DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 50C0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00727

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245493**

2.STATE VENDOR OR MEDICAID NO.
(L2) **470843100**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA CHAPEL VIEW CARE CENTER**
(L4) **615 MINNETONKA MILLS ROAD**
(L5) **HOPKINS, MN** (L6) **55343**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/12/2012** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **118** (L18)

13.Total Certified Beds **118** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	118			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 04/12/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 05/04/2012 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
08/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Uploaded 05/08/12 DB

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/11/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN# 24-5493

At the time of the standard survey completed March 1, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed.

On April 12, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on March 1, 2012, effective April 10, 2012. Therefore, the remedies outlined in our letter dated April 13, 2012, will not be imposed. See attached CMS-2567B forms for the results of the April 12, 2012 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5493 May 4, 2012

Ms. Mary Roy, Administrator
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, Minnesota 55343

Dear Ms. Roy:

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 April 10, 2012 the above facility is certified for:

118 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 118 skilled nursing facility beds.

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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 13, 2012

Ms. Mary Roy, Administrator
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, Minnesota 55343

RE: Project Number S5493022

Dear Ms. Roy:

On March 21, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 1, 2012. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On April 12, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 1, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 10, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 1, 2012, effective April 10, 2012 and therefore remedies outlined in our letter to you dated March 21, 2012, will not be imposed.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3792 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5493r112.rtf

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245493	A. Building B. Wing	4/12/2012

Name of Facility	Street Address, City, State, Zip Code
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0154** Reg. # **483.10(b)(3), 483.10(d)(2)** LSC	Correction Completed **04/10/2012**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **04/10/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **04/10/2012**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/10/2012**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **04/10/2012**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/10/2012**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **04/10/2012**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **04/10/2012**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/sd	04/12/12	18623	04/12/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/1/2012			

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 50C0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00727

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245493**

2.STATE VENDOR OR MEDICAID NO.
(L2) **470843100**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA CHAPEL VIEW CARE CENTER**
(L4) **615 MINNETONKA MILLS ROAD**
(L5) **HOPKINS, MN** (L6) **55343**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/01/2012** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **118** (L18)

13.Total Certified Beds **118** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	118			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Eva Loch, HFE NE II — 03/30/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Program Specialist — 04/09/2012 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
08/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/11/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN# 24-5493

At the time of the standard survey completed March 1, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 5172

March 21, 2012

Ms. Mary Roy, Administrator
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, Minnesota 55343

RE: Project Number S5493022

Dear Ms. Roy:

On March 1, 2012, a standard 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Gloria Derfus
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 10, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

If an acceptable PoC 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 June 1, 2012 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 1, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

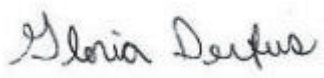
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3792 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5493s12.rtf

5549 3022

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/21/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	03/01/2012

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	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	POC 2012 Augustana Chapel View strives to provide quality care to the patients and residents we serve. The following response and plan of correction does not imply agreement with the areas identified but rather our commitment to improving quality of care and quality of life for those we serve.	
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to obtain an informed consent for use of psychotropic medication for 1 of 3 (R68) residents reviewed for psychotropic use. Findings include: A record review for R68 was conducted at 7:30 a.m. on 3/1/12. R68 had orders for PRN (as needed) Ativan (an antianxiety medication) 0.25	F 154	POC accepted as per ltr 3/30/12	

RECEIVED
MAR 30 2012
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Kay K.M. Ellen — TITLE: Administrator — (X6) DATE: 3-28-12

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
	246493	A. BUILDING _____ B. WING _____	03/01/2012

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 154	Continued From page 1 milligrams (mg) and Doxepin (an antidepressant) 10 mg by mouth at bedtime. The start date for the Ativan was 1/11/12. The start date for the Doxepin was 1/18/12. Both medications were being used for treatment of anxiety. The medical record contained an informed consent for use of the Ativan but not the Doxepin. Clinical nurse manager (NM)-B was interviewed at 7:55 a.m. on 3/1/12, and verified the medical record lacked evidence of the consent for use of Doxepin for R68, but would consult with another nurse manager. At 9:30 a.m. on 3/1/12, NM-C confirmed there was no consent but did obtain one via phone call. A progress noted dated 8:45 a.m. on 3/1/12, stated NM-C was unable to locate consent for the use of Doxepin for R68 and a phone call was made to obtain a verbal consent from the resident's niece. There was no evidence in the medical record that the consent form was mailed to the niece. The facility policy for Psychotropic Medication Monitoring dated 11/11, was reviewed and did state, "The nurse manager is responsible for resident/representative notification. The nurse obtains initial written consent from the resident/representative immediately for any psychotropics, changes in doses of psychotropics, or other changes in psychotropic orders. If verbal, the nurse needs to mail consent for legal representative to sign."	F 154	F 154 Informed Consent for Psychotropic Medication is to be obtained prior to administration of medication. Verbal consent was initially obtained and written consent was subsequently obtained for R 68. Charts were audited facility wide for patients and residents on psychotropic medication to ensure all consents are in place. Consent form has been revised to allow opportunity to include multiple dosage change consent communications on the same form. To ensure consents are obtained timely the consulting pharmacist will review for consents on monthly drug reviews. In addition, psychotropic use will be reviewed at quarterly rehab rounds and again one week later at quarterly care conference. Findings of non-compliance will be brought to Quality Improvement for review and any further recommendations or interventions.	
F 225 SS=C	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have	F 225	Clinical Managers/DON/Consulting Pharmacist responsible. Completion Date 4-10-2012	

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F 225	Continued From page 2 been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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	F 225		

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F 225	Continued From page 3 facility failed to complete reference checks to screen for a history of abuse, neglect or mistreating residents for 3 of 5 new employees (nursing assistant (NA)-A, NA-B, and a dietary aid (DA)-A) whose files were reviewed for background and reference checks. That had the potential to affect all 103 residents who resided in the facility. Findings include: At 2:15 p.m. on 2/28/12, five new employee files were reviewed in the presence of the Director of Human Resources (DHR) for background and reference checks. NA-A was hired on 11/23/11, and had no reference check completed before hire. NA-B was hired on 12/9/11, and had no reference check completed before hire. DA-A was hired on 11/23/11, and had no reference checks completed before hire. During interview with DHR at 2:20 p.m. on 2/28/12, the DHR verified the reference checks were not completed before hire. DHR stated it was the facility's protocol to complete reference checks for new employees before hire. DHR further commented ultimately she was responsible to make sure all the reference checks were completed. The Staffing Coordinator (ST) was interviewed at 8:20 a.m. on 2/29/12. The ST explained NA-A completed orientation on 12/16/12. ST confirmed NA-A worked on all the floors in the facility, which	F 225	F225 3 missing reference checks have been completed. An audit was conducted on all new hires within the past year and any missing reference checks have been sent and or completed. HR will complete reference checks before creating an employee file. Quarterly audits will be done to ensure completion. Audit information will be shared with the Administrator. HR Manager responsible. Completion Date 4-10-2012	

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F 225	Continued From page 4 included both long term units on the lower level (LL), upper level (UL), and the transitional care unit (TCU) unit. Per ST, NA-A did not have an assigned group yet. Per ST, NA-B completed the orientation on 1/4/12, and was working mainly on the upper level, but picked up shifts on the other units also. The Director of food services was interviewed at 9:00 a.m. on 2/29/12, and stated DA-A served food on the TCU units, and also worked in the kitchen. The facility Vulnerable Adult Policy dated 11/11, indicated, "All potential employees will have reference checks before hire."	F 225		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete reference checks to screen for a history of abuse, neglect or mistreatment of the residents for 3 of 5 new employees: nursing assistant (NA)-A, NA-B, and a dietary aid (DA)-A whose files were reviewed for background and reference checks. In addition, the facility's abuse policy failed to include the results of all investigations will be reported to the administrator within five working days of the incident, and failed to clearly indicate all	F 226		

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F 226	Continued From page 5 allegations involving mistreatment, neglect or abuse will be reported immediately to the state agency (SA). That had the potential to affect all 103 residents who resided in the facility. Findings include: Reference checks: The facility did not complete reference checks for 3 of 5 employees before hire. At 2:15 p.m. on 2/28/12, five new employee files were reviewed in the presence of the Director of Human Resources (DHR) for background and reference checks. NA-A was hired on 11/23/11, and had no reference check completed before hire. NA-B was hired on 12/9/11, and had no reference check completed before hire. DA-A was hired on 11/23/11, and had no reference checks completed before hire. During interview with DHR at 2:20 p.m. on 2/28/12, the DHR verified the reference checks for above mentioned employees were not completed before hire. DHR stated it was the facility's protocol to complete reference checks before hire, and ultimately she was responsible to make sure all reference checks were completed. The Staffing Coordinator (ST) was interviewed at 8:20 a.m. on 2/29/12. The ST explained NA-A completed the orientation on 12/16/12, and worked on all the floors in the facility , which included both long term units on the lower level	F 226	F 226 As mentioned previously, missing reference checks have been completed. An audit was conducted on all new hires within the past year and any missing reference checks have been sent and or completed. HR will complete reference checks before creating an employee file. Quarterly audits will be done to ensure completion. Audit information will be shared with the Administrator. HR Manager responsible. Completion Date 4-10-2012	

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F 226	Continued From page 6 (LL), upper level (UL), and the transitional care unit (TCU) unit. Per ST, NA-A have not had an assigned group yet. Per ST, NA-B completed the orientation on 1/4/12, and was working mainly on the upper level, but picked up shifts on the other units also. The Director of food services was interviewed at 9:00 a.m. on 2/29/12, and stated DA-A served food on the TCU units, and also worked in the kitchen. The facility's Vulnerable Adult Policy dated 11/11, indicated, "All potential employees will have reference checks before hire". The facility did not complete the reference checks on the three newly hired staff. Results: The facility's abuse policy failed to include that the results of all investigations will be reported to the administrator and to SA within five working days of the incident. The facility's current Vulnerable Adult Policy with revision date 2/12, and the Vulnerable Adult Reporting and Investigation Procedure with revision date 11/11, were reviewed on 2/29/12. The facility's abuse policy failed to include that the results of all investigations will be reported to the administrator and to SA within five working days of the incident, and failed to clearly indicate that all allegations involving mistreatment, neglect or abuse will be reported immediately to the SA. The Vulnerable Adult policy indicated, "the director of nursing or designee shall be	F 226	F 226 The Vulnerable Adult Reporting and Investigation Policy has been revised to include immediate reporting of all allegations involving mistreatment, neglect or abuse to the SA as well as final investigative results reporting to Administrator and SA within 5 working days of the incident. All staff have been educated on the changes within this policy. Administrator and DON Responsible. Review of VA reports is conducted at the quarterly Quality Improvement for compliance and any resulting changes or recommendations. Completion Date 4-10-2012	

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F 226	Continued From page 7 responsible for immediately reporting and investigating any incidence of maltreatment to the appropriate community and licensing agencies and the administrator", the "Vulnerable Adult reporting and investigation procedure" indicated, "incidents that must be reported to MDH {Minnesota department of health}within 24 hours". There was no clear indication in the policies that all alleged violations must be reported immediately to the SA. During interview with the director of nursing (DON) and the Administrator (ADM) at 1:35 p.m. on 2/29/12, the ADM stated the updates regarding the results of the investigations were made to her verbally by the DON. The ADM verified the facility policies did not include the results of all investigations will be reported to the administrator and to SA within five working days of the incident, and that the policies were inconsistent regarding requirements for immediately reporting to SA.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279		

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F 279	Continued From page 8 highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a comprehensive care plan that identified the care and services provided to 1 of 1 resident (R159) reviewed in the sample in regards to dialysis services. Findings include: R159 was admitted to the facility on 1/19/12, with diagnoses that included end stage renal failure and diabetes. The comprehensive care plan dated 2/7/12, was void of any documentation in regards to dialysis services expect the nutritional care plan. The care plan dated 2/7/12, was reviewed and revealed there was no problems identified for dialysis services and there were no goals or interventions for any care areas except nutritional services. The care plan was divided into three columns; the first column identified the problem, the second column identified the goal, and the third column identified interventions. The care plan was void of any documentation expect the nutritional care plan. An interview was conducted with the clinical	F 279	F 279 A comprehensive care plan has been developed for R 159 inclusive of care and services in regard to dialysis. There are no other residents on dialysis at this time. Clinical Manager/DON will audit all charts of patients/residents receiving dialysis in the future to ensure care plan is completed. Results of the audits will be brought to the quarterly Quality Committee for any recommendations. Clinical Manager/DON responsible. Completion Date 4-10-2012	

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F 279	Continued From page 9 manager (CM)-C, who completed the care plan, at 10:35 a.m. on 3/1/12. The CM-C verified there were no problems identified, no goals specified and no interventions identified for any care areas except nutrition in regards to dialysis services. The CM-C acknowledged the care plan was not complete and did not include care and services in regards to dialysis.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a care plan that identified the care and services provided to one of one resident (R159) reviewed in the sample who received dialysis services. Findings include: The care plan was not developed for dialysis services and did not provide direction to the staff for care and treatment for R159. R159 was admitted to the facility on 1/19/12, with diagnoses that included end stage renal failure and diabetes.	F 309		

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F 309	Continued From page 10 The care plan dated 2/7/12, was reviewed and revealed there was no identification of problems, goals set or interventions for dialysis services. The nutritional services developed care plan was the only area that addressed dialysis. The care plan was divided into three columns; the first column identified the problem, the second column identified the goal, and the third column identified interventions. The care plan was void any documentation for dialysis expect the nutritional care plan. The care plan dated 2/7/12, identified R159's diagnoses of end stage renal failure, diabetes, lower extremity wounds, and deconditioning. The care plan failed to identify R159 received dialysis services, failed to identify where 159's port was located, failed to identify the care and services that was to be provided to R159 on a daily basis (to include check bruit and thrill), and failed to identify emergency procedures for staff. An interview was conducted with the licensed practical nurse (LPN)-C at 10:00 a.m. on 3/1/12. LPN-C indicated if she was gone for several days and came back to work, she would review the care plan, physician orders and talk to the nursing assistants to care for a resident that was new to the unit. The LPN-C identified the care plan, "should have everything on there" to care for the resident. An interview was conducted with the nurse case manager (CM)-B at 10:06 a.m. on 3/1/12. CM-B verified the care plan was not developed. An interview was conducted with CM-C, who completed the care plan, at 10:35 a.m. on 3/1/12,	F 309	F 309 As previously mentioned, a comprehensive care plan has been developed for R 159 inclusive of care and services in regard to dialysis. There are no other residents on dialysis at this time. Clinical Manager/DON will audit all charts of patients/residents receiving dialysis in the future to ensure care plan is completed. Results of the audits will be brought to the quarterly Quality Committee for any recommendations. Clinical Manager/DON responsible. Completion Date 4-10-2012	

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F 309	Continued From page 11 The CM-C identified dialysis needs would be addressed on the care plan under special medical conditions. When that section was reviewed with the CM-C, she verified the care plan did not identify R159 was on dialysis nor did it identify care and treatment for R159 in regards to dialysis. The CM-C acknowledged the entire care plan was not complete. The Dialysis Service Agreement policy dated 6/11, identified both the facility and the dialysis center will exchange information that will be useful and necessary for the care of the resident. That information will help in developing and coordinating that particular resident's plan of care.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		

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F 329	Continued From page 12 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to attempt a gradual dose reduction (GDR) related to the use of duplicative antipsychotic medications and the record lacked documentation to indicate why this would be contraindicated for 1 of 10 residents R104) reviewed for unnecessary medications. Findings include: R104 received psychotropic medications and lacked indications of why a GDR would be contraindicated. R104 had diagnoses which included dementia with anxiety, insomnia, and depression. The quarterly minimum data set (MDS) dated 12/30/11, indicated the resident had only behaviors not directed towards others, and had moderate depression. Review of the current physician's orders dated 1/5/12, indicated R104 received the same dose of Remeron (antidepressant) 30 milligram (mg) po (by mouth) daily at HS (in the evening) for depressive disorder, as well as Ativan (antianxiety) 0.5 mg po at HS for dementia with	F 329	F 329 The primary MD reviewed medical record of R 104 and concluded a GDR was contraindicated and made a chart note regarding this. The Consultant Pharmacist will review records of all patients/residents on psychotropic medications for appropriateness and need for a GDR. If GDR is indicated, a request will be made to the Practitioner. If no dose reduction is indicated, a recommendation will be sent to the Practitioner to address the ongoing need for psychotropic medications at current prescribed levels. The Interdisciplinary Team consisting of Consulting Pharmacist, Nursing and Social Services will review and audit patients/residents on psychotropic medications quarterly at care conference on an ongoing basis and make requests and recommendations for GDR as stated above. Results of the audits will be brought to the quarterly Quality Committee for any recommendations. Consulting Pharmacist responsible. Completion Date 4-10-2012	

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F 329	Continued From page 13 anxiety/ insomnia since 8/24/09. R104 also had order for Ativan 0.5 mg po once daily as needed. There was no indication in the medical record why a GDR attempt was not completed. The record lacked evidence as to why a GDR would be contraindicated. The physician and nurse practitioner's progress notes were reviewed. The notes had no documentation to indicate why a GDR would be contraindicated. The clinical manger (CM)-C was interviewed at 10:06 a.m. on 3/1/12. CM-C verified the lack of dose reduction and the lack of evidence to support the clinical indication for the continued use of the Ativan and Remeron. CM-C stated she relied on the CP's recommendations. The director of nursing (DON) was interviewed at 12:15 a.m. on 3/1/12. The DON stated the facility's practice was to have at least yearly GDR's for psychotropic medications, and if GDR was not appropriate, the physician supposed to document about it. The DON also stated the CP was in charge to review the resident's medications and to write recommendations. The Psychotropic Medication Monitoring policy dated 11/11, indicated, "Any unnecessary drugs being utilized require dosage reduction and /or documentation justifying its usage."	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		

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	245493	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 14 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility did not ensure the consultant pharmacist identified and reported irregularities to the attending physician and the director of nursing (DON) for 1 of 10 residents (R104) in the sample who were reviewed for unnecessary medications. Findings include: R104 had diagnoses which included dementia with anxiety, insomnia, and depression. R104 received psychotropic medications and lacked indications of why a GDR would be contraindicated. The pharmacist did not report the irregularity to the physician or the DON. Review of the current physician's orders, dated 1/5/12, indicated R104 received the same dose of Remeron (antidepressant) 30 milligram (mg) po (by mouth) daily at HS (in the evening) for depressive disorder, as well as Ativan (antianxiety) 0.5 mg po at HS for dementia with anxiety/ insomnia since 8/24/09. R104 also had order for Ativan 0.5 mg po once daily as needed. There was no evidence in the medical record that an attempt was made for gradual dose reduction (GDR), and the record lacked evidence to	F 428	F 428 The drug regimen of each patient/resident is reviewed once a month by the Consulting Pharmacist. As previously stated, the primary MD reviewed the medical record of R 104 and concluded a GDR was contraindicated and made a chart note regarding this. The Consultant Pharmacist will review records of all patients/residents on psychotropic medications for appropriateness and need for a GDR. If GDR is indicated, a request will be made to the Practitioner. If no dose reduction is indicated, a recommendation will be sent to the Practitioner to address the ongoing need for psychotropic medications at current prescribed levels.	

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F 428	Continued From page 15 Indicate why a GDR would be contraindicated. The physician and nurse practitioner's progress notes were reviewed. The notes lacked evidence to indicate why a GDR would be contraindicated. The monthly Pharmacist's Medication Regimen Review forms from 4/27/10, going forward were reviewed. There were no irregularities identified regarding Ativan and Remeron use. The last progress notes written by the Consultant Pharmacist (CP), dated 2/22/12, indicated, "Medication regimen review completed, no irregularities". The clinical manger (CM)-C was interviewed at 10:06 a.m. on 3/1/12. CM-C verified the lack of dose reduction and the lack of documentation to support the clinical indication for the continued use of the Ativan and Remeron. CM-C stated she relied on the CP's recommendations. The CP was interviewed at 11:30 a.m. on 3/1/12. The CP stated in her professional opinion R104 would have not benefit from dose reduction due to her old age, and therefore she did not request a GDR or the physician to document on why GDR was not recommended. The DON was interviewed at 12:15 a.m. on 3/1/12. The DON stated the facility's practice was to have at least yearly GDR's for psychotropic medications, and if GDR was not appropriate, the physician supposed to document about it. The DON also stated the CP was in charge to review the resident's medications and to write recommendations.	F 428	F 428 Cont'd The Interdisciplinary Team consisting of Consulting Pharmacist, Nursing and Social Services will review and audit patients/residents on psychotropic medications quarterly at care conference on an ongoing basis and make requests and recommendations for GDR as stated above. Results of the audits will be brought to the quarterly Quality Committee for any recommendations. Consulting Pharmacist responsible. Completion Date 4-10-2012	

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F 428	Continued From page 16 The Psychotropic Medication Monitoring policy dated 11/11, indicated, "Any unnecessary drugs being utilized require dosage reduction and /or documentation justifying its usage."	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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F 431	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document review, the facility failed to maintain secure storage of medications on 2 of 6 medication carts (the lower level north medication cart and the upper level north medication cart.) This had the potential to affect all 103 residents in the facility. Findings include: During the initial tour of the facility's lower level on 2/27/12, the facility did not ensure the medications carts were secured. The lower level north medication cart was left unlocked by licensed practical nurse (LPN)-A. LPN-A went to administer medications in the lower level north dining room at 12:12 p.m. on 2/27/12, and then went into a resident room at 12:22 p.m. At 12:38 p.m. LPN-A went down the east hallway to get a blood pressure cuff. During the observations several residents, non - nursing staff, and visitors were traversing the area at the time when the medication cart was unsecured. The unlocked medication cart was left unattended from 12:12 p.m. to 12:38 p.m. (26 minutes). The lower north unit was home to residents, some of whom held a diagnoses of varying degrees of dementia. The nurse manager (NM)-A confirmed the medication cart was unlocked and unattended at 12:39 p.m. on 2/27/12. The NM-A went over to lock the unattended north medication cart and	F 431	F 431 Nurses have all received education on the importance of securing medication carts. Random audits are being completed twice weekly for one month to ensure compliance and then spot checks will be done to maintain ongoing compliance. Results of the audits will be brought to the quarterly Quality Committee for any additional recommendations. Clinical Manager and DON responsible. Completion Date 4-10-2012	

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F 431	Continued From page 18 reminded LPN-A the medication cart needed to be locked when unattended. Additionally, a continuous observation was conducted on 2/28/12, at 12:43 p.m. on the upper level. The upper level north medication cart was observed to be unlocked and unattended from 12:43 p.m. to 1:05 p.m. (22 minutes). At 1:05 p.m. LPN-B locked the medication cart as she walked by it and was interviewed at that time. She stated normally they do keep the carts locked when unattended but she must have "forgotten today." During the observations several residents, non-nursing staff, and visitors were traversing the area at the time when the medication cart was unsecured. The upper north unit was home to residents, who were short term care. Both medication carts stored medications that were prescribed by the doctor, which included over-the-counter medications, narcotics, and medications of various classifications. The facility Medication Storage Policy dated 9/11, was obtained and reviewed at 2:45 p.m. on 2/29/12. The policy stated, "All medications must be stored in locked cabinets or carts."	F 431		

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	245493	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2012**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Augustana Chapel View Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 2-story split level building was determined to be of Type II(000) construction. It has a partial basement and is fully fire sprinkler protected. The facility 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 118 beds and had a census of 107 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is 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.