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 _____	09/03/2020

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure resident representatives were notified of a change in condition or treatment for 2 of 3 residents (R3, R1) who experienced a change in condition or whose medication therapy was changed. Findings include: R3 R3's admission Minimum Data Set ((MDS) dated [DATE], identified R3 had moderate cognitive impairment and [DIAGNOSES REDACTED]. The MDS indicated R3 required set up help only with eating, was independent with locomotion off the unit and required extensive assistance with all other activities of daily living. R3's Care Plan dated 7/6/20, indicated R3 had a psychosocial well-being problem potential related to illness/disease process, [DIAGNOSES REDACTED]. R3's care plan listed various interventions which included staff to increase communication between R3, family and caregivers about care and living environment; explain all procedures and treatments, medications, results of labs/tests, condition, all changes, rules, and options. On 9/2/20, at 8:53 a.m. family member-(A) indicated she had concerns regarding the facility's lack of communication of changes in R3's condition. FM-A indicated R3 had experienced three infections within 2 weeks and had a urinalysis completed, however, she was unsure of the results of the laboratory tests. FM-A stated R3 had received antibiotics for all three infections and ultimately required hospitalization and surgery to drain an abscess. FM-A stated during this time, she had been in contact with R3 who on one occasion had been confused and reported to her he felt delusional. FM-A indicated she had been doing the footwork to contact them (the facility) and sometimes it felt like days before she could get in contact with anyone. FM-A stated she would call the facility's main number, her call would be transferred and would ring forever and would then transfer back to reception. She would ask to leave a message and no one would return her call. FM-A indicated she had left messages for the nurses and social worker. However, the social worker's voicemail was full so she could not leave a voicemail. FM-A denied being notified when R3 was diagnosed with [REDACTED]. FM-A indicated the facility had not even contacted her until hours later when R3 had been discharged to the hospital and stated R3 had informed her of his admission to the hospital before the facility had done so. Review of R3's Progress Notes dated 8/14/20 to 8/28/20 revealed the following: -8/14/20, at 10:43 a.m. resident is running a temp (101.6, 99.6, 101.8 (degrees Fahrenheit)). NP (nurse practitioner) and nurse manager updated. Resident is alert and oriented x 3, no shortness of breath/weakness noted. Resident is incontinent of bowel and bladder, he at 30% of breakfast. Tylenol 650 (milligrams) administered, COVID-19 test was done by nurse manager, resident was put on airborne precaution. Resident vitals is every 4 hours, lab order sent to lab, still awaiting their arrival. Will continue to monitor. -8/14/20 at 10:34 p.m. New order for [MEDICATION NAME] (antibiotic) will start 8/15/20 for UTI (urinary tract infection). -8/15/20 at 6:47 p.m. urinalysis and urine culture results faxed. Call placed to the on-call (provider), no new order but to continue with [MEDICATION NAME] antibiotic medication until primary (physician) is updated. -8/18/20 at 1:38 pm. Social Service Note: Care conference held today with R3, therapy, nurse manager, activities, social worker and family member (FM)-A via phone conference. Medications reviewed. Code status DNR (do not resuscitate). R3 has case manager and spouse in the community. Weight is 240 pounds. Family would like R3 to return home, however, would need to walk in the bathroom. Therapy will continue to work with R3 toward goals. The care conference notes did not identity R3's family had been notified of the UTI and antibiotic use. -8/22/20 at 12:39 a.m. Resident is on antibiotics, BP is within the limit but resident is running high fever. Temperature is within 99 and 100 (degrees Fahrenheit). Need to follow up with the NP about the antibiotic medication because of no improvement. -8/22/20 at 2:37 p.m. resident appears weak and refused getting up from bed. It is reported that resident was running a fever during the previous shift. NP notified and has stat lab order and chest X-ray. Lab drawn and pending result. -8/22/20 at 6:16 p.m. Resident started on antibiotic [MEDICATION NAME] and [MEDICATION NAME] medications for pneumonia. R3's medical record lacked documentation R3's representative had been notified of the changes in condition and treatments related to UTI or pneumonia. On 9/2/20, at 10:51 a.m. the director of nursing (DON) stated if there was a change in a resident's condition it should documented in a progress note right away and the physician or nurse practitioner and family were to be notified immediately or within 2 hours. On 9/02/20, at 1:29 p.m. FM-B indicated he had heard of R3's change in condition from FM-A and even though he had told the facility to notify him of any changes, they had never done so. FM-B indicated he had called the facility and tried to talk to a nurse but would not get a reply or they would say wait a minute and not get back to me. FM-B denied notification of R3's UTI, pneumonia or hospitalization and stated he was given no kind of notification at all. On 9/2/20, at 2:04 p.m. licensed practical nurse (LPN)-C stated for any resident change in condition, she contacted the supervisor, resident physician and then the resident family. LPN-C stated this should be documented in a progress note. On 9/2/20, at 2:19 p.m. LPN-A stated if a resident experienced a change in condition she would first update the nurse manager and the nurse practitioner. LPN-A stated she would also call the family but the documentation depended on the type of change, and indicated something like a bruise would be documented in a progress note. LPN-A stated she had called FM-A when R3 had a fever. LPN-A confirmed the progress note she completed on dated 8/14/20, did not indicate she had called family but stated she remembered talking to FM-A on the phone. On 9/2/20, at 3:14 p.m. LPN-D stated would notify the primary doctor, family and the DON as soon as a resident experienced a change in condition and document in the notification in the progress notes. LPN-D verified his note dated 8/22/20 at 6:16 p.m. did not include documentation family had been notified of R3's pneumonia, however indicated R3 had not been his assigned resident at the time; he had just been helping out to enter orders. On 9/2/20, at 3:32 p.m. DON confirmed R3's record lacked documentation family had been notified of R3's UTI or pneumonia and indicated she would have expected family to have been notified when the NP was contacted. R1 R1 Significant Change of Status Minimum Data Set ((MDS) dated [DATE], indicated R1 had [DIAGNOSES REDACTED]. The MDS indicated R1 had severe cognitive impairment and identified R1's behaviors of care rejection or wandering which worsened compared to prior assessments. R1's Cognitive Loss/Dementia CAA dated 8/19/20 indicated Cognitive loss has triggered by R1 experiencing long and short term memory impairment. Contributing factors include [DIAGNOSES REDACTED].[MEDICAL CONDITION].R1 was confused and required redirection. R1 had a wander guard and guardianship in progress as resident unable to make own decisions. R1's progress noted dated 8/28/20, at 12.54 p.m. stated R1 was seen by the in-house psychiatrist on 8/25/2020 with the following orders: discontinue (D/C) [MEDICATION NAME] (an antipsychotic medications), add [MEDICATION NAME] (an antidepressant) 20 milligram (mg) every AM for three (3) weeks, then increase to 40 mg every AM DX: depression, and follow-up on 10/20/20. On 9/2/2020, at 1:56 p.m. during telephone interview with R1's family member (FM)-C she stated the facility did not really keep in contact with her about changes with her R1. FM-C stated if anything happened it was usually her mother who calls her with updates. FM-C stated she had not been informed in the change on medications ordered on [DATE], and stated she would like to have known the changes due to the effect the changes could have on her mood and was

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

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F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) concerned with the order to discontinue her [MEDICATION NAME]. FM-C also stated she had been trying to contact the facility to check because she understood R1 needed a follow up with neurology due to recent tremors and an eye doctor due to changes in R1's eyes. On 9/2/20, at 3:18 p.m. licensed practical nurse (LPN)-B stated if a resident had a change in health status, fall, accident, went to the hospital or changes in significant medications the resident representative should be notified as soon as possible. On 9/2/20, at 3:14 p.m. registered nurse (RN)-A stated family should be informed whenever there is a change of condition of resident, if they go to the hospital, have a fall, injury or accident, and if there were any changes in residents' medications due to a provider visit. Upon review of R1's documentation, she could not verify if representative had been called and could not recall calling them. RN-A stated they should have been called. An undated facility policy titled, Change in Resident's Condition or Status, indicated the facility would promptly notify the resident, his or her attending physician and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The policy directed unless otherwise instructed by the resident, the nurse supervisor/charge nurse would notify the resident's family or representative (sponsor) when: a. The resident is involved in any accident or incident that results in injury including injuries of an unknown source; b. There is a significant change in the resident's physical, mental, or psychosocial status; c. There is a need to change the resident's room assignment; d. A decision has been made to discharge the resident from the facility; and/or e. It is necessary to transfer the resident to a hospital/treatment center. The policy further indicated except in medical emergencies, notifications would be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.