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	01/15/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F880Based on observation, interview and document review the facility failed to store soiled linens, and transport linens to prevent the spread of infection. This had the potential to affect all 65 residents whose personal laundry was done at facility.Findings include: An observation on 1/14/26 at 8:16 a.m., laundry assistant (LA) carried an arm load of clean laundry on hangers, draped over arm, up against scrubs and brought into an unidentified resident's room.An observation on 1/14/26 at 8:19 a.m., on the outside laundry room door, a yellow sign stated: NURSING STAFF 1. Soiled linen MUST be bagged and taken to laundry room. Placed in proper container/bin, at the end of every shift. 2. Outgoing laundry must be put in blue bag, placed in proper bin in soiled room [ROOM NUMBER]. DO NOT put any soiled linens on the floor. Inside of the laundry room, there were large containers for facility laundry, empty blue fabric bags on a table, and two filled blue bags sitting on the floor in front of containers. There were four plastic bags filled with mop heads and rags, on the floor by the door leading into the washing and drying room. Also, multiple used cleaning rags and 3 dirty mop heads were unbagged and laying on the floor. By the back wall were two plastic bags filled with resident's clothes on the floor. A container for resident's clothes was labeled. A sign on the inside of laundry room door stated, PUT FACILITY LAUNDRY INTO BLUE BAG AND PLACE INSIDE OF BIN, NOT ON FLOOR.A tour of the laundry room and interview on 1/14/26 at 8:28 a.m.LA stated they were the only employee for the laundry department in the facility. The facility laundered all 65 resident's personal clothing and linens were shipped out and done off site. LA confirmed the items on the floor in the soiled laundry room and stated she relied on the staff to place the items in proper bags and containers. Soiled items in or out of bags were not permitted on the floor. Lastly, she stated the clean laundry was transported to the resident room was done incorrectly. The items should have been covered on a cart, while in transport. The rationale was to decrease infections in the facility.During interview on 1/14/26 at 9:01 a.m., with infection preventionist (IP) confirmed the observations in the laundry facility, the soiled items on the floor, stated that was against the policy and procedure for handling laundry. IP confirmed the signage and recognized that all staff were responsible for the proper handling of soiled linen. Soiled laundry on the floor was an infection control issue and proper storage, and transport of laundry decreased the risk of contamination and infection to be spread. The expectation of staff was to follow the policy and procedures of handling laundry.During interview on 1/15/26 at 10:30 a.m., trained medication aide (TMA)-A stated they were educated on the policy and procedure of laundry, that the soiled resident's linen was to be in a plastic bag, closed, and placed into bin in the soiled laundry room area, not on the floor, to decrease infections in the facility.During interview on 1/15/26 at 11:28 a.m., the director of nursing (DON) stated that IP oversees the laundry facility, however, the DON was involved in the role of proper handling of laundry by nursing staff. The expectation was to follow the policy and procedures for laundry. Laundry was to be handled using standard precautions, soiled laundry was to be bagged and placed in proper containers, the rationale for proper laundry handling was to decrease infections.A facility policy titled Laundry and Bedding, Soiled dated 9/2022, directed staff to transported and process laundry according to best practices for infection prevention and control. furthermore, staff should handle laundry using standard precautions and with minimum agitation to (continued on next page)

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	01/15/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	avoid the contamination of air, surfaces, and persons. Soiled laundry was to be bagged and placed in proper containers.

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	01/15/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to allow active resident and resident representative participation in the development and review of care plans for 4 of 4 residents, (R3, R25, R30, R14) reviewed for care planning and coordination of services while residing at the facility. Findings include: R3 R3's quarterly Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition, no adverse behaviors, and was dependent on staff for wheelchair mobility. R3's medical record identified the most recent care conference was held on 8/20/25, and no additional care conferences were held. R3 had an additional quarterly MDS completed on 11/9/25, There was no indication in the progress notes or medical record of any care conference held at the time of this assessment. During an interview on 1/13/26 at 8:22 a.m., R3's representative (RR)-A stated he was not invited to a recent care conference, and he had concerns about communication with the facility. R25 R25's quarterly MDS dated [DATE], identified intact cognition, no adverse behaviors, and was independent with wheelchair mobility. R25's medical record identified the most recent care conference was held on 8/19/25, and no additional care conferences were held. R25 had an additional quarterly MDS completed on 11/9/25, There was no indication in the progress notes or medical record of any care conference held at the time of this assessment. During an interview on 1/12/26 at 1:24 p.m., R25 stated he was not invited to a recent care conference, and he would have wanted one to bring up some concerns. R30 R30's admission MDS dated [DATE], identified R30 had moderate impaired cognition, diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type 2 diabetes mellitus, chronic obstructive pulmonary disease, and major depressive disorder. In addition, MDS indicated R30 communicated needs, and understood direction and conversation. Furthermore, MDS indicated R30 exhibited no adverse behaviors. R30's medical record lacked documentation of any care conferences. During interview on 1/15/26 at 1138 a.m., the director of nursing (DON) verified the medical record did not have a care conference documented at any time for R30. The expectation for care conferences were to be completed within the first 48 hours of admission, quarterly and as necessary. (continued on next page)

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	01/15/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R14 R14's quarterly MDS dated [DATE], indicated intact cognition and diagnoses of acute transverse myelitis in demyelinating disease (inflammation of the spinal cord that damages myelin), type II diabetes, and legal blindness. It further indicated R14 required partial assistance with most ADL's and supervision with mobility. R14's medical record indicated the most recent care conference was held on 8/18/25. R14's medical record showed no additional care conferences since 8/18/25. R14's progress notes (since admission on [DATE]), lacked documentation that a care conference had been completed. During interview on 1/12/2026 at 2:12 p.m., R14 stated he had not had a care conference since being admitted to the facility. During interview on 1/15/25 at 9:27 a.m., the DON stated the social worker was responsible for completing care conferences and they should be completed upon admission (within 48 hours) and then quarterly. The DON verified R14's last care conference was on 8/18/25, R25's was on 8/19/25, and R3's was on 8/20/25. He stated all 3 residents should've had another care conference in December and he expected care conferences to be completed quarterly following admission. A facility policy titled care conferences dated 9/2013, did not address how often care conferences should be completed.

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	01/15/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to obtain and document an informed consent including explanation of risk and benefits, for 1 of 1 newly admitted resident (R80) reviewed for use of psychotropic medications.Findings include:R80's admission Minimum Data Set (MDS) dated [DATE], identified intact cognition, no adverse behaviors and moderately severe depression. R80 was dependent on staff for bed mobility and had a diagnosis of complete paraplegia (complete loss of sensation and movement from the chest down). Medications included antianxiety and antidepressant.R80's Medication Administration Record (MAR) dated 12/30/25 through 12/31/25, identified alprazolam (antianxiety medication) 1 milligram (mg) by mouth as needed (PRN) for anxiety was given twice on 12/31/25, and documented as E which meant effective.R80's MAR dated 1/1/26 through 1/15/26, identified PRN alprazolam was given twice on 1/1/26, twice on 1/4/26, once on 1/5/26, twice on 1/6/25, once on 1/7/26, once on 1/8/26 and once on 1/9/26. All administrations were documented as E which meant the PRN was effective.R80's MAR dated 1/1/26 through 1/15/26, identified on 1/1/26, escitalopram (antidepressant medication) 20 milligrams (mg) by mouth was added one time a day for depression and was given daily.R80's Doctor's Order Sheet dated 1/9/26, identified: Discontinue alprazolam (antianxiety medication) and add clonazepam 1 mg as needed (PRN) maximum of two per day. End date 3/2/26, for diagnosis of major depression.R80's MAR dated 1/9/26 through 1/15/26, identified a new medication clonazepam 1 mg by mouth every 6 hours as needed for major depression until 3/6/26. The PRN clonazepam was administered daily on 1/10/26 through 1/14/26 and documented as effective.R80's medical record including progress notes, provider orders and assessments was reviewed and lacked evidence consent for use of the medication was obtained. Further, the record lacked evidence the risks or expected benefits of the medication regimen had been reviewed or discussed prior to initiation of the medications.During an interview on 1/15/26 at 9:01 a.m., R80 stated no one has explained the risks and benefits to the medications he was put on for his mental health. R80 stated he would like to know and felt like everything was rushed. During an interview on 1/15/26 at 9:02 a.m., licensed practical nurse (LPN)-A stated she was not sure about consent when a resident started on a psychotropic medication and would have to talk to her boss.During an interview on 1/15/26 at 9:02 a.m., the infection preventionist (IP) stated she was not sure about a consent or risk benefit discussion when a resident started on a psychotropic medication and would have to ask the director of nursing (DON).During an interview on 1/15/26 at 9:04 a.m., the DON provided a psychotropic medications policy and stated consent with risk and benefit discussion was a verbal discussion with the residents and their prescribers. There was not a process for the facility to document the details. The DON stated surveyor should reach out to Medical Doctor (MD)-A.A phone call was placed to the MD-A on 1/15/26 at 12:54 p.m., and voicemail left with call back instructions. A return call was not received.The facility's Psychotropic Medication policy dated 4/25/25, identified antidepressants and antianxiety medications were considered psychotropic medication and were subject to prescribing, monitoring and review requirements specific to psychotropic medications.

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	01/15/2026

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 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 observation, interview and document review, the facility failed to follow standards of practice to provide resident education and update the provider for 1 of 1 resident (R33) who routinely refused their diuretic medication.Findings include:R33's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition, no adverse behaviors, was independent with meals and hygiene and had a diagnosis of chronic systolic (congestive) heart failure (CHF).R33's care plan dated 11/8/25, identified he was on a diuretic medication related to CHF. Interventions included administer diuretic medications as ordered by physician and monitor/document/report adverse reactions to diuretic therapy.R33's orders identified start date of 2/20/25, for bumetanide 1 milligram (mg) tablet, give two tablets two times a day related to CHF.R33's Medication Administration Record (MAR) dated 11/1/25 through 11/30/25, identified bumetanide was refused 45 out of 60 opportunities. The MAR dated 12/1/25 through 12/31/25, identified bumetanide was refused 55 out of 62 opportunities. The MAR dated 1/1/26 through 1/15/26, identified bumetanide was refused 26 out of 29 opportunities.R33's nursing progress notes dated 11/1/25 through 1/15/26, lacked documentation of rationale for the refusal or that the risks and consequences had been discussed.R33's nurse practitioner's visit noted dated 11/12/25, and physician's visit note dated 12/1/25, lacked documentation of diuretic refusal.During an interview on 1/14/26 at 7:40 a.m., trained medication aide (TMA)-B stated R33 refused his diuretic and if a medication was refused the TMA should update the nurse.During an observation on 1/14/26 at 8:20 a.m., TMA-B prepared R33's morning medications, minus the bumetanide and brought the medications into his room.During an interview on 1/14/26 at 9:47 a.m., R33 stated he had not wanted his diuretic because it made him go to the bathroom too often.During an interview on 1/14/26 at 9:55 a.m., licensed practica nurse (LPN)-B stated a diuretic was an important medication and if a resident refused that medication more than one to three times, the providers should be updated. LPN-B stated that it would not necessarily be documented in a nursing progress note if a provider was updated on a medication refusal and to check the provider's notes instead.During an interview on 1/15/26 at 9:15 a.m., Medical Doctor (MD)-B stated if a concern about a medication was brought up to the provider group and it would be in the visit notes. MD-B declined to acknowledge awareness of R33 refusing diuretic medication, however acknowledged there was no documentation his notes or the nurse practitioner notes. MD-B stated if a medication was refused the patient should know the risk and benefits and the provider should be updated if the resident had a change in condition.During an interview on 1/15/26 at 12:39 p.m., the director of nursing (DON) stated medications should be given as ordered for safety purposes and to help the residents regain health. A diuretic was a high-risk medication, and residents had the right to refuse, however, nursing should have provided and documented education on risks and consequences of diuretic refusal.The facility's Medication Administration policy dated 4/2018, identified if a drug was refused the individual administering the medication shall be coded as indicated on the MAR space provided for that drug and dose. Additionally, as required or indicated for a medication the individual administering the medication would record in the resident's medical record any complaints or symptoms for which the drug was administered and any results achieved and when those results were observed.