STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on observation, interview and document review, the facility failed to implement actions to correct an identified concern related to staff intentionally disabling resident call light systems. This failure affected 1 of 8 residents (R2) observed to have her call light intentionally disabled and had the potential to affect 55 of 56 residents who utilized the call light to summon assistance. Findings include: On 7/30/20, at 1:39 p.m. R2 was observed in her room, seated in a wheelchair. R2's call light was noted to be hanging on the opposite side of the bed, out of her reach. The surveyor pushed the call light to activate in order to test function. Upon activation, R2's call light did not turn on which was verified by nursing assistant (NA)-F. NA-F stated when the bathroom call light activation switch was in the neutral position, it would disable the call light in the resident room. NA-F confirmed R2's bathroom call light was in the neutral position and proceeded to demonstrate how R2's call light was be disabled. On 7/30/20, at 1:53 p.m. the administrator stated on 4/13/20, the disabling of resident call lights was identified when he had found out that if the bathroom call light switch was in the neutral position it would dismantle the room call light. Upon this discovery, the facility had performed an audit to determine if the cause was mechanical or intentional and it was determined that staff had been intentionally disabling the resident call lights. The administrator stated even though the concern was identified in April 2020, no one had been assigned responsibility to follow up on the concern to ensure it did not continue to occur. At 2:20 p.m. the administrator stated an audit form had been developed on 4/13/20. He stated one audit had been completed since 4/13/20, but he was unable to locate it. The administrator verified no additional follow up audits had been completed. At 2:53 p.m. social worker (SW)-A stated she was aware staff had sometimes put the call light switch in the middle position in order to disable the call light from resident use. SW-A further stated the facility had intentions of doing daily audits to ensure the call lights remained usable, but it got really busy therefore they had not been completed. At 3:42 p.m. the administrator verified no quality assurance activities had been completed related to the identified concern of the intentional disabling of call lights by staff therefore was not aware that the problem continued.
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure call lights were accessible and functional for 1 of 8 residents (R2) reviewed who utilized a call light to summon for assitance. findings include: R2's quarterly Minimum (MDS) data set [DATE], indicated she was moderately cognitively impaired, required extensive assistance from two staff for all activities of daily living and was always incontinent of bowel and bladder. R3's care plan dated 7/23/20, identified a self care deficit and directed the staff to place call light within reach so R2 could summon for assistance. On 7/30/20, at 1:39 p.m. R2 was observed in her room, seated in a wheelchair. R2's call light was noted to be hanging on the opposite side of the bed, out of her reach. The surveyor pushed the call light to activate in order to test function. Upon activation, R2's call light did not turn on which was verified by nursing assistant (NA)-F. NA-F stated when the bathroom call light activation switch was in the neutral position, it would disable the call light in the resident room. NA-F confirmed R2's bathroom call light was in the neutral position and proceeded to demonstrate how R2's call light had been disabled. R2 stated that was why she would call the facility's front desk for assistance because her call light did not get answered, and sometime she waited hours and would become frustrated so she would call the police. A review of R2's facility Progress Notes revealed the following: 7/3/20, R2 called 911 and reported having difficulty breathing. 7/9/20, R2 called 911 to request to go to the hospital. 7/12/20, R2 called the front desk to ask staff to get her up in her wheelchair. On 7/30/20, at 1:53 p.m. the administrator stated on 4/13/20, he had found out that if the bathroom call light switch was in the neutral position it would dismantle the room call light. The administrator stated upon this discovery, the facility had performed an audit to determine if the cause was mechanical or intentional and determined the staff had been intentionally disabling the resident call lights. The administrator verified the concern was identified on 4/13/20, and stated a sign had been posted for staff regarding intentionally dismantling the call lights however, he stated no one was assigned the responsibility to follow up on the concern in order to ensure the disabling of the call lights did not continue to occur. At 2:20 p.m. the administrator stated an audit form had been developed on 4/13/20, to monitor the call lights. He stated one audit had been completed which he was unable to locate and verified no further follow up audits had been completed. The administrator stated he was not sure how it came to his attention that staff were intentionally disabling the call light, but thought there had been more than usual concerns raised from residents regarding staff response to call lights. At 2:53 p.m. social worker (SW)-A stated she was aware the staff had sometimes put the call light switch in the middle neutral position i in order to disable the call light and that a memo had been put out telling staff they could not do that. SW-A stated the residents had told her they knew staff did something in the bathroom. SW-A confirmed the facility had conducted only one initial audit and had intentions of doing daily call light audits, but it got really busy therefore audits were not completed. An untitled facility document dated 4/17/20, to: all Victory staff, subject: tampering with call lights, indicated staff who intentionally and willfully dismantled or inactivated a call light would be suspended pending investigation and disciplined up to termination. The document indicated all managers were aware of possible tampering with call lights and indicated this practice was defined as neglect and was a terminable offense.

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

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.