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 _____	05/20/2020

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to comprehensively assess skin integrity and failed to ensure care plan interventions were implemented to prevent development of pressure ulcers for 1 of 3 residents (R2) reviewed who were at risk for pressure ulcers. This resulted in actual harm when a resident developed two stage two pressure ulcers. Findings include: The National Pressure Ulcer Advisory Panel (NPUAP) definition of Stage 2 pressure ulcer includes: Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. R2's undated face sheet identified R2 had [DIAGNOSES REDACTED].) R2 had been admitted to the facility on [DATE], and discharged on [DATE]. R2's admission Minimum Data Set ((MDS) dated [DATE], identified R2 had severely impaired cognition. R2 had not rejected cares. Further, R2 was totally dependent on staff assist for bed mobility and toileting. R2 was at risk for pressure ulcers and the MDS identified R2 had no current pressure ulcers. R2's MDS lacked documentation for skin care interventions such as turn and reposition program and lacked documentation for pressure relieving device on bed or wheelchair. R2's admission care plan dated 4/23/20, indicated R2 had intact skin and R2 was incontinent of bowel and bladder. R2 was confused and non-verbal. The care plan lacked documentation of skin care interventions. R2's physician orders [REDACTED]. R2's admission skin assessment dated [DATE], indicated R2 had no pressure areas. R2 had a scar noted to the top of scalp and [DEVICE] (gastric feeding tube tube inserted through a small incision in the abdomen into the stomach and is used for long-term enteral nutrition) noted on the abdomen. The skin assessment lacked a facility risk assessment tool or Braden Scale (used to identify residents at risk for pressure ulcer). R2's admission tissue tolerance assessment (assessment to determine an appropriate repositioning schedule) indicated no change in color skin alteration after one hour interval. The tissue tolerance assessment lacked documentation for a two hour interval. R2's progress notes indicated on 4/24/20, at 12:35 a.m. R2 was alert and oriented x 1 and unable to make needs known. R2 was on a [DEVICE] running at 55 mL(milliliter)/hour Vital AF (formula). Incontinent of bowel and bladder. Resident restless and not aware of safety. Would require a lower bed to prevent future falls. R2 was one assist with all ADLs and two with transfer. Skin intact no concerns noted. R2's physician progress notes [REDACTED]. R2 was described as thin, alert, calm and cooperative. No acute distress. Skin had no visible rash or [MEDICAL CONDITION]. The progress notes lacked documentation of R2's change in condition and being sent to emergency roiagnom on [DATE], and lacked any documentation of altercation in skin integrity or pressure ulcers. R2's emergency department (ED) admission paperwork dated 4/29/20, indicated R2 had a pressure injury stage 2 on left posterior elbow. Additionally, R2 had a stage 2 pressure injury to middle groin area. ED documentation indicated both pressure injuries had occurred prior to arrival at ED. Lastly, R2 had been admitted to the hospital from the ED [MEDICAL CONDITION] (a potentially life-threatening condition caused by the body's response to an infection) [MEDICATION NAME] bacteremia. During phone interview on 5/19/20, at 10:41 a.m. family member (FM)-A stated R2 had only been at Victory five days when R2 had to be rushed to the hospital. FM-A stated R2 was sent to the North Memorial ED due to a change in level of responsiveness. FM-A stated the ED doctor told FM-A that R2 had sores on (R2's) bottom and had two infections. FM-A stated R2 did not have a history of sores until R2's admission to Victory Health and Rehab. FM-A stated R2 was admitted to the hospital from the ED. FM-A stated R2 had since then been admitted to a new nursing home. During interview 5/19/20, at 12:20 p.m. licensed practical nurse (LPN)-A stated they had worked with R2 once. LPN-A stated R2 had not refused cares. R2 was described as bedbound, ill, weak, restless. LPN-A stated R2 had no open areas to the skin. LPN-A did not remember what skin care interventions R2 had in place but typically it would be in the orders. During interview on 5/19/20 at 12:37 p.m. registered nurse (RN)-A stated they had worked with R2 once and on that day sent R2 to the ED due to change in condition. RN-A was unable to comment on what cares were in place for R2 or if R2 was at risk for pressure ulcers. During interview via phone 5/20/20, at 12:07 p.m. Hospitalist physician (MD)-A confirmed R2 had documented pressures ulcers upon arrival to the ED. MD-A stated [MEDICAL CONDITION] was from bacteria of unknown source. MD-A stated it was uncertain if [MEDICAL CONDITION] was connected to the pressure ulcers because the wounds were not cultured. During interview via phone on 5/20/20, at 12:53 p.m. facility medical director (MD)-B stated R2 was clearly at risk for pressure ulcers due to being so debilitated. MD-B stated it would not take a lot for R2 to get to a stage 2 pressure ulcer and that pressure ulcer could occur in less than a two hour window. MD-B confirmed R2 had no documented pressures sores upon admission to the facility. MD-B stated for residents that were at risk for pressure ulcers it would be the expectation for the facility nurses to implement interventions right away such as a pressure relief mattress and orders to be moved frequently. During interview via phone on 5/20/20, at 1:39 p.m. nurse practitioner (NP)-A stated R2 was seen via telemedicine on 4/27/20. NP-A stated R2 was frail, complicated and definitely at risk for pressure ulcers. (R2) cannot position independently. NP-A stated pressure ulcers are usually preventable. NP-A stated the expectation would be for the nursing staff to place the at risk residents on at least an every two hours repositioning schedule. During interview via phone on 5/20/20, at 2:13 p.m. assistant director of nursing (ADON) stated, Most people who are in bed and cannot move around are at risk for pressure ulcers. The ADON stated the expectation would be for the nurse that identified the risk to consult with the ADON, put in orders for supplies and update the care plan for repositioning for residents at risk. The ADON stated, Not quite sure what (R2) had in place for pressure ulcer prevention. During interview via phone on 5/20/20, at 3:23 p.m. nursing assistant (NA)-B stated they had worked with R2. NA-B could not recall what interventions were placed for R2 for repositioning or cares and stated would talk to the nurse if NA-B had questions on care. During interview via phone on 5/20/20, at 4:10 p.m. the director of nursing stated, Absolutely, (R2) should have had a preventative plan in place for pressure ulcers and did not. DON further stated they were unaware if any preventative skin care interventions had been placed or implemented during R2's stay. Facility policy titled Pressure Ulcer Risk Assessment, undated, indicated residents were to have a pressure ulcer risk assessment completed upon admission, weekly for three weeks, with each additional assessment, quarterly, annually and with significant changes. Additionally, at-risk residents need to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. Risk factors include: immobility, altered mental status, incontinence, poor nutrition. Staff were to proceed to care planning and interventions individualized for the resident and their particular risk factors. Facility policy titled Repositioning, undated, indicated residents who are in bed should be on at least an every two hour repositioning schedule. Residents who are in a chair should be on an every one hour repositioning schedule.

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.