., R3 did not recall the incident with R2. During an interview on 6/2/26 at 10:58 a.m., NA-B reviewed the 15-minute check sheets for R1, R2, and R3 and did not recognize the forms, and did not know their purpose. During an interview on 6/2/26 at 11:44 a.m., the family member (FM)-A stated R3 was racist, swore at staff and residents, and raised her middle finger often to them, and thought staff was protecting R3 as best they could.During an interview on 6/2/26 at 1:20 p.m., the LPN-A stated she was aware of the incidents between R1 and R2, and R2 with R3. The LPN-A stated that when residents are assaulted, the nursing staff assessed each resident for injuries and implemented 15-minute checks to ensure the residents were not in the same place at the same time. The LPN-A (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated a skin assessment was documented for each resident in the progress notes, and VS should be recorded. If a resident is injured, nursing staff would keep monitoring to ensure the resident's condition did not worsen. During an interview on 6/2/26 at 12:09 p.m., the DON stated she was notified of both incidents. Staff were expected to separate the residents after an altercation, start 15-minute checks, perform skin assessments and VS, and notify family, the DON, and administrator. The DON stated she saw the progress noted on 5/26/26 at 8:01 p.m., in which a skin assessment was noted with scratches, but the nurse did not describe the scratches, the treatment that was administered, record the VS, or perform a pain assessment, but should have. The DON further acknowledged R3's incident progress noted indicated VS were assessed, but the progress note lacked the VS values. Additionally, the DON acknowledged 15-minute checks were supposed to have been completed for 72 hours for R1 and R3, but were not completed as long as they should have been, and were not completed every 15 minutes as they should have been. Also, R2's order for 15-minute checks had no end date, so R2 should have remained on 15-minute checks until the order was discontinued. The DON stated the 15-minute checks were implemented for the safety of each resident, and if they were not completed, another incident could occur. The DON further stated 15-minute checks were in the facility's batch orders, and each resident on 15-minute checks should have an order for them, but R1 and R3 did not. The Resident-to-Resident Altercation policy dated December 2016 indicated if two residents were involved in an altercation staff would document in the resident's clinical record all interventions and their effectiveness and complete a Report of Incident/Accident form and document the incident, findings, and any corrective measures taken in the resident's medical/clinical record.