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 _____	06/10/2020

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively assess and/or develop and implement fall interventions in order to minimize the risk for falls and/or injury for 1 of 3 residents (R3) reviewed for falls. Findings included: R3's significant change Minimum Data Set ((MDS) dated [DATE], indicated R3's [DIAGNOSES REDACTED]. The MDS also indicated R3 had severe cognitive impairment, had no falls since last assessment, had no [MEDICAL CONDITION], physical, verbal or other behavioral symptoms, rejection of care or wandering and required extensive assistance with all activities of daily living (ADL) except eating. R3's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 5/19/20, indicated R3 was mainly bedridden and staff assisted with all cares. The CAA identified R3 was at risk for skin breakdown, urinary tract infections, falls and isolation. Although R3 had identified falls, the MDS coordinator was unaware of the falls dated 3/26/20 and 5/3/20, therefore R3's Falls were not identified and the CAA did not trigger for further assessment. R3's Care Plan revised 3/27/20, indicated R3 was high risk for falls related to the stroke with residual right sided weakness and gait/balance problems. The care plan also indicated R3 had experienced falls without injury on 3/16/20, 3/17/20, and 3/26/20. After the fall on 3/16/20, R3 had been provided a new wheelchair with cushion. The care plan directed the staff to provide a perimeter mattress, appropriate footwear, call light within reach, the bed in low position at all times except during cares, and assistance of two staff with transfers with a transfer belt and to not leave R3 unattended while seated in the wheelchair, in own room. The care plan further directed staff to review information on R3's past falls and attempt to determine cause of falls, record possible root causes, and remove any/potential causes, if possible. Review of R3's clinical record revealed the following: -Incident report dated 3/16/20, at 14:29 (2:29 p.m.) indicated R3 was seen lying on floor with right hand straight, on his side, left hand under his head, and legs apart. R3 stated he was trying to get in bed and fell . No injury. Intervention: new wheelchair with cushion. No further information available. -Incident report dated 3/17/20 at 10:45 a.m. indicated R3 was found lying flat on his back on the floor next to his wheelchair. Resident had his call light attached to his wheelchair. R3 stated he was trying to get back in bed. No injuries. Intervention: resident not to be left alone in wheelchair. When in wheelchair encourage activities. No further information available. -Progress note dated 3/26/20, at 17:24 (5:24 p.m.) R3 found on floor by side of bed, lying on left side. Unable to report what happened but may have rolled off bed while attempting to turn from back to side. No injuries. Interventions: perimeter mattress. No further information available. -Progress note dated 5/3/20, at 16:28 (4:28 p.m.) R3 sustained a fall at 1545 (3:45 p.m.), stated he was attempting to reposition himself in the chair but slid out landing on his buttocks. No interventions identified. No further information was available. -Incident report dated 5/26/20, at 14:37 (2:37 p.m.) identified the writer was standing outside R3's room administering medication to another resident when R3 was witnessed to slide off his wheelchair. The writer tried to prevent the fall but was unable to reach R3 in time. No injuries. No interventions identified. R3's clinical record lacked comprehensive assessments and identified interventions to address the falls which occurred 5/3/20 and 5/26/20. On 6/9/20, at 9:36 a.m. R3 was observed in his room, laying in a low bed. The bed was positioned against the wall and a thick, covered cushion/mat was noted on the floor on the outer side of the bed. R3 was sleeping, unable to determine if perimeter mattress on the bed. On 6/9/20, at 12:38 p.m. R3 was observed lying on the bed, on top of the covers, dressed. The bed remained in low position and the head of the bed was elevated approximately 45 degrees. The cushion/mattress remained on the floor next to the bed and a wheelchair was positioned at the end of the foot board of the bed. R3 was sleeping, unable to determine if perimeter mattress on the bed. On 6/9/20, at 5:00 p.m. nursing assistant (NA)-A verified R3 was a fall risk and stated he was not to be left unsupervised in his room when seated in the wheelchair. NA-A also stated R3 moved around a lot when in bed so he needed a low bed and a fall mat on the floor next to the bed. On 6/9/20, at 5:08 p.m. NA-B stated R3 required total care, was at risk for falls, and required the use of a low bed and fall mat. NA-B confirmed R3 was not to be unattended when seated in a wheelchair, in his room and stated if he was in his wheelchair, he must be in a supervised area. On 6/9/20, at 5:41 p.m. the administrator stated resident falls were reviewed by the interdisciplinary team during their morning meetings and he tried to ensure the notes section of each risk management form (incident report) had identified the root cause of each fall. The administrator stated he did not have a risk management form for R3's falls dated 3/26 or 5/3 and confirmed assessments had not been completed for the falls as they had occurred during the facility's staffing crisis related to COVID-19. The administrator verified the risk management forms dated 3/16/20, 3/17/20, and 5/26/20, did not identify a root cause for the fall and confirmed interventions had not been identified following the 5/3/20, fall. The administrator stated he would check with physical therapy for additional interventions which may have been identified. On 6/10/20, at 9:19 a.m. the physical therapy assistant (PTA) indicated R3 had been referred for a physical therapy (PT) screening on 5/27/20 after the fall on 5/26/20. PTA stated following the screening, a restorative program for transfers and strengthening was initiated for R3 and a recommendation was made for staff to provide supervision when upright due to R3's impulsiveness. PTA verified there was nothing noted in R3's PT documentation regarding R3's fall on 5/3. On 6/10/20, at 10:28 a.m. during follow up interview, the administrator confirmed the documentation of R3's fall on 5/26, identified R3 had slid out of the wheelchair in his room and verified according to the documentation, the care plan was not followed. The undated Assessing Falls and Their Causes policy indicated within 24 hours of a fall, the nursing staff would begin to try to identify possible or likely causes of the incident. They would refer to resident-specific evidence including medical history, known functional impairments, etc. Staff would evaluate chains of events or circumstances preceding a recent fall including: a. Time of day of the fall; b. Time of the last meal; c. What the resident was doing; d. Whether the resident was standing, walking, reaching, or transferring from one position to another; e. Whether the resident was among other persons or alone; f. Whether the resident was trying to get to the toilet; g. Whether any environmental risk factors were involved (e.g., slippery floor, poor lighting, furniture or objects in the way); and/or h. Whether there is a pattern of falls for this resident The policy also directed staff would continue to collect and evaluate information until they either identified the cause of the fall or determined that the cause could not be found. The undated Managing Falls and Fall Risk policy indicated if the resident continued to fall, staff would re-evaluate the situation and whether it was appropriate to continue or change current interventions.
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** Based on observation, interview and document review, the facility failed to avoid new admission cohorting as recommended by the state agency (SA) in order to minimize or prevent the potential spread of COVID-19 for 2 of 2 residents (R4, R5) who were admitted to the facility from an acute and long-term care setting. Findings include: On 6/9/20 at 2:44 p.m. two

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.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) separate EMT (emergency medical technician) crews were observed to transport R4 and R5 via gurneys into the same room on the South wing of the facility. An unidentified EMT stated R4 had been transferred from a COVID-19 unit. R4's Admission Record identified she was admitted to the facility on [DATE]. R4's 2019 Novel Coronavirus laboratory reports dated 5/17/20 and 5/19/210, both indicated COVID-19 was not detected. R5's Admission Record identified she was admitted on [DATE]. R5's transfer orders identified R5 was admitted to the facility from the hospital. R5's 2019 Novel Coronavirus laboratory report dated 5/24/20, indicated COVID-19 was not detected. On 6/9/20, at 2:50 p.m. the health unit coordinator (HUC) verified R4 and R5 were both new admissions and had been admitted into to the same room. When asked, the HUC stated room assignments was determined by the facility social worker. The HUC verified the unidentified EMT had indicated R4 had been transferred from a COVID-19 unit. -At 2:56 p.m. licensed practical nurse (LPN)-A verified R4 and R5 were new admissions to the facility and cohorted to the same room. LPN-A stated R4 and R5 would be monitored for 14 days which would include temperature and symptoms checks every shift for 14 days. LPN-A clarified R4 had been admitted from a COVID-19 facility but not a COVID unit and indicated R4's test for COVID-19 had been negative. -At 3:35 p.m. the facility's licensed social worker (LSW) stated both R4 and R5 had negative COVID-19 test results prior to admission. LSW indicated although the facility had additional rooms available, R4 and R5 had not been put in private rooms with private baths as she didn't want to get bed locked meaning she wanted to keep rooms available for other potential admissions. LSW indicated R4 had already had COVID-19 and had since recovered so she thought placing R4 in the same room with R5 would be a good fit. LSW stated she had not heard that a facility should not cohort new admissions if the facility had available rooms, so was just trying to do the best she could for everybody. -At 4:16 p.m. LSW verified the facility had an assigned case manager from the state agency for COVID- related concerns, however, confirmed she had not spoken to the case manager regarding cohorting prior to R4 and R5's admissions. On 6/10/2020 9:57 a.m. the director of operations (DO) stated they had felt they were safe to cohort R4 and R5 in the same room as they had been tested twice with negative results and R4 had previously been positive and had since recovered from COVID-19. DO stated if R4 had not previously tested positive for COVID-19 they would have separated R4 and R5 and given them private rooms from the start. DO indicated R5 had been moved to a private room after the conversation with LSW the previous day. -At 11:16 a.m. the administrator indicated the facility utilized the Minnesota Department of Health (MDH) toolkit for COVID-19. -At 11:45 a.m. during a follow up interview with the DO, the administrator and LSW, indicated R4 had been admitted from another long-term care facility and R5 had been admitted from the hospital. DO and the administrator were coordinating with the MDH case manager regarding facility admissions and the administrator stated they had a conference call with her and were given the direction for residents to have 2 negative COVID-19 tests and ten days without symptoms prior to admission to the facility. The administrator stated he did not recall discussing the cohorting of residents in the same room on that conference call. The MDH COVID-19 Toolkit dated 6/5/20, directed facilities to isolate and restrict incoming residents discharged from hospitals, or other facilities, to their room for 14 days. The toolkit also directed plans to cohort, or group, residents should be carefully established in advance, before testing results are received, and they should be centered on implementation of robust IPC (infection prevention and control) practices. The toolkit further provided additional information from MDH: Interim Guidance for Hospital Discharge to Home or Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions dated 5/2/20. The guidance directed patients investigated for possible COVID-19 with a negative test or patients with no clinical concern (e.g., no presence of symptoms consistent with COVID-19), could be discharged from a hospital to a congregate living setting. In both instances, the resident should be placed in a single-person room with private bathroom or in a separate admission/re-admission observation area, for monitoring of signs and symptoms of COVID-19. Residents could be transferred out of the observation area to the main facility if they remained afebrile and without symptoms for 14 days after admission The facility undated COVID-19 Step by Step Preparation policy directed if there was a suspected or confirmed case of COVID-19 isolate the resident to a private room with private bath. The policy did not address cohorting of new admissions or readmissions.