DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 9, 2022

Administrator
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, MN 55343

RE: CCN: 245493
Cycle Start Date: April 7, 2022

Dear Administrator:

On June 1, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 9, 2022

Administrator
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, MN 55343

Re: Reinspection Results
Event ID: 4BGW12

Dear Administrator:

On June 1, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 7, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 9, 2022

CMS Certification Number (CCN): 245493

Administrator
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, MN 55343

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 16, 2022 the above facility is certified for:

100 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 100 skilled nursing facility beds.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 9, 2022

Administrator
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, MN 55343

RE: CCN: 245493
Cycle Start Date: April 7, 2022

Dear Administrator:

On June 1, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 19, 2022

Administrator
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, MN 55343

RE: CCN: 245493
Cycle Start Date: April 7, 2022

Dear Administrator:

On April 7, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an E tag), i.e., the plan of correction should be directed to:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 7, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 7, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	**615 MINNETONKA MILLS ROAD HOPKINS, MN 55343**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/4/22 through 4/7/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/4/22 through 4/7/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5493093C (MN82357), with deficiencies cited at F600 and F610. The following complaints were found to be UNSUBSTANTIATED: H5493087C (MN81412), H5493088C (MN80776), H5493089C (MN78541), H5493090C (MN78268), H5493091C (MN76756), and H5493092C (MN76390). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will	F 000		

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

Electronically Signed | 04/28/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	**615 MINNETONKA MILLS ROAD HOPKINS, MN 55343**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she	F 578		5/16/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 2 has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure conflicting orders for emergency care (i.e., cardiopulmonary resuscitation (CPR)) were clarified to for 1 of 1 resident (R10) whose medical record was found to have incorrect and conflicting information. Findings include: R10's quarterly Minimum Data Set (MDS) dated 12/8/22, indicated R10 was cognitively intact, and had diagnoses of dementia and bipolar disorder. On 4/4/22, R10's electronic medical record (EMR) was reviewed. On the header of R10's record (an area outlining basic resident information) read "Full Code" (Initiate CPR) in green and DNI (Do Not Intubate) in red. R10's provider order dated 4/4/22, indicated R10's previous order "full code" was discontinued and a new order for "full code, DNI" was placed. R10's provider order for life sustaining treatment (POLST) dated 9/16/19, indicated both "attempt resuscitation/CPR" was and "comfort focused treatment (allow natural death)" were checked.	F 578	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. F578- Request/Refuse/Discontinue Treatment: Advance Directives It is the policy of Chapel View Living to comply with F578 To assure continued compliance, the following plan has been put into place; Regarding cited resident: R10□s wishes were reviewed with resident during survey process. A new and updated POLST for resident R10 was done on 4/5/2022. Actions taken to identify other potential residents having similar occurrences: A facility wide audit was done of all records to ensure POLSTs were completed according to document specifications. Measures put in place to ensure deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 3 During an interview on 4/4/22, at 6:34p.m. R10 stated she wanted to be full code with both CPR and intubation. R10 further stated family member (FM)-A helped her make decisions. During an interview on 4/5/22, at 9:26 a.m. the nurse practitioner (NP)-A stated their expectation would be to default to full code as it appeared the POLST was not filled out correctly. Further, NP-A stated R10's POLST had to be addressed as it did not make sense. NP-A stated she reviewed POLSTS upon admission and with any change in condition. NP-A was not aware of any changed orders for code status of R10. During an interview on 4/5/22, at 9:57 a.m. FM-A stated while he was R10's power of attorney and he only assisted her with decision making. R10 was alert and aware enough to decide. R10 had not made any decisions about R10's code status and believed R10 was full code. FM-A stated the facility had not discussed this with him prior and would need to talk further with R10. During an interview on 4/5/22, at 10:07 a.m. registered nurse (RN)-A stated if R10 became pulseless or stopped breathing CPR would be initiated, but the order was confusing. In reviewing R10's POLST for clarification, RN-A stated it was misleading, but would start CPR. During an interview on 04/05/22, at 10:09 a.m. RN-B stated the order did not make sense and the POLST had not either. RN-B stated they would immediately call the provider for instruction.	F 578	practice does not recur: To prevent recurrence, re-education on the POLST document specifications was done with those responsible for facilitating completion of the form with patients, residents and families. Effective implementation of actions will be monitored by: To ensure ongoing compliance, bi-weekly audits of 10 residents□ POLSTs will be done for 8 weeks and ongoing with scheduled annual, quarterly and significant change care conferences. In addition, routine audits will be done quarterly by Health Information to validate this sustained compliance. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: Social Services/Health Information Director. Completion date for certification purposes only is: 5/16/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	**615 MINNETONKA MILLS ROAD HOPKINS, MN 55343**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 4	F 578		

During an interview on 4/5/22, at 12:35 p.m. social worker (SW)-A stated the POLST was part of the admission packet and was reviewed with residents upon admission. R10's code status was reviewed every three months, and R10 had always wanted full code and that was R10's order. SW- stated the POLST was not reviewed at care conferences, only the order in the EMR. Furthermore, SW-A stated R10's POLST had conflicting information as both attempt resuscitation and allow natural death were both checked and SW- was going to review the POLST with R10 today. SW-A was not aware R10's order was changed yesterday.

During an interview on 4/5/22, at 1:50 p.m. the medical records director (MRD) stated an audit of resident POLSTs was completed to ensure resident banners matched up with their POLST. MRD verified she had discontinued R10's full code order and replaced with full code, DNI. Furthermore, MRD believed since R10 had no check next to "selective treatment, do not intubate" R10 had not wanted intubation and had changed the order. MRD had not discussed the order change with R10 or NP-A.

During an interview on 4/5/22, at 2:12 p.m. the Administrator stated their expectation would be to clarify with the resident or representative if any discrepancy was found and before orders were changed.

A facility policy titled Legal Health Records revised 6/23/20, directed a resident medical record was used in support of making decision s in a resident's care.

A facility policy titled "POLST, Advanced Directive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	**615 MINNETONKA MILLS ROAD HOPKINS, MN 55343**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 5 form implementation, revised 5/26/21, directed the physicians electronic order and POLST order must match. Furthermore, the POLST needed to be reviewed during care conferences or with a change in condition.	F 578		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from verbal abuse for 1 of 3 residents (R40). Findings include: R40's quarterly Minimum Data Set (MDS) dated 2/28/22, indicated R40 was cognitively intact and had diagnoses of schizoaffective disorder and anxiety. R40's care plan dated 12/20/19, indicated R40 was vulnerable and at risk for abuse related to	F 600	F600 □ Free From Abuse and Neglect It is the policy of Chapel View Senior Health and Living to comply with F600 To assure continued compliance, the following plan has been put into place; Regarding cited Resident: R40 is routinely seen by the Associated Clinic of Psychology. His Licensed Clinical Social Worker was made aware of this occurrence and has since increased the frequency of visits for him. Through these visits, the Clinical Social Worker	5/16/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 6 schizoaffective disorder. A Nursing Home Incident Report (NHIR) dated 4/3/22, alleged "a staff member said inappropriate words "[expletive] pedophile" to [R40] which upset him. R40 had reported incident to staff who had then reported to the supervisor. The report further indicated the staff member was dietary aid (DA)-A. The DA-A left the facility and was instructed not to return until the facility investigation was completed. During an interview on 4/4/22 at 3:57 p.m., R40 stated last weekend (he walked past the stairs by the stairs near the kitchen and when DA-A said, "[expletive] pedophile" when DA-A walked by. R40 had not said anything to DA-A before hearing this and does not know why DA-A said that. R40 verified there other staff or residents were not present when DA's comment was stated. R40 stated the comment made him upset and angry. During a follow-up interview on 4/7/22, at 9:16 a.m. R40 stated he wished DA-A was fired, but it was not up to him. He was told by DON and social worker (SW)-A it just slipped out and wasn't directed at him. R40 stated he does not think seeing DA-A "will impact" him too much. During an interview on 4/7/22, at 9:49 a.m. DA-A verified the statement was said to R40. DA-A verified he was suspended and was returning to work on 4/8/22. The dietary director (DD) had called and talked about therapy and online education. During an interview on 4/7/22, at 10:46 a.m. the director of nursing (DON) stated DA-A's duties included dishes, tray set up, tray delivery to the	F 600	offers facility staff updates on resident□s overall mental health status and recommends interventions to best meet resident□s need to feel safe and supported. Additionally, R40□s facility Social Worker continues to meet regularly with resident to further these discussions and to ensure open communication. Resident□s Vulnerability care plan has since been updated. The Vulnerability care plan was updated for R40. The Vulnerability care plan for other residents with mental health with behavioral expressions were reviewed and updated as necessary. All other resident care plans will be reviewed and updated at the next quarterly care conference. Actions taken to identify other potential residents having similar occurrences: Interviews were held with all residents in the facility to ensure there were no other similar areas of concerns. No other residents reported similar concerns. Measures put in place to ensure deficient practice does not recur: Re-education on Vulnerable Adult is being done with all employees. This education includes the resident rights as well as employee responsibilities. Effective implementation of actions will be monitored by: Bi-weekly audits of 10 residents will be done for 8 weeks and then as needed to ensure ongoing compliance. Additionally, all resident□s emotional wellbeing will continue being assessed with scheduled MDS assessments with care plans being	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	**615 MINNETONKA MILLS ROAD HOPKINS, MN 55343**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 7 units, and bussing tables. DA-A had little interaction with residents alone and was usually around other staff and residents in the dining rooms. DON verified R40 was very fluid throughout the building and often went to the kitchen for snacks or meal requests. DON stated other residents did this as well, but other residents made their requests in passing, while R40 lingered and talked to staff. DON stated this was an isolated incident between DA-A and R40 and there was not any housewide education was not needed. Huddles were started to remind staff about reporting and the abuse policy but this incident was truly just between DA-A and R40. DON asked if writer had talked to DD-A and had an awareness of DD-A's past, further stating "again, it doesn't excuse it, but yeah". During an interview on 4/7/22, at 12:41 p.m., the dietary director (DD) stated she was surprised DA-A had made the comment to R40. The DD further stated she was aware of previous comments and frustrations from DA-A prior and had told DA-A R40 had disucssions with DA-A about R40's mental health issues and vulnerable status. The DD stated DA-A had reached out to her at times when something was triggering DD-A's anxiety and he needed a break. DD stated sometimes these situations were related to R40. The DD stated DD-A had tried to stay away from R40, even before this current event. During an interview on 4/7/22, at 1:51 p.m. the Administrator stated DA-A's comments had not been directed towards R40 or anyone. DA-A was 10 feet away and R40 assumed the comment was directed at him. Administrator further stated a person wouldn't think the comment would be heard from that far away with a mask on, but R40	F 600	reviewed and updated at scheduled care conferences. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: Administrator/DON/Social Services responsible. Completion date for certification purposes only is: 5/16/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	**615 MINNETONKA MILLS ROAD HOPKINS, MN 55343**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 8 heard it and thought it was directed at him. A facility policy titled Vulnerable Adult MN reviewed 7/20/21, indicated verbal abuse as any use of oral, written, or gestured language that willfully incudes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of age, disability, or ability to comprehend.	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate an allegation of verbal abuse and implement appropriate interventions for 1 of 3 residents (R40).	F 610	F610 □ Investigate/Prevent/Correct Alleged Violation It is the policy of Chapel View Senior Health and Living to comply with F610 To assure continued compliance, the following plan has been put into place;	5/16/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 9 Findings include: A Nursing Home Incident Report (NHIR) dated 4/3/22, alleged "a staff member said inappropriate words "[expletive] pedophile" to [R40] which upset him. R40 had reported incident to staff who had then reported to the supervisor. The report further indicated the staff member was dietary aid (DA)-A. The DA-A left the facility and was instructed not to return until the facility investigation was completed. The facility investigation consisted of interviews with R40, DA-A, the administrator, director of nursing (DON) dietary director (DD), and the dietary supervisor and R75. The investigation failed to include interviews from other residents that could interact with DA-A to determine if there was a pattern of abuse and to ensure other residents felt safe. The facility also failed to complete staff interviews to determine if there were other incidents of potential abuse between DA-A and any other residents. The facility determined action taken to prevent reoccurrence to other residents was not applicable as this was an isolated incident. There was also no measures identified on how to protect R40 from further verbal abuse. R40's quarterly Minimum Data Set (MDS) dated 2/28/22, indicated R40 was cognitively intact and had diagnoses of schizoaffective disorder and anxiety. R40's care plan dated 12/20/19, indicated R40 was vulnerable and at risk for abuse related to schizoaffective disorder. There was no mention of how R40 would be kept safe from other incidents of verbal abuse.	F 610	Regarding cited resident: The incident referenced was investigated by the facility. Affected resident denied any further concerns. An interview was held with another resident with whom DA-A had direct 1:1 contact and there were no concerns. The AP was suspended for the duration of the investigation. Before returning to work the AP completed the Relias Vulnerable Adult learning module and was mandated to contact the employee assistance program/resource Vital Work Life. Further, the AP was given a formal Final Written Warning and an unpaid 3-day suspension and will be monitored by supervisor. The AP also has a private therapist that he sees on a regular basis. The AP□s duties have been adjusted to eliminate contact with R40. Actions taken to identify other potential residents having similar occurrences: In addition as stated above, interviews were held with all residents in the facility to ensure there were no other similar areas of concern and there were none noted. Interviews were conducted with AP□s co-workers to determine if there was awareness of any other similar areas of concern and none were identified. Measures put in place to ensure deficient practice does not recur: To prevent recurrence, re-education on Vulnerable Adult is being done with employees. This education includes resident rights as well as employee responsibilities. Effective implementation of actions will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 10 During an interview on 4/4/22 at 3:57 p.m., R40 stated last weekend (he walked past the stairs by the stairs near the kitchen and when DA-A said, "[expletive] pedophile" when DA-A walked by. R40 had not said anything to DA-A before hearing this and does not know why DA-A said that. R40 verified there other staff or residents were not present when DA's comment was stated. R40 stated the comment made him upset and angry. During a follow-up interview on 4/7/22, at 9:16 a.m. R40 stated he wished DA-A was fired, but it was not up to him. He was told by DON and social worker (SW)-A it just slipped out and wasn't directed at him. R40 stated he does not think seeing DA-A "will impact" him too much. During an interview on 4/7/22, at 9:49 a.m. DA-A verified the statement was said to R40. DA-A verified he was suspended and was returning to work on 4/8/22. The dietary director (DD) had called and talked about therapy and online education. During an interview on 4/7/22, at 10:46 a.m. the director of nursing (DON) stated DA-A's duties included dishes, tray set up, tray delivery to the units, and bussing tables. DA-A had little interaction with residents alone and was usually around other staff and residents in the dining rooms. DON verified R40 was very fluid throughout the building and often went to the kitchen for snacks or meal requests. DON stated other residents did this as well, but other residents made their requests in passing, while R40 lingered and talked to staff. DON stated this was an isolated incident between DA-A and R40 and there was not any house-wide education was	F 610	monitored by: Bi-weekly audits of 10 residents will be done for 8 weeks and then as needed to ensure ongoing compliance. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: Administrator/DON/Social Services responsible. Completion date for certification purposes only is: 5/16/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 11	F 610		

not needed. Huddles were started to remind staff about reporting and the abuse policy but this incident was truly just between DA-A and R40. DON asked if writer had talked to DD-A and had an awareness of DD-A's past, further stating "again, it doesn't excuse it, but yeah".

During an interview on 4/7/22, at 12:41 p.m., the dietary director (DD) stated she was surprised DA-A had made the comment to R40. The DD further stated she was aware of previous comments and frustrations from DA-A prior and had told DA-A R40 had discussions with DA-A about R40's mental health issues and vulnerable status. The DD stated DA-A had reached out to her at times when something was triggering DD-A's anxiety and he needed a break. DD stated sometimes these situations were related to R40. The DD stated DD-A had tried to stay away from R40, even before this current event.

During an interview on 4/7/22, at 1:51 p.m. the Administrator stated DA-A's comments had not been directed towards R40 or anyone. DA-A was 10 feet away and R40 assumed the comment was directed at him. Administrator further stated a person wouldn't think the comment would be heard from that far away with a mask on, but R40 heard it and thought it was directed at him.

A facility policy titled Vulnerable Adult MN reviewed 7/20/21, directed all reports of abuse were to be promptly and thoroughly investigated and was to include interviews of any potential witnesses and other residents whom the alleged perpetrator provides cares or services for. The interdisciplinary team was to evaluate the vulnerability of each resident and develop interventions as part of the resident's plan of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	**615 MINNETONKA MILLS ROAD HOPKINS, MN 55343**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 12 care. The facility was to take all necessary corrective action. The results of all investigations were to be reported to the administrator or designee. If the alleged violation is verified, appropriate corrective action must be taken. If employee is found to have perpetrated the incident, the facility was to follow the employee handbook. The facility was to analyze the occurrence to determine what changes were needed, if any, to policies and procedures to prevent further occurrences. The facility was also to report to Quality Assurance Committee (QAPI) for determination of additional actions to be taken.	F 610		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		5/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 13 Based on observation, interview and document review, the facility failed to have a method to consistently monitor dish machine temperatures to ensure proper sanitation of dishware. This had the potential for food-borne illness and could affect 92 of 93 residents who recieved meals prepared and served by the facility. Findings include: Review of the Food Code 2017 included, "Adequate cleaning and sanitization of dishes and utensils using a ware-washing machine is directly dependent on the exposure time during the wash, rinse, and sanitizing cycles. Failure to meet manufacturer and Code requirements for cycle times could result in failure to clean and sanitize. For example, high temperature machines depend on the buildup of heat on the surface of dishes to accomplish sanitization. If the exposure time during any of the cycles is not met, the surface of the items may not reach the time-temperature parameter required for sanitization. Contact time is also important in ware-washing machines that use a chemical sanitizer since the sanitizer must contact the items long enough for sanitization to occur. In addition, a chemical sanitizer will not sanitize a dirty dish; therefore, the cycle times during the wash and rinse phases are critical to sanitization." During interview on 4/7/22, at 10:44 a.m. dietary director (DD) stated the dishwasher wash temperature gauge should indicate 170 degrees Fahrenheit (°F) and the rinse gauge should indicate over 180°F during the rinse cycle. The gauges were observed at that time to be within acceptable range at 172°F and 182°F respectively. Upon review of the High	F 812	F812 □ Food Procurement, Store/Prepare/Serve/Sanitary It is the policy of Chapel View Senior Health and Living to store, prepare, distribute and serve food under sanitary conditions. Regarding cited issue: Food Service Staff were immediately educated on the proper monitoring and documentation of dish machine temperatures and what actions should be taken if outside the proper temperatures for sanitation. Measures put in Place: Sanitation Policy and Procedure was reviewed and remains appropriate. High Temperature Dish Machine Log was reviewed and remains appropriate. Specialized staff education Proper Monitoring of Dish Machine Temperatures was designed and implemented for all food service staff. Staff training completed on May 10, 2022. Dish Machine temperature audit tool was developed. Monitoring Mechanisms put in place to ensure deficient practice does not recur: Monitoring for compliance will be ensured through random weekly audits of the dish machine temperature log. Audits will continue for a minimum of 8 weeks. Facility QAPI Committee will review results of audits and make further recommendations if needed. Those responsible to maintain compliance will be: Food Service Director or Designee responsible. Completion date: 5/10/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	**615 MINNETONKA MILLS ROAD HOPKINS, MN 55343**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 14	F 812		

Temperature Dish Machine logs for March and April, she acknowledged there were "holes". She stated the temperatures should have been recorded three times per day, every day. She stated without documentation they would not know if the temperatures were appropriate, and dishes would not come out clean. She stated should "notice and not use them". The cook would "look to see why they were so dirty and check the machin"e. She expected staff to document the temperatures to ensure appropriate monitoring of dishware sanitation occured.

The High Temperature Dish Machine form identified wash temperatures should be between 150-165°F or per manufacturer, and rinse temperature should be at least 180°F or per manufacturer.

The High Temperature Dish Machine log dated 3/22, indicated dishwasher wash and rinse temperatures were recorded for 32 of 93 meals (34.4%) during the period from 3/1/22, through 3/31/22.

The High Temp Dish Machine log dated 4/22, indicated dishwasher wash and rinse temperatures were recorded for 6 of 20 meals (30.0%) during the period from 4/1/22, through the lunch meal on 4/7/22.

During interview on 4/7/22, at 3:03 p.m. DD stated dietary shift supervisors ran temperature test strips (an indicator which turns color change once temperature has been reached.) through the dish machine once per week alternating between day shift and night shift, but there was no planned schedule. She stated the dietary shift supervisors communicated with each other and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	**615 MINNETONKA MILLS ROAD HOPKINS, MN 55343**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 15	F 812		

informed her if "something wasn't right". DD stated staff were very good about telling her when the dishes "didn't feel hot", and they "knew by touch" if something was wrong with the temperatures. She ran the test strips herself sometimes, but did not usually keep any of them, and there was no tracking log identifying when the strips were run or any documentation of results.

During interview on 4/7/22, at 1:38 p.m. Administrator stated she was concerned to hear about the lack of documentation of dishwasher temperature monitoring. Her expectation was dietary staff should have been completing checks as scheduled and/or required. She stated it was "unfortunate", and not per facility policy or sanitation standards. Regarding resident risk, she stated it was not a "good thing" and agreed residents were at risk for food-borne illness related to lack of appropriate sanitization.

The C-Line A & W Dishwashers instruction manual dated Ferbruary 2006, indicated the minimum wash temperature was 160°F and the minimum final rinse temperature was 180°F.

The facility Food and Nutrition Services Sanitation policy dated 1/6/21, indicated "Dishwashing machines must be operated using the following specifications or per manufacturer's recommendations (whichever is higher). If the below specifications are not reached, culinary staff should stop using the machine immediately, contact their supervisor and/or maintenance and begin manual washing dishes or using disposables." The policy indicated high-temperature dishwasher wash temperature must range between 150-160°F and rinse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	**615 MINNETONKA MILLS ROAD HOPKINS, MN 55343**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 16 temperature of 180°F, however, it lacked procedures pertaining to monitoring of temperature gauges and use of test strips to ensure the machine was working appropriately.	F 812		

Electronically delivered
April 19, 2022

Administrator
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, MN 55343

Re: State Nursing Home Licensing Orders
Event ID: 4BGW11

Dear Administrator:

The above facility was surveyed on April 4, 2022 through April 7, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00727	A. BUILDING: _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/4/22 through 4/7/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00727	A. BUILDING: _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 date when they will be completed. The following complaint was found to be SUBSTANTIATED: H5493093C (MN82357), however, NO licensing orders were issued. The following complaints were found to be UNSUBSTANTIATED: H5493087C (MN81412), H5493088C (MN80776), H5493089C (MN78541), H5493090C (MN78268), H5493091C (MN76756), and H5493092C (MN76390). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00727	A. BUILDING: _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to have a method to consistently monitor dish machine temperatures to ensure proper sanitation of dishware. This had the potential for food-borne illness and could affect 92 of 93 residents who recieved meals prepared and served by the facility. Findings include: Review of the Food Code 2017 included, "Adequate cleaning and sanitization of dishes and utensils using a ware-washing machine is directly	21015	Corrected	5/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00727	A. BUILDING: _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 3	21015		

dependent on the exposure time during the wash, rinse, and sanitizing cycles. Failure to meet manufacturer and Code requirements for cycle times could result in failure to clean and sanitize. For example, high temperature machines depend on the buildup of heat on the surface of dishes to accomplish sanitization. If the exposure time during any of the cycles is not met, the surface of the items may not reach the time-temperature parameter required for sanitization. Contact time is also important in ware-washing machines that use a chemical sanitizer since the sanitizer must contact the items long enough for sanitization to occur. In addition, a chemical sanitizer will not sanitize a dirty dish; therefore, the cycle times during the wash and rinse phases are critical to sanitization."

During interview on 4/7/22, at 10:44 a.m. dietary director (DD) stated the dishwasher wash temperature gauge should indicate 170 degrees Fahrenheit (°F) and the rinse gauge should indicate over 180°F during the rinse cycle. The gauges were observed at that time to be within acceptable range at 172°F and 182°F respectively. Upon review of the High Temperature Dish Machine logs for March and April, she acknowledged there were "holes". She stated the temperatures should have been recorded three times per day, every day. She stated without documentation they would not know if the temperatures were appropriate, and dishes would not come out clean. She stated should "notice and not use them". The cook would "look to see why they were so dirty and check the machin"e. She expected staff to document the temperatures to ensure appropriate monitoring of dishware sanitation occured.

The High Temperature Dish Machine form

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00727	A. BUILDING: _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 4	21015		

identified wash temperatures should be between 150-165°F or per manufacturer, and rinse temperature should be at least 180°F or per manufacturer.

The High Temperature Dish Machine log dated 3/22, indicated dishwasher wash and rinse temperatures were recorded for 32 of 93 meals (34.4%) during the period from 3/1/22, through 3/31/22.

The High Temp Dish Machine log dated 4/22, indicated dishwasher wash and rinse temperatures were recorded for 6 of 20 meals (30.0%) during the period from 4/1/22, through the lunch meal on 4/7/22.

During interview on 4/7/22, at 3:03 p.m. DD stated dietary shift supervisors ran temperature test strips (an indicator which turns color change once temperature has been reached.) through the dish machine once per week alternating between day shift and night shift, but there was no planned schedule. She stated the dietary shift supervisors communicated with each other and informed her if "something wasn't right". DD stated staff were very good about telling her when the dishes "didn't feel hot", and they "knew by touch" if something was wrong with the temperatures. She ran the test strips herself sometimes, but did not usually keep any of them, and there was no tracking log identifying when the strips were run or any documentation of results.

During interview on 4/7/22, at 1:38 p.m. Administrator stated she was concerned to hear about the lack of documentation of dishwasher temperature monitoring. Her expectation was dietary staff should have been completing checks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00727	A. BUILDING: _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 5 as scheduled and/or required. She stated it was "unfortunate", and not per facility policy or sanitation standards. Regarding resident risk, she stated it was not a "good thing" and agreed residents were at risk for food-borne illness related to lack of appropriate sanitization. The C-Line A & W Dishwashers instruction manual dated Ferbruary 2006, indicated the minimum wash temperature was 160°F and the minimum final rinse temperature was 180°F. The facility Food and Nutrition Services Sanitation policy dated 1/6/21, indicated "Dishwashing machines must be operated using the following specifications or per manufacturer's recommendations (whichever is higher). If the below specifications are not reached, culinary staff should stop using the machine immediately, contact their supervisor and/or maintenance and begin manual washing dishes or using disposables." The policy indicated high-temperature dishwasher wash temperature must range between 150-160°F and rinse temperature of 180°F, however, it lacked procedures pertaining to monitoring of temperature gauges and use of test strips to ensure the machine was working appropriately. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate security and sanitation of food items and or equipment in the kitchen and dining areas. The facility should also ensure appropriate storage of food occurs. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00727	A. BUILDING: _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 6 Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	**615 MINNETONKA MILLS ROAD HOPKINS, MN 55343**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/05/2022. At the time of this survey, Augustana Chapel View Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Augustana Chapel View Care Center is a 2-story split level building with a partial basement was determined to be built of Type II(111) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 100 beds and had a census of 96 at time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are MET.	K 000		

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.