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	06/13/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview, and record review, the facility failed to include individualized approaches for care, including non-pharmacological interventions to aid in the management of behavior, in the comprehensive care plan for 2 of 5 residents (R1, R6) reviewed for unnecessary medications. Findings include: R1's significant change Minimum Data Set (MDS) dated [DATE], included R1 was moderately cognitively impaired, had diagnoses of dementia, depression, and psychotic disorder (other than schizophrenia). R1 took antidepressant and antipsychotic medications on a routine basis. R1's Mood State Care Area Assessment (CAA) was not triggered. R1's Psychotropic Drug Use Care Area Assessment (CAA) indicated R1 took antipsychotic medications, was at risk for adverse reactions from the medications, and had no noted side effects. R1's Order Summary Report dated 6/5/24, included: *Aripiprazole tablet 5 milligrams (mg) one time per day for psychosis starting 6/1/24. *Sertraline HCl (hydrochloride) tablet, 150 mg one time per day for major depressive disorder starting 1/6/24. *Trazodone HCl tablet 100 mg (an antidepressant), one time per day at bedtime for insomnia starting 10/23/23. R1's care plan dated 10/30/23, indicated the resident had anxiety and included the following interventions: *Adhere to resident's stated choice of routine/activity pattern. *Allow resident to express concerns--validate/offer TLC (tender loving care) as appropriate. *Allow the resident time to answer questions and to verbalize feelings perceptions, and fears. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Assess placement needs as needed/appropriate. *Be attentive to resident's need--observe for any s/s of discomfort, anxiety, being overwhelmed, etc. *Consult with: Pastoral care, Social services, Psychology services *Educate resident and/or family regarding discharge planning needs. *Encourage participation in activities/decisions from resident who depends on others to make own decisions. The care plan also included R1 had a mood problem dated 10/30/23, and included interventions of: *Administer medications as ordered. Monitor/document for side effects and effectiveness. *Behavioral health consults as needed psycho-geriatric team, psychiatrist etc. *Educate the resident/family/caregivers regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance. *Monitor/document/report PRN (as needed) any risk for harm to self: suicidal plan, past attempt at suicide, risky actions stockpiling pills, saying goodbye to family, giving away possessions or writing a note, intentionally harmed, or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment, or safety awareness. *Monitor/record mood to determine if problems seem to be related to external causes, i.e., medications, treatments, concern over diagnosis. *Monitor/record/report to MD (medical doctor) prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills *Monitor/record/report to MD prn mood patterns s/sx (signs/symptoms) of depression, anxiety, sad mood as per facility behavior monitoring protocols. In addition, R1 had depression and took an antidepressant medication, and the care plan dated 11/2/23, instructed staff to: *Administer medications as ordered. Monitor/document for side effects and effectiveness. *Arrange for psych consult, follow up as indicated. *Discuss with the resident/family/caregivers any concerns, fears, issues regarding health or other subjects (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment, or safety awareness. *Monitor/document/report PRN any s/sx of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness. *Monitor/record/report to MD prn risk for harming others: increased anger, labile mood, or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons *Pharmacy review monthly or per protocol. *The resident needs time to talk. Encourage the resident to express feelings. *The resident needs adequate rest periods. The resident prefers to rest. *Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness *Educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms of anti-depressant drugs being given). *Monitor/document/report PRN adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, n/v (nauseas/vomiting), dry mouth, dry eyes R1 used psychotropic medications and the care plan dated 10/24/23, included the following interventions: *The resident will reduce the use of psychotropic medication through the review date. *Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness. *Consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly. *Discuss with MD, family re ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Monitor/document/report PRN any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (extrapyramidal side effects caused by psychotropic medications, such as shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. The care plan lacked evidence of non-pharmacological, resident-specific interventions. During observation on 6/10/24 at 1:28 p.m., R1 was heard crying in their room, stating numerous times, I feel like shit, I feel like shit while staff were in the room attempting to assist R1. R1 continued to verbalize negative comments, many unintelligible. Staff placed R1 in their bed and left the room. R1 was noted to be sleeping in bed at 2:20 p.m., and 5:18 p.m. During interview on 6/12/24, at 7:42 a.m., registered nurse (RN)-A stated mental health and behavioral interventions should be in the care plan and be specific for each resident based upon the cause of the behavior or situation. Once potential causes were assessed and interventions were identified, staff would know how best to help. During interview on 6/12/24 at 8:57 a.m., trained medication aide (TMA)-A stated if a resident demonstrated they were in distress, either by words or behaviors, they would ask what they needed and try to fix it, and/or let the nurse know to possibly give medication. They were unaware of any resident-specific interventions for R1 and addressed each resident in the same manner. During interview on 6/12/24 at 10:01b a.m., licensed practical nurse (LPN)-C stated if there was a behavioral or mental health concerns, they talked with the resident to figure out why they were acting out and tried to address it. LPN-C indicated R1 a history of suicidal ideation and anxiety, and made comments including nobody cares, or let me lay down, however there were no resident-specific interventions in R1's care plan. During interview on 6/12/24 at 10:12 a.m., director of nursing (DON) stated interventions should be individualized and in the care plan, and any behaviors and successful interventions documented so staff could use what was known to be helpful before trying other things. DON reviewed R1's medical record and care plan and verified there were no resident-specific interventions related to their depression, anxiety, and mental health in general, however it was important to identify a list of things which could be helpful since everyone reacts differently in varying situations. It was important to learn what was helpful and spread the word to make the resident feel better. The Antipsychotic Medication Use Policy dated 12/2016, included antipsychotic medications will be considered if behavioral interventions have been attempted and included in the plan of care, except in emergency.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview, and record review the facility failed to ensure coordination of scheduled and/or follow up appointments was completed for 2 of 3 residents (R38, R47) who required services from outside medical providers, and failed to ensure monitoring for edema (condition where fluid builds up in the body) for 1 of 1 residents (R19) reviewed for edema. Furthermore, the facility failed to ensure medications were administered following standard practice for 1 of 1 resident (R58) reviewed for tube feeding. Findings include: coordination of appointments R38's significant change Minimum Data Set (MDS) dated [DATE], indicated R38 had cognitive impairment and diagnoses of glioblastoma (aggressive type of brain cancer) and schizophrenia. R38's clinical appointment list dated 6/12/24, indicated R38 did not show up/had rescheduled appointments for 12/1/23, 12/15/23, 1/3/24, and 1/16/24. R38's neurosurgery clinic call documentation note dated 11/28/23 at 9:01 a.m., indicated the clinic called the facility about a tentative appointment for follow up scheduled on 12/1/24. The note indicated a call back was requested from the facility to confirm. R38's neurosurgery clinic call documentation note dated 11/29/23 at 9:44 a.m., indicated the clinic called the facility to confirm R38's appointment on 12/1/23. R38's provider order dated 11/29/23, directed staff to note neurosurgery follow up appointment on 12/1/23 and ensure transportation was set up. R38's medical record lacked indication R38 had attended the neurosurgery follow up appointment on 12/1/24 and had seen neurosurgery on 12/4/23. R38's neurosurgery after visit summary dated 12/4/23, indicated R38 required a referral to see a radiation oncologist. R38's nursing progress note dated 12/27/23 at 11:38 a.m., the facility was notified by the radiation oncology clinic of R38's appointment scheduled on 1/3/24. R38's oncology clinic call documentation dated 1/4/24 at 11:43 a.m., indicated the clinic called the facility to inquire about R38 not showing for a clinic visit on 1/3/24. R38's clinic visit was rescheduled for 1/16/24. R38's oncology clinic call documentation dated 1/19/24 at 2:07 p.m., indicated health unit coordinator (HUC) was called to ensure R38 made it to the follow up appointments on 1/25/24. The note further indicated R38 had not showed for the prior 4 appointments. The HUC indicated she was unaware of the prior appointments. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R38's medical record lacked indication R38 had attended their scheduled appointments on 12/1/23 or 12/15/23, 1/3/24, and 1/16/24. When interviewed on 6/11/24 at 2:55 p.m., HUC stated when residents were admitted or returned from an appointment the paperwork was given either to them or the nursing staff for review. The HUC stated she was responsible for coordinating the appointments and rides if needed. Once the appointment was made, HUC placed the appointment in the electronic medical record as well as their appointment book. Closer to the appointment date, transportation would be arraigned, and an envelope created for the resident to take to the appointment to foster communication with the outside provider. HUC verified R38 had missed appointments and further stated the facility wasn't aware of them. The HUC further stated there wasn't any communication with the facility from the outside providers about the appointments initially. The HUC stated she called and received an appointment list from them at the end of January and R38 had been going to the appointments since then. When interviewed on 3/13/24 at 9:12 a.m., the radiation clinic coordinator CC verified R38's missed appointments. She was not sure why the appointments were missed and verified clinic staff did contact the facility to coordinate appointments, but something got missed along the way. CC further stated typically residents came with a form to complete and send back with follow up information. CC further stated if a form was sent it was completed. When interviewed on 6/13/24 at 10:01 p.m., licensed practical nurse (LPN)-A stated when a resident has orders for an appointment or already has an appointment scheduled, the order was signed off and scanned into the chart. If the appointment needed to be made or transportation set, the HUC would receive the information. The HUC then placed appointment information into the EMR in the dashboard. This lets everyone know when residents had appointments scheduled. LPN-A further stated when a resident returned from an appointment, the paperwork was given either to her or the HUC. The HUC was then responsible for coordinating new appointments while nursing took care of any new orders. LPN-A stated R38 had some missed appointments and sated she wasn't sure why they were missed. During a follow up interview on 6/13/24 at 9:55 p.m., HUC stated not all residents returned with paperwork or they may return it to the nurse. HUC stated sometimes a phone call was made to the clinic to know if further appointments were needed, however verified the phone call was not routinely documented. R47's significant change Minimum Data Set (MDS) dated [DATE], indicated R47 was understood and able to understand others. R47's vision was adequate; he was able to see fine detail and regular print in newspapers and books. Corrective lenses were not required. Review of R47's medical record indicated R47 was seen for his vision on 11/15/23. At that time R47 reported, wavy vision at a distance, as well as, blurry vision, primarily in his left eye. It was noted these symptom were reported by R47 for approximately three years. At the time of this appointment, R47 felt the symptoms had improved. Also on this report, it was noted R47 had a history of remarkable retinal detachment of the right eye and eye surgery consisted of cataract surgery. A provider note dated 2/20/24, indicated R47 received a referral for an eye specialist exam. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 6/10/24 at 12:50 p.m., R47 stated he was waiting for an update regarding a vision appointment. He had requested this previously but felt facility was not being helpful. R47 reported his left was, much worse. During interview on 6/11/24 at 10:05 a.m., health unit coordinator (HUC) stated R47 declined the appointment for the eye specialist when discussed in 2/2024. HUC stated she placed a call on this day (6/11/24) to schedule an appointment with another eye provider, but had not received a call back. During interview on 6/13/24 at 11:38 a.m., director of nursing (DON) stated there is a, huge communication gap for appointments. No documentation process was currently in place for attempts to make appointments but there was a dashboard. DON noted R47 was not listed on the dashboard. DON stated there was no follow up being done for appointments. DON expected those responsible for reviewing appointment notes were checking the notes for follow up appointments needed, to set up those appointments and to document attempts. A facility procedure/policy for coordination of appointments was requeted however was not provided. edema montioring R19's admission MDS dated [DATE], indicated R19 was cognitively intact and had diagnoses of liver failure with ascites (fluid that can accumulate in the abdomen) and was taking medication to help reduce edema. R19's admission assessment dated [DATE], indicated R19 had edema and used a diuretic medication. R19's provider and nursing order summary indicated the following: -lacked indication R19 required monitoring for edema. -a provider order dated 5/10/24, directed staff to obtain weekly weights for 4 weeks and then monthly. - a provider order dated 5/11/24, indicated R19 required spironolactone 50 milligrams (mg) in the morning for edema A review of R19's weights showed the following: -5/10/24, 270 pounds -5/23/24, 290.2 pounds -6/7/24 318.2 pounds R19's weights indicated a 48.2-pound weight gain between 5/10/24 and 6/7/24. R19's care plan dated 5/17/24, lacked indication R19 required monitoring for edema. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245544	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R19's progress note dated 6/7/24 at indicated R19 had gained 28 pounds since previous weight 2 weeks ago. Resident was assessed with no edema or swelling noted. R19's provider was notified and as aware of R19's dietary habits. A dietary consult placed. When interviewed on 6/10/24 at 2:08 p.m., R19 was sitting up on her bed with a lunch tray. A second tray was on her bedside table with 2 wrapped sandwiches. R19 stated they just keep swelling up. R19 stated she had liver failure and kidney problems that caused swelling. R19 was worried that her legs would start to weep soon as that had happened before when the swelling had gotten bad. R19 further stated she had told staff about the swelling but wasn't sure if anything was done to help. When interviewed on 6/11/24 at 11:09 a.m., registered nurse (RN)-A stated residents with edema would have assessments done of their extremities and lung sounds. If there were significant changes in swelling or trouble breathing the provider would be notified. RN-A stated R19 had some concerns off and on about edema, but really had no changes. RN-A verified R19's orders and care plan lacked monitoring or interventions to prevent increased edema. RN-A verified R19's weight gain and gaps in weight checks. RN-A stated the provider was aware of the weight gain and R19 usually ordered double or triple portions during meals and the weight gain was attributed to that. Furthermore, RN-A stated it was challenging to assess R19's edema as her legs were large due to obesity. At 11:16 a.m., RN-A entered R19's room assess R19 for edema. R19's was lying in bed and RN-A assisted to remove R19's socks. The tops of the socks were tight and had left marks on both of R19's ankles. RN-A stated R19 had plus one pitting edema to both feet/ankle areas. R19 further stated he felt this was baseline but was not sure as there wasn't much documentation of the edema. When interviewed on 6/12/24 at 12:25 p.m., the interim Director of Nursing (DON) DON stated R19 was on a diuretic medication and a history of needing paracentesis (procedure to remove fluid from the abdomen) due to liver failure. DON expected staff to be monitoring and documenting residents with edema for signs or symptoms of increased edema and the care plan should include interventions. A facility policy for assessments for edema/fluids was requested however was not received. 35992 Feeding tube med admin R58's admission MDS dated [DATE], indicated R58's diagnoses include stroke, hypertension, hemiplegia (paralysis of one side of the body), and depression. R58 required use of a feeding tube for nutrition. During observation on 6/11/24 at 9:16 a.m., registered nurse (RN)-A was observed entering R58 room while holding two cups of liquid and a syringe of dilute, brown liquid with particles present in the liquid. RN-A disconnected R58 feeding tube from infusion, flushed the tube to check for placement, instilled the contents of the syringe into R58 feeding tube, followed by another flush of water. During interview on 6/11/24 at 11:55 a.m., RN-A confirmed the dilute, brown liquid with particles in the syringe contained R58 medications which include: Amlodipine besylate (for hypertension) 10mg (milligrams) tablet- crushed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fluoxetine (for depression) 20mg/5mL (milliliters) 2.5mL Lisinopril (for hypertension) 40mg tablet- crushed Modafinil 200mg (to promote wakefulness) 200mg tablet- crushed Multivitamin 15mL Polyethylene glycol 3350 (for constipation) 17GM (grams) powder Acetaminophen 160mg/5mL- 20.3mL R58 medication profile did not include an order to cocktail (crush medications and mix with powered and liquid medications for administration at the same time) medications. RN-A verified there was no order to cocktail R58 medications. RN-A stated he used his nursing knowledge to determine if there was a contraindication to cocktail any residents' medications that were given through their feeding tube. During interview on 6/13/24 at 8:53 a.m., DON stated she expected a minimal flush with water of 15mL between each medication administered in a feeding tube. Each medication, crushed, powder or liquid should be in a separate cup, dissolved in at least 10-15mL of water. DON expected an order in the resident's chart if the medications could be cocktailed.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview and record review, the facility failed to identify individualized approaches for care, including non-pharmacological interventions to aid in the management of mood and behavior, for 2 of 5 residents (R1, R27) reviewed for unnecessary medications. Findings include: R1's significant change Minimum Data Set (MDS) dated [DATE], included R1 was moderately cognitively impaired, had diagnoses of dementia, depression, and psychotic disorder (other than schizophrenia). R1 took antidepressant and antipsychotic medications on a routine basis. R1's Mood State Care Area Assessment (CAA) was not triggered. R1's Psychotropic Drug Use Care Area Assessment (CAA) indicated R1 took antipsychotic medications, was at risk for adverse reactions from the medications, and had no noted side effects. R1's Order Summary Report dated 6/5/24, included: *Aripiprazole tablet 5 milligrams (mg) one time per day for psychosis starting 6/1/24. *Sertraline HCl (hydrochloride) tablet, 150 mg one time per day for major depressive disorder starting 1/6/24. *Trazodone HCl tablet 100 mg (an antidepressant), one time per day at bedtime for insomnia starting 10/23/23. R1's care plan dated 10/30/23, indicated the resident had anxiety and included the following interventions: *Adhere to resident's stated choice of routine/activity pattern. *Allow resident to express concerns--validate/offer TLC (tender loving care) as appropriate. *Allow the resident time to answer questions and to verbalize feelings perceptions, and fears. *Assess placement needs as needed/appropriate. *Be attentive to resident's need--observe for any s/s of discomfort, anxiety, being overwhelmed, etc. *Consult with: Pastoral care, Social services, Psychology services *Educate resident and/or family regarding discharge planning needs. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Encourage participation in activities/decisions from resident who depends on others to make own decisions. The care plan also included R1 had a mood problem dated 10/30/23, and included interventions of: *Administer medications as ordered. Monitor/document for side effects and effectiveness. *Behavioral health consults as needed psycho-geriatric team, psychiatrist etc. *Educate the resident/family/caregivers regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance. *Monitor/document/report PRN (as needed) any risk for harm to self: suicidal plan, past attempt at suicide, risky actions stockpiling pills, saying goodbye to family, giving away possessions or writing a note, intentionally harmed, or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment, or safety awareness. *Monitor/record mood to determine if problems seem to be related to external causes, i.e., medications, treatments, concern over diagnosis. *Monitor/record/report to MD (medical doctor) prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills *Monitor/record/report to MD prn mood patterns s/sx (signs/symptoms) of depression, anxiety, sad mood as per facility behavior monitoring protocols. In addition, R1 had depression and took an antidepressant medication, and the care plan dated 11/2/23, instructed staff to: *Administer medications as ordered. Monitor/document for side effects and effectiveness. *Arrange for psych consult, follow up as indicated. *Discuss with the resident/family/caregivers any concerns, fears, issues regarding health or other subjects *Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment, or safety awareness. *Monitor/document/report PRN any s/sx of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness. (continued on next page)

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Victory Health & Rehabilitation Center	512 49th Avenue North Minneapolis, MN 55430

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Monitor/record/report to MD prn risk for harming others: increased anger, labile mood, or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons *Pharmacy review monthly or per protocol. *The resident needs time to talk. Encourage the resident to express feelings. *The resident needs adequate rest periods. The resident prefers to rest. *Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness *Educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms of anti-depressant drugs being given). *Monitor/document/report PRN adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, n/v (nausea/vomiting), dry mouth, dry eyes R1 used psychotropic medications and the care plan dated 10/24/23, included the following interventions: *The resident will reduce the use of psychotropic medication through the review date. *Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness. *Consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly. *Discuss with MD, family re ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. *Monitor/document/report PRN any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (extrapyramidal side effects caused by psychotropic medications, such as shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. The care plan lacked evidence of non-pharmacological, resident-specific interventions. During observation on 6/10/24 at 1:28 p.m., R1 was heard crying in their room, stating numerous times, I feel like shit, I feel like shit while staff were in the room attempting to assist R1. R1 continued to verbalize negative comments, many unintelligible. Staff placed R1 in their bed and left the room. R1 was noted to be sleeping in bed at 2:20 p.m., and 5:18 p.m. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/12/24, at 7:42 a.m., registered nurse (RN)-A stated mental health and behavioral interventions should be in the care plan and be specific for each resident based upon the cause of the behavior or situation. Once potential causes were assessed and interventions were identified, staff would know how best to help. During observation on 6/12/24 at 8:45 a.m., R1 was being pushed in their wheelchair by a staff member and repeatedly stated they wanted to go to bed. While staff was transferring R12 to bed, R1 cried out AH in a loud, fearful voice. After being placed in bed staff left the room and R1 remained quiet. During interview on 6/12/24 at 8:57 a.m., trained medication aide (TMA)-A stated if a resident demonstrated they were in distress, either by words or behaviors, they would ask what they needed and try to fix it, and/or let the nurse know to possibly give medication. They were unaware of any resident-specific interventions for R1 and addressed each resident in the same manner. During interview on 6/12/24 at 10:01 a.m., licensed practical nurse (LPN)-C stated if there was a behavioral or mental health concerns, they talked with the resident to figure out why they were acting out and tried to address it. LPN-C indicated R1 a history of suicidal ideation and anxiety, and made comments including nobody cares, or let me lay down, however there were no resident-specific interventions outlined for each resident, including R1. During interview on 6/12/24 at 10:08 a.m., nursing assistant (NA)-A stated if a resident had dementia or behaviors, they spoke to them politely in a way they would understand. They indicated R1 had behaviors and would sometimes yell at the staff, and NA-A spoke calmly to de-escalate, but there were no resident-specific interventions identified for R1 and they knew what worked by getting to know the residents over time. During interview on 6/12/24 at 10:12 a.m., director of nursing (DON) stated interventions should be individualized and in the care plan, and any behaviors and successful interventions documented so staff could use what was known to be helpful before trying other things. DON reviewed R1's medical record and care plan and verified there were no resident-specific interventions related to their depression, anxiety, and mental health in general, however it was important to identify a list of things which could be helpful since everyone reacts differently in varying situations. It was important to learn what was helpful and spread the word to make the resident feel better. 42586 Findings include: R27's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition and diagnoses of mood disorder and major depressive disorder with recurrent, severe, psychotic symptoms. R27 was dependent on staff for all activities of daily living (ADL), mobility, and received an antipsychotic medication on a routine basis. R27's physicians orders dated 5/10/24, indicated Quetiapine Fumarate (Seroquel) oral tablet. Give 12.5 milligram (mg) tablet by mouth at bedtime related to mood disorder due to known physiological condition with depressive features. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27's care plan indicated R27 had mood problem with interventions to: -administer medications as ordered, monitor/document for side effects and effectiveness. -behavioral health consults as needed psycho-geriatric team, psychiatrist etc. -monitor/document/report (as needed) any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. -monitor/record mood to determine if problems seem to be related to external causes. medications, treatments, concern over diagnosis. -monitor/record/report to MD prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills -monitor/record/report to MD prn mood patterns s/sx of depression, anxiety, sad mood as per facility behaviour monitoring protocols. -Monitor/record/report to medical doctor as needed risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons -The resident needs time to talk. Encourage the resident to express feelings. R27's care plan dated // indicated R27 used psychotropic medications Seroquel related to behavior management/depression with interventions to: -administer psychotropic medications as ordered by physician. -monitor for side effects and effectiveness every shift (1. akathisia (restlessness/pacing/inability to sit still), 2. excessive sedation, 3. tremors, 4. tardive dyskinesia, 5. stiffness of neck, 6. hypotension, 7).urinary retention, 8. dry mouth, 9. blurred vision, 10. confusion, 11. constipation, 12. tachycardia, 13. weight gain, 14 .profuse drooling, 15. falls / dizziness, 16. none) -consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly. -discuss with medical doctor and family regarding the ongoing need for use of medication. -review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. -educate the Dale/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of Seroquel (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-monitor/document/report as needed any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. -monitor/record occurrence of for target behavior symptoms: inappropriate response to verbal communication, violence/aggression towards staff/others- yelling at staff and document per facility protocol. -psychotropic behavior monitoring:: 1. agitation, 2. isolation in room [ROOM NUMBER]. weight gain 4. decreased appetite 5. increased depression 6. lethargy 7. none R27's care plan lacked evidence of non-pharmacological, resident-specific interventions. The Antipsychotic Medication Use Policy dated 12/2016, included antipsychotic medications will be considered if behavioral interventions have been attempted and included in the plan of care, except in emergency.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44651 Based on observation, interview, and document review, the facility failed to ensure proper sanitization of dishware used for meal preparation and resident service when 1 of 1 low-temperature chemical sanitizing commercial dishwashers was identified as not reaching adequate wash and rinse temperatures. This had potential to affect all 62 residents within the facility, staff, and visitors who consumed food from the main production kitchen. Findings include: During observation and interview on 6/11/24 at 12:04 p.m., dietary manager (DM) stated staff used chlorine test strips to determine if the chemical sanitizer concentration was adequate for sanitization by dipping the strip into the bottom reservoir of the dish machine and comparing the color to the key on the test strip label container. They indicated it must read between 100-200 parts per million (ppm). DM demonstrated the process, and the solution tested at 100 ppm. DM loaded a tray of pans, placed it in the dish machine, and closed the door to start the unit. The water temperature gauge read 113 degrees Fahrenheit (F). DM verified the temperature reading, and stated the pans were sanitized because it was a low temperature dishwasher, so the water temperature did not matter. The dish machine was identified as an Ecolab ES2000. During observation and interview on 6/12/24 at 11:17 a.m., dietary aide (DA)-A demonstrated the use of the facility dish machine. They loaded a rack with nine plates and two bowls, placed the rack in the dishwasher, and closed the door to start the unit, allowing it to run until the cycle was complete. When asked about the water temperature requirements for dish sanitization, DA-A demonstrated the facility testing method by placing an indicator strip in the refuse drain trap underneath the dish machine where the soiled water was ejected from the machine. The strip read 50 ppm. DA-A stated it should read 100-200, obtained another test strip, and inserted it into the water at the bottom of the inside of the machine where it read 100 ppm. DA-A stated the strip indicated the water temperature, but the process was confusing to them. They then stated the water temperature did not matter, and it will temp how it's supposed to be. They indicated they recorded the temperature on the log hanging on the wall, which should be between 120-150 F, which was the reading on the test strip, and then indicated they thought it was a measure of the water pressure but did not know. DA-A ran a load of dishes and verified the temperature reached 112 F. A second load was run and reached 114 F. They indicated the water pressure was not reaching 150 F and told the dietary manager (DM). DM stated the water temperature was set to 120 F, and if they set it any higher the laundry had issues. DA-A wrote 150 F in the breakfast and lunch DM TEMP columns on the temperature log. The Sanitizer Solution Logs for 3/24, 4/24, 5/24, and 6/24, indicated the water temperature for each meal, every day, was exactly 120 F, except for breakfast and lunch on 6/12/24, which were recorded as 150 F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation and interview on 6/12/24 at 12:12 p.m., DM stated the dishwasher was on the same line as the laundry, so if they turned the temperature up too high in the laundry, the water in the dishwasher didn't get hot, however the dishwasher used chemicals to sanitize. DM stated staff measured the sanitizer concentration using a test strip indicator each shift, which should read between 100 ppm and 200 ppm, and recorded it on the log. They stated if it was below 100 ppm they called the service technician to come out to adjust it. Regardless of the water temperature, DM considered dishware sanitized if the test strips were within acceptable range. A rack of dishware was sent through the machine, where the water temperature reached 113 F. DM stated they were going to call maintenance, to look at it, and indicated dishware needed to be sanitized to kill bacteria. During observation and interview on 6/12/24 at 1:39 p.m., maintenance staff stated the dishwasher temperature reached 120 F during the rinse cycle when it was running. Two loads of dishes were washed, the first reached 112 F, the second reached 118 F. Maintenance stated if there was an issue with the dishwasher, they called the service company, however they were unaware of the inadequate temperature and the service company had not been called. During interview on 6/12/24 at 1:55 p.m., administrator stated they did not have a user manual for the dish machine and was unsure how often the water temperature was checked or documented. They suggested speaking with DM and the dietician to obtain accurate information; however, they assumed the chemical sanitizer was working based upon the results of the test strips. The indicated proper sanitization was important to protect the residents. The dietician was unavailable for interview. During interview on 6/12/24 at 2:40 p.m., dishwasher service representative stated low-temperature dishwashers using chemical sanitizing required a heat temperature at or above 120 F, and the rinse could be between 120 F and 160 F if the sanitizer concentration was within appropriate parameters according to the test strips. They stated they had not been contacted by the facility to service the dishwashing unit but would come out the following day to assess. During observation on 6/13/24 at 8:57 a.m., dietary staff placed seven plates, one tray, two ceramic bowls, and two plastic bowls into a rack, placed the rack in the machine, and ran the cycle. The temperature on the gauge reached 112 F. A second rack containing six lids, one divided plate, one carafe, one ceramic bowl, one plastic bowl, and three trays was placed into the dishwasher for sanitization. The temperature again reached 112 F. In an email dated 6/13/24, dishwasher service representative indicated they went to the facility to service the machine that afternoon and determined it used the building's hot water supply which was not reaching the required temperature for proper sanitization. The Ecolab Regular Service Call summary dated 6/13/24, identified the dish machine chemical levels were in compliance, however the water temperature was identified as 115 F and included, Monitor wash temp for compliance to protect guests, reputations, and machine efficiency. The ES Series Door Type, Chemical Sanitizing, Single and Dual Rack Dishmachines Installation and Operation Manual dated 12/5/2007, indicated the machine required a minimum water temperature of 120 F during the wash and rinse cycles. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Dishwashing Machine Use policy dated 3/2010, included food service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation. The policy lacked information relating to water temperature requirements during chemical sanitation. The Sanitization policy (undated), indicated low-temperature dishwashing machines must be operated using a wash temperature of 120 F.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35992 Based on observation and interview, the facility failed to ensure appropriate hand hygiene practices were performed following personal cares and catheter care for 1 of 1 resident (R58) observed during cares. In addition the facility failed to ensure enhanced barrier precautions (EBP) were utilized for 1 of 1 resident (R56) reviewed who received dialysis. Findings include: R58's admission Minimum Data Set (MDS) dated [DATE], identified R58 had moderately impaired cognition and required physical assist from another person for activities of daily living (ADLs) including toileting hygiene, bathing, upper and lower body dressing and personal hygiene. Diagnoses included stroke, hemiplegia (one-sided paralysis), and cataracts. R58 had an indwelling catheter. R58 care plan dated 5/29/24 noted R58 was on enhanced barrier precautions related to an indwelling catheter and tube feeding. During observation on 6/11/24 at 9:38 a.m., nursing assistants (NA)-B and NA-C we observed wearing isolation gowns and gloves during cares. NA-B completed catheter care, then without doffing gloves, performing hand hygiene and donning clean gloves brought the wash basin to the bathroom, opened the bathroom door, emptied the basin, turned on warm water, filled the basin, turned of the water and returned to R58's bedside. NA-B completed perineal care from the head of the penis, to the meatus then down the catheter. R58 was positioned on his side and buttocks was washed with soap and water, this included an open on his buttocks. Following cares, NA-B , without doffing gloves, performing hand hygiene and donning clean gloves, changed bed linens which also included clean pillow cases. NA-B handed R58 his call light and television remote. Bed controls were used to return R58's bed to the low position while still wearing the same gloves. During interview on 6/11/24 at 10:00 a.m., NA-B accurately explained gloves were changed between cares and hand hygiene performed when transitioning from a dirty area to a clean area. NA-B confirmed she did not change her gloves or perform hand hygiene after completing catheter care and perineal care prior to touching the bathroom door handle, the bathroom door, sink faucet, R58's dresser, changing bed linens, handing R58 his call light and television remote. During interview on 6/12/24 at 10:38 a.m., infection preventionist (RN)-D stated hand washing was the first defense, it was the key to everything. RN-D expected handwashing was completed before donning gloves and after doffing gloves. Gloves should be changed during cares, when moving from a clean area to a dirty area. A facility policy related to hand hygiene and donning/doffing of gloves was requested but was not received. 44647 R56's admission MDS dated [DATE], indicated R56 had severe cognitive impairment and diagnoses of kidney failure, stroke, and was dependent on dialysis. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R56's nursing admission assessment dated [DATE], indicated R56 had a dialysis port in the right chest. R56's provider order dated 5/9/24, directed staff to auscultate the vascular access site to R56's right chest to detect a bruit or swishing sound that indicates patency every evening shift after dialysis on Tuesday, Thursday, and Saturday. R56's electronic medical record lacked indication R56 required EBP. An observation on 6/11/24 at 3:46 p.m., R56's door had a sign indicating Enhanced Barrier Precautions and directed staff to wear a gown and gloves when providing close contact cares that include hygiene, dressing, transfers, or device care. Licensed practical nurse (LPN)-B performed hand hygiene and obtained gloves from the personal protective storage on R56's door and walked into R56's room with a blood pressure machine. R56 was seated at the edge of his bed. LPN-B placed the gloves on the bedside table. Without donning a gown or the gloves, LPN-B assisted R56 to remove a flannel shirt from their arm to obtain a blood pressure. LPN-B then obtained the blood pressure. Still without gloves or a gown, LPN-B assisted R56 to lift the long-sleeved shirt up so R56's right dialysis line was visualized. Without touching the line, LPN-B verified the line dressing was intact and had no drainage. LPN-B then assisted with pulling down R56's shirt and placing the left arm back into the flannel shirt. LPN-B then assisted R56 to stand, turn and sit in the wheelchair so he could be brought to the shower room for a weight. LPN-B then placed the gloves on R56's table and took a sanitizing wipe from the basket of the blood pressure machine to wipe down the machine before removing it from the room. LPN-B then removed gloves and performed hand hygiene before pushing R56 to the shower room. On the shower room door was the same Enhanced Barrier Precautions sign. Under the sign was another sign that directed staff to use personal protective equipment inside room for those on EBP. LPN-B wheeled R56 into the shower room and placed the wheelchair next to the scale. LPN-B did not don a gown or gloves before assisting R56 to stand and take a few steps onto the scale. The weight was obtained and then LPN-B assisted R56 back into his chair and out of the shower room. LPN-B then performed hand hygiene. When interviewed on 6/11/24 at 4:03 p.m., LPN-B stated EBP was not needed for R56, and the sign on the door was intended for R56's roommate. LPN-B further stated if R56 was on EBP, a gown and gloves had to be worn with the assessments and transfers that were just completed. When interviewed on 6/11/24 at 4:03 p.m., registered nurse (RN)-B stated EBP were required for R56 because R56 had an indwelling dialysis line. RN-B further stated any resident with the Enhanced Barrier Precaution sign on the door needed gown and gloves with any close contact cares such as dressing, transferring, and bathing. RN-B further stated those with EBP were typically roomed together, so the signs were for both residents in the room. When interviewed on 6/12/24 at 12:33 p.m., the interim Director of Nursing (DON) expected EBP to be utilized with those with indwelling lines, such as R56's dialysis line. DON stated some residents were roomed with those who did not require EBP. If a sign was posted on the door, a small sticker was next to the resident's name indicating to staff which resident required EBP. DON acknowledged initially R56 had not been in EBP but should have been due to the line. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Enhanced Barrier Precautions revised 10/18/2022, directed staff to wear gown and gloves during high contact resident care activities such as dressing, transferring, and device care. Furthermore, the policy directed EBP were indicated for residents with wounds and indwelling medical devices regardless of multi-drug resistant organism colonization.