DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 16, 2023

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

RE: CCN: 245493
Cycle Start Date: September 19, 2023

Dear Administrator:

On September 28, 2023, we informed you that we may impose enforcement remedies.

On October 5, 2023, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 19, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 19, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 19, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 19, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Augustana Chapel View Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 19, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Nathan Schreier, 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: nate.schreier@state.mn.us
Office: (651) 201-4348 Mobile (651) 392-2726

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 March 19, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@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 10/05/2023

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

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E 000	Initial Comments On 10/2/23-10/5/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		11/15/23

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

Electronically Signed | 10/23/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

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E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure Emergency Power Supply System (EPSS) was tested per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.4, 8.3.4.1, 8.4.1, 8.4.9, 8.4.9.1, and 8.4.9.2. This had the potential to impact all residents who reside in the facility. Findings include: On 10/03/2023 between 09:30 AM and 12:45 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that the facility's Emergency Power Supply System (EPSS) was tested for at least four hours within the last 36 months. An interview with the Administrator and the Director of Maintenance verified this deficient finding at the time of discovery.	E 041	E041 Emergency Power It is the policy of Chapel View to comply with E041 It is the policy of Chapel View to comply with E041 Detailed description of the corrective action or planned to correct the deficiency: Emergency Power Supply System (EPSS) will be tested and a schedule maintained by maintenance director to assure testing including four-hour full load for every 36 months to maintain compliance for all required generator-testing schedules. After survey during contact with Cummins, generator contractor, to schedule said four-hour load test Cummins explained that they had completed a four-hour full load test of the generator on 3/2/2021, which results in us still complying with generator testing. Cummins report had incorrect email from Terry Bush, maintenance director at that time, so we never received the report in 2021. Copy of Cummins load test of 3/2/2021 was emailed to fire marshal Greg Hubbard. We are 32 months from last survey and will be scheduling four-hour full load generator test well before 3/2/2024. No residents were affected, due to generator 4-hour load test being completed within timeframe of regulations. Address measures that will be put in place to ensure the deficiency does not reoccur: A schedule will be maintained to assure testing of the EPSS to run for four hours every 36 months. This schedule will be	

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E 041	Continued From page 4	E 041	included in the Emergency Preparedness binder maintained by facility, and reviewed annually by the Administrator and Director of Maintenance for redundancy. How the facility plans to monitor future performance to ensure solutions are sustained: Generator testing results will be maintained and noted in a logbook kept in the maintenance director's office, with the schedule for the 4-hour test every 36 months maintained in the facility's Emergency Preparedness binder. Maintenance Staff, along with the administrator, will be re-educated on the need to maintain the generator-testing schedule and ensuring proper documentation is received from the generator contractor timely. Identify who is responsible for the corrective actions and monitoring of compliance: The maintenance director will be responsible for maintaining the generator testing schedules. Compliance with generator testing will be audited and brought to quarterly QAPI meetings to ensure continued compliance. Date for completion of the remedy: November 15, 2023	
F 000	INITIAL COMMENTS On 10/2/230-10/5/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		

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F 000	Continued From page 5 The following complaints were reviewed with NO deficiencies cited: H54936085C (MN95686) H54936065C (MN95165) H54936083C (MN94875) H54936068C (MN91733) H54936084C (MN85193) The following complaints were reviewed: H54936066C (MN96750) with a deficiency cited at F695. 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 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 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when	F 582		11/15/23

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F 582	Continued From page 6 changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 582		

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F 582	Continued From page 7 Based on interview and document review, the facility failed to ensure the required Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), was not provided to 1 of 3 residents (R111) who continued to reside in the facility upon termination of Medicare A benefits. Findings include: R111's SNFABN was requested but not received. Documentation review found R111's Notice of Medicare Non-Coverage (NOMNC) benefits were set to end 09/22/2023. R111 was made aware of this on 09/22/2023. R111's guardian was made aware of this via telephone on 09/20/2023. In neither instance, the SNFABN was not presented. Review of R111's electronic medical chart (EMR) confirmed that there was no documentation to contact R111's representative/guardian regarding the SNFABN. On 10/03/2023 at 02:21 p.m., Social worker (SS)-C stated R111 did not have a SNFABN due to being in foster care. SS-C stated communication with family representative was via email, as R111 doesn't "really talk". SS-C confirmed that SNFABN was not presented. Continued conversation with (SS)-C identified that there had been a facility staff miscommunication and that is why the SNFABN was not completed. SS-C stated that her role was to backup the normal staff who performs the SNFABN and NOMNC process. SS-C stated the normal process was whenever a last covered day is issued, notice is given to resident or representative, that they can choose to use a different pay source depending on the different	F 582	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. F582 Medicaid/Medicare Coverage/Liability Notice It is the policy of Chapel View to comply with F582. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Regarding cited resident R111: Resident R111 will have SNFABN signed upon guardians return to the country on or around 10/25/2023. How the facility will identify other residents having the potential to be affected by the same deficient practice: Audits were done of other residents remaining in the facility to ensure SNFABN was in place. Measures put into place to ensure deficient practice will not recur: Social Services staff were re-educated on the SNFABN policy to ensure proper understanding. Monitoring to ensure the deficient practice is corrected: Reimbursement nurse will be monitoring the process and keeping a log to ensure NOMNC/SNFABN process is complete on an ongoing basis. Log will be reviewed monthly by administrator with social services for first three months then quarterly thereafter with a goal of all being completed. Log results will be reviewed	

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F 582	Continued From page 8 insurance provider, and that this process normally isn't completed in a phone conversation. That form has information on how to appeal. SS-C further stated that the data for these forms are on the facility shared drive. The reason they process the SFNABN, is to ensure the information has been delivered, and that the resident or family representative understand the benefits. This is completed by social services in cooperation with the insurance nurse. In an interview on 10/4/23, the administrator stated staff contact the resident or family representative via telephone, voicemail, or in person. And that these attempts should be documented in the progress notes. This information is delivered so they understand the benefits. The documentation is completed by social services in cooperation with the insurance nurse. A facility policy titled Medicare Denial Notices revised 8/1/22 directed staff to inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services.	F 582	quarterly at QAPI meetings. Date deficiency corrected: November 15, 2023	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an	F 645		11/15/23

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F 645	Continued From page 9 independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the	F 645		

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F 645	Continued From page 10 condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a level I Pre-Admission Screening and Resident Review (PASRR) level I was completed and accurate prior to admission to the facility for 2 of 3 residents (R2, R22) reviewed for pre-admission screening (PAS). Findings include: R2's quarterly Minimum Data Set (MDS) dated 9/26/23, indicated R2 was moderately cognitively impaired and had diagnoses of dementia, anxiety disorder, depression, and psychotic disorder. R2's Initial Pre-Admission Screening assessment and corresponding letter from Senior LinkAge Line dated 7/13/18, indicated Senior LinkAge Line did not complete the PAS and forwarded the request to the county for completion.	F 645	F645 PRE-ADMISSION Screening and Resident Review (PASARR) It is the policy of Chapel View to comply with F645 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Current medical records for Resident R2 and R22 lacked evidence of a level I PAS during survey. Appropriate screens were obtained from former/old Matrix system and uploaded to current system. How the facility will identify other residents having the potential to be affected by the same deficient practice: Audits were conducted of all residents to ensure we have all appropriate Level I and II PAS screens in medical records. What measures/systems will be put into	

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F 645	Continued From page 11 R2's medical record lacked evidence a level I PAS was completed prior to admission to the facility. R22's quarterly MDS dated 7/25/23, indicated he was moderately cognitively impaired, and had diagnoses of seizure disorder and depression. R22's medical record lacked evidence a level I PAS was completed prior to admission to the facility. During interview on 10/5/23 at 9:58 a.m. director of admissions (DA) stated usually the hospital completed the pre-admission screenings and coordinated any required county assessments prior to admission, and he had never had to reach out to the county for this information. During interview on 10/5/23 at 10:18 a.m. director of nursing stated it was important to complete all aspects of the pre-admission screening process to ensure the resident is appropriate for the setting. The facility Preadmission Screening for Nursing Facility Admission Policies and Procedures dated 1/6/22, indicated the PAS was required for all people prior to entering the facility and was completed to identify and refer people to other professionals to evaluate the need for specialized mental health or developmental disability services	F 645	place to ensure that the deficient practice will not recur: Re-education has been given to admissions director and social workers to assure compliance and tracking log has been established and will be used on an ongoing basis. Back-up staff have been assigned to process in event of staff absence/vacation to assure ongoing practice stays in compliance. The admissions director requests from a health care professional seeking nursing facility admission for a potential resident the online Preadmission Screening (PAS) form. Preadmission screenings will be conducted and/or triaged to the appropriate lead agency by the Senior LinkAge Line to determine the need for Nursing Facility Level of care and to complete OBRA Level 1 screening. PAS assessments are uploaded to each resident's medical record by the admissions director who will be maintaining a log of request/completion activity. How the facility plans to monitor corrective action, ensure future performance is in compliance, and not recur: PAS initial assessments are uploaded to each resident's medical record by the admissions director and social services staff obtains Level II screens. All screening activity is recorded to facility tracking log, which will be reviewed monthly. PASARR completion will be audited by the administrator and brought to quarterly QAPI meetings to ensure continued compliance. Identify who is responsible for the corrective actions and monitoring of	

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F 645	Continued From page 12	F 645	compliance: admissions director is responsible for obtaining appropriate screenings and uploading them into the resident medical record within required deadline. Social services is responsible for secondary screens and administrator will monitor screening log each month for compliance. Medical records director will serve as a backup for absence/vacation of responsible staff. The actual or proposed date for completion of the remedy: November 15, 2023	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide oral care for 1 of 1 residents (R14) reviewed for activities of daily living for dependant residents. Findings include: R14's quarterly Minimum Data Set (MDS) dated 7/4/23, indicated R14 was moderately cognitively impaired, required assistance of one staff for oral care, had diagnoses of cerebral palsy, Parkinson's disease, lung disease, and received hospice services. The MDS indicated he did not refuse cares. R14's care plan dated 12/20/19, indicated R14	F 677	F677 ADL Care Provided for Dependent Residents-Oral Care It is the policy of Chapel View to comply with F677 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: R14 care plan was reviewed to ensure oral care was addressed and care plan was reviewed with primary care team. R14 passed at the facility on 10/16/2023. How the facility will identify other residents having the potential to be affected by the same deficient practice: Care plans of other dependent residents were reviewed	11/15/23

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F 677	Continued From page 13 had his own teeth and required set-up assistance and assist of one staff as needed for oral care. R14's dental Chart Progress Note dated 9/15/23, indicated he was at high risk for caries (cavities) and had an application of a decay-arresting product. He had moderate generalized gingivitis, tooth decay, moderate plaque, and should brush his teeth for two minutes twice daily focusing on the gumline. R14's Point of Care History identified R14 was dependent on staff for oral hygiene and was document once from 10/2/23 through 10/4/23. During observation and interview on 10/2/23 at 3:05 p.m., family member (FM)-A stated staff did not brush R14's teeth. R14's teeth were dark in color with black stains around the teeth and gumline. A dry basin containing a dry plastic cup and a partially used tube of toothpaste was in a wire basket attached to the wall next to the sink and covered with clear empty garbage bags, and no toothbrush or oral swabs were visible. During observation and interview on 10/3/23 at 2:47 p.m., R14 indicated staff did not help him brush his teeth that morning. R14's basin sat as it was the previous day, dry and undisturbed under the garbage bags. An electric toothbrush was on a stand on a table near the window. During interview on 10/3/23 at 6:39 p.m., R14 was lying in bed for the night and identified staff did not brush his teeth before going to bed. R14's basin sat as it was the previous day, dry and undisturbed under the garbage bags. During observation and interview on 10/4/23 at	F 677	to ensure care plan was reflective of dependent need. What measures will be put into place/changes made, to ensure that the deficient practice will not recur: Education is being provided to nursing department staff re: the oral care policy. Monitoring to ensure deficient practice is corrected and will not recur: There will be weekly audits of five residents dependent in oral care done every week for 3 months and then at random to ensure ongoing compliance. Nursing leadership will maintain audits/audit results which will be reviewed quarterly at QAPI meetings. Date of completion: November 15, 2023	

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F 677	Continued From page 14 8:15 a.m. R14 was seated at the dining table for breakfast. Upon review of R14's room, the contents of the wire shelf by the sink remained unchanged and in their same position as previous observations. R14's roommate was present and stated all those items belonged to R14, and he did not use that area to get ready as he could not reach it in his wheelchair. During interview on 10/4/23 at 1:21 p.m., R14 identified staff did not brush his teeth that morning. During interview on 10/4/23 at 1:32 p.m., NA-E stated R14 had an electric toothbrush stored on the table next to the window, and R14 usually wanted his teeth brushed after breakfast. They stated they thought they may have brushed R14's teeth the previous morning but did not that day because R14 declined. R14's basin sat as it was the previous day, dry and undisturbed under the garbage bags. During interview on 10/5/23 at 8:55 a.m. dental office representative staff stated R14 had a history of caries (dental cavities) and had a product applied to his teeth and gums to stop decay on 9/15/23. She stated the product temporarily stained the gumline and should fade in a couple of weeks. She stated brushing would not remove the stains, but oral care was still important to provide to prevent further decay. During interview on 10/5/23 at 9:07 a.m., nursing assistant (NA)-D stated they brushed R14's teeth that morning with morning cares. When asked where R14's toothbrush was, they went to R14's room and looked around the sink area, lifted the garbage bags, and reviewed the items in the wire	F 677		

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F 677	Continued From page 15 basket and could not locate his toothbrush. They were unaware it was stored on a table near the window. They then stated R14 usually used an oral swab, but NA-D could not find any oral swabs in the room. During interview on 10/5/23 at 9:36 a.m., director of nursing stated oral care should be completed during morning and evening cares to maintain healthy teeth, gums, and mucus membranes, but there was no required documentation unless a resident was in an MDS assessment period. Staff should notify the nurse if a resident refused cares, but R14 usually did not. The Oral Care policy reviewed 4/4/23, indicated residents will be provided oral care at least twice per day top prevent mucus membranes from becoming dry and cracked, prevent formation of oral sores, keep teeth and gums clean and health, and prevent halitosis (bad breath).	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		11/15/23

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F 690	Continued From page 16 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper catheter care and maintenance to reduce the risk of urinary tract infections (UTIs) for 2 of 2 (R27, R75) residents reviewed for catheters. Findings include: R75's admission Minimum Data Set (MDS) dated 7/26/23, indicated R75 was cognitively intact, required extensive physical assistance with most activities of daily living (ADL), and had an indwelling urinary catheter. R75's diagnoses included hemiplegia/hemiparesis (one sided weakness/paralysis) following cerebral infarction (stroke) affecting left non-dominant side, retention of urine, and acute kidney failure.	F 690	F690 Catheter Care and Maintenance It is the policy of Chapel View to comply with F690 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Cited resident R75 bag is being hung below the level of the bladder. The bed is in the low position so the bag is placed on a barrier surface to prevent contact with the floor. How the facility will identify other residents having the potential to be affected by the same deficient practice: Other residents with indwelling catheters were audited to ensure drainage bags were below the level of the bladder and that a barrier	

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F 690	Continued From page 17 R75's indwelling catheter care plan (CP) last reviewed 9/20/23, indicated R75 required and indwelling catheter related to urinary retention with a goal "resident will not exhibiting [sic] signs of urinary tract infection." The CP instructed staff to monitor urinary output every shift and provide catheter care twice a day and as needed. R75's resident profile document dated 9/28/23, indicated a new diagnosis of urinary tract infection. R75's hospital discharge summary dated 9/16/23, indicated R75 had a "Urinary tract infection associated with indwelling urethral catheter." The note indicated a clean catheter was placed and the urinalysis "clearly abnormal." During interview on 10/2/23 at 1:36 p.m., R75 stated she had to be hospitalized once due to urinary tract infection since admission to the facility. During observation and interview on 10/3/23 at 3:21 p.m., nursing assistant (NA)- A, and registered nurses (RN-A and RN-B) in to assist R75 back to bed using the Hoyer lift. Once tucked into bed, staff offered to remove her pants, but R75 declined. Staff left the room. R75's urine bag was not visible. R75 stated it was still attached to her leg under her pants and would only be placed on the side of her bed when her pants were removed. R75 was lying flat in bed with head of bed only slightly elevated. During observation and interview on 10/3/23 at 3:56 p.m., RN-A stated R75's leg bag should be hanging on the side of the bed to allow it to drain	F 690	surface was in place to prevent contact with the floor. Measures put into place to ensure deficient practice will not recur: Education is being provided to all nursing department staff regarding catheter care policy inclusive of donning gloves for any contact with catheter bag or tubing, drainage bags being placed below the level of the bladder and that drainage bags have a barrier surface to prevent contact with the floor. Monitoring to ensure deficient practice is corrected: Weekly audits of 5 residents with indwelling catheters will be done every week for 3 months and then random to ensure ongoing compliance. Audit results will be reviewed quarterly at QAPI meetings. F690 Catheter Care and Maintenance continued It is the policy of Chapel View to comply with F690 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Cited resident R27 received updated order to include catheter and balloon size, catheter bag changed to bed bag to facilitate placement below the level of the bladder. Actions to identify other potential residents affected: All residents with catheters had orders reviewed to ensure catheter and balloon size were included in the order. Other non-ambulatory residents were also changed to bed bags to facilitate placement below the level of the bladder.	

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F 690	Continued From page 18 properly. RN-A removed it from R75's leg and placed it on the side of the bed. RN-A stated the collection bag should be kept below the level of the bladder and if not, it can back up into the bladder and cause an infection. RN-A stated R75 had a history of UTIs. During interview with 10/3/23 at 4:33 p.m., RN-C stated a urine bag should always be below the level of the bladder and if it was at the level or above it could cause a UTI since the urine would not drain properly and could back up into the bladder. During observation and interview on 10/4/23 at 7:58 a.m., NA-B entered R75's room to offer a reposition and to sit up for breakfast. R75 declined stated they would wait for spouse to arrive. R75's urine bag was attached to the side of the bed and the bed was low. The urine bag was resting on towel on the floor. NA-B removed the towel and stated not sure why that was there as R75's bag was not known to leak. NA-B moved the urine bag to under the bed, raised the bed slightly leaving the bag and outlet (tap) resting on the floor without a barrier. During interview on 10/4/23 at 8:11 a.m., RN-D confirmed R75's urine leg bag was on the floor, and it should not be. RN-D stated that was an infection control issue and could potentially lead to a UTI. During interview on 10/4/23 at 8:13 a.m., nurse practitioner (NP)-A stated a urine collection leg bag should be below the level of the bladder and if not, it can impede urine drainage, can cause urine to back up and can be a contributing factor for a UTI. NP-A further stated the bag nor outlet	F 690	Measures put in place to ensure deficient practice does not recur: Education is being provided to all nursing department staff re: catheter care policy inclusive of donning gloves for any contact with catheter bag or tubing, drainage bags being placed below the level of the bladder and that drainage bags have a barrier surface to prevent contact with the floor. Monitoring to ensure deficient practice is corrected: Nursing leadership will schedule weekly audits of 5 residents with indwelling catheters will be done every week for 3 months and then at random to ensure ongoing compliance. Audit results will be reviewed quarterly at QAPI meetings. Date of deficiency completion: November 15, 2023	

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 10/05/2023

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F 690	Continued From page 19 should ever be placed on the ground for infection control purposes. During interview on 10/4/23 at 10:46 a.m., director of nursing (DON) stated a urine bag should be kept below the level of the bladder, however the leg bags that the facility used did contain an anti-flow back valve which would help prevent urine from backing up into the bladder. DON stated the bag should still be kept below the level of the bladder to promote urine drainage, and prevent stasis, or retention. DON stated a urine bag should not be on the floor without a barrier for proper infection control practice. Facility policy Urinary Indwelling Catheter Insertion and Management last reviewed 4/14/23, indicated, "When a catheter is needed the aim of nursing care is to prevent catheter-associated urinary tract infections." The policy further indicated, "Be sure the catheter tubing and drainage bag are kept off the floor." The policy indicated a catheter bag should be always positioned lower than the bladder to prevent urine in the tubing and bag from flowing back into the bladder, unless equipped with an anti-reflux valve. Based on observation, interview, and document review, the facility failed to ensure appropriate management of an indwelling catheter was provided to minimize risk of infection for 1 of 1 resident (R27) reviewed for indwelling catheters. Finding include: R27's quarterly Minimum Data Set (MDS) dated 08/01/23, identified R27 has an indwelling catheter, had an unsuccessful trial voiding	F 690		

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F 690	Continued From page 20 attempt and always incontinent of bowel. The MDS also identified that R27 has severe cognitive impairment and has a neuromuscular dysfunction of bladder, unspecified. R27's Care Area Assessment (CAA) dated 5/02/23. indicated R27's has an indwelling catheter in place with related to neurogenic bladder. R27 was dependent on staff for all indwelling catheter management. R27 did not have a toileting program. R27's care plan revised 9/19/23, identified R27 as always incontinent of bowel and has an indwelling catheter. R27 was at risk for urinary tract infection (UTI) related to dementia, history of UTI, and indwelling catheter. R27's care plan indicated R27's catheter to be changed monthly, the catheter drainage bag to be changed twice monthly unless otherwise indicated by the attending physician or designee. R27's provider order dated 5/24/23, indicated R27 required catheter changes monthly and as needed. Furthermore, R27's order lacked indication of R27's catheter or balloon size. During a continuous observation on 10/04/23 at 7:03 a.m., nursing assistant (NA)-C was performing morning cares for R27. R27 was lying in bed with her catheter bag placed on the bed next to her with approximately 100 cubic centimeters (cc) of clear, yellow urine in the collection bag and a small amount of urine in the drainage tubing. After incontinent cares were completed, NA-C left the room. R27's catheter bag was still lying on the bed. At 7:13 a.m., NA-C returned with towels and continued to assist R27 with morning cares. NA-C left R37's room to	F 690		

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F 690	Continued From page 21 obtain supplies for R27's catheter and left the catheter bag lying on the bed. At 7:22 a.m., NA-C returned. Without donning gloves, NA-C moved and adjusted R27's catheter tubing around and applied a catheter securing device. NA-C then assisted R27 with dressing. Without donning gloves, NA-C threaded R27's catheter bag & tubing through pant leg and placed back on R27's bed. Without donning gloves, NA-C then removed bag hanger from catheter and used elastic straps to attach catheter drainage bag to R27's left lower leg. NA-C assisted R27 to place the lift sling underneath and left to get help. At 7:43 a.m., NA-C returned with NA-F and assisted R27 into the wheelchair. At this time R27's catheter bag was now positioned to facilitate draining. An interview on 10/02/23 at 11:39 a.m., family member (FM)-B stated R27 was recently sent to the ER due to the catheter not being switched out frequently. FM-B also stated that no one oversees changing the catheter, that it's up to the nurse. FM-B stated R27 was more "off" than usual and that the facility did some tests that were positive, and a second urine culture was negative. FM-B stated that R27 has a history of Alzheimer's and that current symptoms of previous UTI's left her unable to make decisions and that the last UTI was "really bad". When interviewed on 10/4/23 at 7:25 a.m., NA-C stated gloves were not needed when handling or adjusting a residents' catheters. NA-C further explained the catheter and tubing was clean as R27 just came from the shower. Furthermore, NA-C acknowledged R27's catheter was placed on the bed during cares and further stated catheter drainage bags should be hung below the	F 690		

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F 690	Continued From page 22 kidneys to help drain the urine. When interviewed on 10/04/23 at 8:00 a.m., licensed practical nurse (LPN)-C stated the provider ordered how often catheter changes were needed and the order gave the catheter size. LPN-C checked R27's order and verified the size of the catheter was not listed in the current orders. LPN-C stated staff needed to verify the catheter size from the provider before changing. LPN-C stated R27's catheter bag should be hung on the side of bed when R27 was in bed so the urine can drain to gravity. If the bag is on the bed, it might not drain and might slow it down or not drain. LPC-C further stated if the catheter was not draining well, it can lead to urinary infection. When interviewed on 10/4/23 at 9:12 a.m., registered nurse manager (RN)-G stated the leg bags had to hang off the bed so the urine drained and did not back up. Furthermore, gloves should be worn when touching or moving the catheter to prevent risk of infection. (RN)-G also stated that unless a provider writes an order to change the catheter, it is changed monthly. There should be an order for catheter size. Sometimes when changing the order they might click (the computer) and it might disappear. If you can't find the order, you go with the size the resident currently has. The catheter needs to be changed when the urine is cloudy, it's not draining, or not patent change per standing order (SO)." When interviewed 10/4/23 at 10:46 a.m., the Director of Nursing (DON) stated an order was needed for individualized catheter changes that should state the catheter size, change frequency, and catheter cares. The DON also stated that the	F 690		

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F 690	Continued From page 23 urine collection bag should below the bladder. That the facility urine collection bags have the anti-flowback valve, but that the bag should still be below the bladder as it could cause an infection. Staff are expected to wear gloves when there was potential contact with bodily fluids. A facility policy titled Urinary Indwelling Catheter Insertion and Management revised 4/29/22, directed staff to provide care to prevent catheter associated UTIs. The policy also directed staff to ensure the urinary drainage bag was always positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder, unless the system is equipped with an anti-reflux valve. The policy further states that the tubing placement allows for an unobstructed downward flow.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to administer oxygen in accordance with the provider orders for 1 of 1 residents (R14) reviewed for respiratory care. Findings include:	F 695	F695 Respiratory Care It is the policy of Chapel View to comply with F695 How corrective action will be accomplished for those residents found to have been affected by the deficient	11/15/23

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F 695	Continued From page 24 R14's quarterly Minimum Data Set (MDS) dated 7/4/23, indicated R14 was moderately cognitively impaired, had diagnoses of lung disease, cerebral palsy, and Parkinson's disease, and was on hospice. The MDS did not indicate R14 used oxygen (O2) therapy. R14's care plan dated 12/20/19 included administer oxygen at 1 to 4 LPM via nasal cannula to keep sats (saturation - blood oxygenation level) greater than 89 percent. R14's Physician Order Report dated 10/4/23, included the following: - Continuous oxygen at 2 liters per minute (LPM) per nasal cannula unless resident requests not to wear starting 4/23/13, discontinued 9/25/23. - Continuous oxygen at 3 LPM per nasal cannula unless resident requests not to wear starting 9/25/23. - Nurse ensure oxygen is 2 liters after giving 1:00 p.m. Ativan (antianxiety medication which can cause drowsiness). The order included "Oxygen usually forgotten and not turned on." Starting 8/15/23 and discontinued 10/3/23. - Nurse to ensure oxygen is 2 LPM after giving 1:00 p.m. Ativan starting 10/3/23. During observation and interview on 10/2/23 at 3:05 p.m., family member (FM)-A stated the aides did not remember to turn on R14's oxygen when transferring from the portable unit to the large oxygen canister and back again, and the oxygen vendor came in the previous month and both tanks were empty. A hand-written sign was on the wall above R14's bed reminding staff to ensure R14's oxygen was always on.	F 695	practice: Cited resident R14 oxygen use was assessed during survey and delivered as ordered. Resident passed at facility on 10/16/2023. Oxygen orders were reviewed with hospice posthumously for clarification and to prevent further recurrence. Actions to identify other potential residents affected: Other residents with continuous oxygen use have been reviewed to ensure orders are clear and appropriate. Measures put into place to ensure deficient practice does not recur: Nursing department staff are being re-educated on oxygen administration policy including the need to transfer tubing from standard tank to portable tank and the need to ensure flow rate is accurate and tank is on, to ensure portable tanks have sufficient supply, tubing must not be allowed to touch floor and if it does it must be cleansed with alcohol swab. Monitoring to ensure deficient practice is corrected: Nursing leadership will conduct weekly audits of 5 residents with continuous oxygen will be done every other week for 3 months and then randomly to ensure ongoing compliance for all residents on continuous oxygen. Audit results will be reviewed quarterly at QAPI meetings. Date of deficiency completion: November 15, 2023	

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F 695	Continued From page 25 During observation on 10/3/23 at 5:35 p.m., R14 was seated at the dining table wearing his oxygen cannula with a portable oxygen unit on the back of his chair set at 2 LPM. During observation and interview on 10/3/23 at 6:39 p.m., R14 was laying in his bed toward his right side with his head off his pillow coughing and wearing his oxygen tubing connected to a large oxygen tank which was turned off. Registered nurse (RN)-C entered the room, noted the coughing, repositioned R14 on his pillow, and elevated the head of the bed. RN-C stated R14 had his oxygen tubing on, and RN-C was going to ask RN-G if R14 was scheduled to receive a breathing treatment. At 6:43 p.m. RN-C and RN-G returned. R14 stated he was not feeling well, and RN-G stated R14 already had his breathing treatment. RN-G identified R14's oxygen tank was not turned on and set it to 2 LPM. RN-G stated aides could change a residents oxygen source from one to another and called a nurse to check it. They stated R14 was on oxygen for comfort as he was on hospice. R14 stated he was having a little trouble breathing and RN-G left the room and returned to check R14's O2 sats. R14's first reading was 85%, and a subsequent reading one minute later was 94%. During interview on 10/3/23 at 6:51 p.m., RN-C stated when aides transferred residents to and from bed they left the resident on the original oxygen source and called the nurse to change it. During interview on 10/3/23 at 6:52 p.m., RN-E stated usually the nurse changed the oxygen source but sometimes the aides did it and called the nurse to check to make sure it was at the right level. RN-E stated they were on break and	F 695		

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F 695	Continued From page 26 did not check R14's oxygen tank and thought another staff person checked it. During interview on 10/3/23 at 7:08 p.m., nursing assistant (NA)-G stated NA-H assisted them with transferring R14 to bed after dinner. NA-G identified the nurse usually changed the oxygen source when a resident was transferred, but NA-H changed it at that time. During interview on 10/3/23 at 7:13 p.m., NA-H stated they helped transfer R14 to bed but did not touch his oxygen. During observation on 10/4/23 at 8:19 a.m., R14 was eating breakfast in the dining room wearing his oxygen cannula. The portable oxygen tank was set at 2 LPM. During interview on 10/4/23 at 9:21 a.m., RN-H stated R14's orders included O2 at 3 LPM continuous, and nurses checked the tanks during the day. During interview on 10/4/23 at 1:32 p.m., NA-E stated they change R14's oxygen from the large tank to the portable unit when R14 got out of bed in the morning and set it a 3 LPM, but it used to be 2 LPM. During interview on 10/5/23 at 9:36 a.m., director of nursing (DON) stated oxygen orders, including the flow rate, should be followed, and staff should check to ensure the oxygen sources are turned on and flowing and respiratory status should be monitored to ensure resident O2 sats did not drop. The 'Oxygen, portable liquid tanks' policy	F 695		

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F 695	Continued From page 27 reviewed 10/17/22, indicated oxygen should be turned to the prescribed flow rate. Licensed nurses and trained medication aides can adjust or initiate oxygen per orders. NAs are not allowed to adjust the flow rate for oxygen. NAs may switch a resident from one oxygen source to another if they do not adjust the liter flow.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess the resident for risk of entrapment, review risks and benefits of bed rails with the resident or their representative,	F 700	F700 Bedrails It is the policy of Chapel View to comply with F700 How corrective action will be	11/15/23

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F 700	Continued From page 28 and obtain informed consent for 1 of 1 residents (R21) reviewed for bilaterial grab bars on their bed. Findings include: R21's quarterly Minimum Data Set (MDS) dated 9/12/23, identified R21 had severe cognitive impairment and no rejection of cares. R21 required extensive assistance with 1 to 2 persons with bed mobility, transfers, dressing, and toilet use. R21's diagnoses included hemiplegia or hemiparesis (complete or partial loss of muscle function on one side of the body) and seizure disorder or epilepsy (sudden, uncontrolled burst of electrical activity in the brain that causes temporary abnormalities in muscle tone or movements, behaviors, sensations or states of awareness). R21's care plan problem dated 2/29/16, identified 21's potential decline in ability to participate in bed mobility. R21's bed mobility/range of motion approach dated 10/6/20, identified use of two grab bars. The Comprehensive Nursing Observation-Includes Braden Scale Observation Information dated 6/5/22, 9/7/22, 12/7/22 and 3/8/23, did not identify nor assess R21's use of grab bars. The Device-Equipment Observation Information dated 6/9/23 and 9/7/23, did not identify nor assess R21's use of grab bars. During observation on 10/2/23 at 2:10 p.m., R21 had bilateral grab bars on their bed. During interview on 10/4/23 at 9:55 a.m., nursing	F 700	accomplished for those residents found to have been affected by the deficient practice: Cited resident R21 Device Observation was updated to include bilateral side rails and consent was obtained. Actions to identify other potential affected residents: Audit of grab bar use was conducted and process is in place to correct all missing pieces by 11/6/2023. Measures put into place to ensure deficient practice does not recur: Education is being provided to all nursing and therapy staff for assessing, installing and monitoring the application of Grab Bars. Monitoring to ensure deficient practice is corrected: Nursing leadership will conduct weekly audits of 5 residents with grab bars and will be done every other week for 3 months and then randomly to ensure ongoing compliance. Audit results will be reviewed quarterly at QAPI meetings. A log will be maintained to track grab bar use to ensure compliance and ongoing use of grab bars. Date of deficiency correction: November 15, 2023	

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F 700	Continued From page 29 assistant (NA)-J stated R21 used the grab bars during cares and repositioning. During interview on 10/4/23 at 11:08 a.m., registered nurse (RN)-I stated the facility had an assessment for grab bars which had to be completed to make sure residents needed the grab bars or to determine if grab bars were not needed. During interview on 10/5/23 at 9:29 a.m., RN-G stated therapy evaluated and recommended residents to have grab bars. Nursing then evaluated the residents to see if they were able to use the grab bars appropriately and obtained resident and/or responsible party consent. RN-G stated grab bars were evaluated during quarterly and annual assessments. RN-G reviewed the Device-Equipment Observation Information dated 9/7/23 and stated the assessment did not show grab bars were assessed for R21. During interview on 10/5/23 at 12:39 p.m., the director of nursing (DON) stated therapy noted residents who may benefit from grab bars, then nursing completed a device assessment. If appropriate after the nursing assessment, nursing obtained consent from the resident and/or responsible party. Device assessments were expected to be completed during admission, quarterly, annually, and with new devices. The DON reviewed the Device-Equipment Observation Information dated 6/9/23 and stated R21's wheelchair and lift use were marked as assessed but not R21's bilateral grab bars. The Quarterly Nursing Observation- Includes Braden Scale Observation Information dated 3/8/23 was reviewed and bilateral grab bars were not marked as assessed.	F 700		

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(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 700	Continued From page 30 The facility's policy SNF-Side Rail/Grab Bar Inspection Overall Process reviewed 4/13/23, identified clinical staff will do routine audits of those with side rails/grab or assist rails and will document the results of these audits on the designated audit tool form.	F 700		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		11/15/23

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	245493	A. BUILDING _____ B. WING _____	C 10/05/2023

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F 880	Continued From page 31 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: INFECTIOUS DISEASE SURVEILLANCE	F 880	F880 Infection Control and Prevention Surveillance	

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F 880	Continued From page 32 Based on observation, interview, and document review, the facility failed to implement an ongoing surveillance program for infectious disease tracking of new admissions that could affect all 90 residents and all staff at the facility, ensured hand hygiene and infection control was completed for 2 of 3 resident (R27 & R46) observed for incontinent cares and hand hygiene was completed during catheter cares to minimal risk of infection for 1of 1 residents (R27) reviewed for infection control practices. During an interview on 10/4/23 at 12:33 p.m., the facility infection preventionist (IP) stated the facility conducts infection surveillance for tracking and trending infections via spreadsheets. The IP further stated that the facility does not keep track of the active infections of new admissions, only the residents that develop an infection while residing at the facility. Review of monthly facility infection surveillance spreadsheets from January 2023 through September 2023 lacked documentation of any infections of new admissions, including all community-acquired infections. During an interview on 10/5/23 at 9:22 a.m., the director of nursing (DON) stated it was the practice of the facility to only log infections that were acquired in-house. DON further stated there was no method the facility used to log infections of their new admissions. A facility policy titled "Surveillance, infection" dated 11/13/18 indicated the facility would have an ongoing system of surveillance to assist in identification of possible communicable diseases or infections before they can spread to other	F 880	It is the policy of Chapel View to comply with F880. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Chapel does have a program for infection control prevention including surveillance, however, residents admitted to the facility with infections were not being tracked. To correct this area infections going back 30 days were added to the surveillance log. Moving forward newly admitted residents continue to be added. Measures put into place to ensure deficient practice does not recur: Infection Control Practitioner has reviewed regulations for this area to ensure compliance. Measures to ensure deficient practice is correct: A monthly audit of the infection log will be done by director of nursing or designee. Audit results will be reviewed quarterly at QAPI meetings. F880 Infection Control Handwashing It is the policy of Chapel View to comply with F880 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Cited resident R46 Primary NA-R involved in this observation received re-education and return demonstration to ensure appropriate technique. Actions to identify other potential affected residents: Re-education on handwashing is being done with all nursing department staff. Measures put into place to ensure	

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F 880	Continued From page 33 people in the facility. The policy further indicated the infection report would be completed by the IP (or designee) each month and surveillance would include infection data on all body sites. HANDWASHING Findings include: R27's quarterly Minimum Data Set (MDS) dated 08/01/23, identified R27 has an indwelling catheter and history of urinary tract infections (UTI). The MDS also identified that R27 has severe cognitive impairment. R27's care plan revised 9/19/23, identified R27 as always incontinent of bowel and has an indwelling catheter. R27 was at risk for urinary tract infection (UTI) related to dementia, history of UTI, and indwelling catheter. R27's care plan indicated R27's catheter to be changed monthly, the catheter drainage bag to be changed twice monthly unless otherwise indicated by the attending physician or designee. During a continuous observation on 10/04/23 at 7:03 a.m., nursing assistant (NA)-C was wearing gloves and repositioned R27's catheter bag and tube which was lying on the bed. NA-C performed peri care for soiled brief. R27 was assisted to her side and NA-C obtained a wet washcloths to clean R27 who had been incontinent of bowel. Without glove removal or hand hygiene, NA-C left R27's bedside, moving the hoyer lift and R27's bedside table to get to the sink. NA-C turned on the water to wet the washcloth and proceeded back to cleaning R27. NA-C then removed R27's soiled brief and placed it in a garbage bag. Without removing gloves and performing hand hygiene, NA-C placed and	F 880	deficient practice does not recur: Infection control nurse will conduct Weekly audits of 5 episodes of handwashing for 3 months and then at random to ensure ongoing compliance. Audit results will be shared quarterly with QAPI committee. Date of deficiency correction: November 15, 2023	

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F 880	Continued From page 34 fastened R27's clean brief and gave R27 the call light. NA-C removed their right glove and washed the right hand while holding the soiled linen bag in left hand and left R27's room. At 7:13 a.m., NA-C returned to R27's room with fresh towels. NA-C washed hands and moved call light away from R-27. NA-C applied lotion to feet without donning gloves. Without donning gloves or performing hand hygiene, NA-C then adjusted R27's catheter tubing. At 7:22 a.m., NA-C return to room, washed hands and without donning gloves moved and adjusted R27's catheter tubing and applied a catheter securing device to R27's leg. NA-C obtained R27's pants and without donning gloves or performing hand hygiene, NA-C threaded R27's catheter bag & tubing through pant leg and placed back on R27's bed. Without donning gloves or doing hand hygiene, NA-C then removed bag hanger from catheter and used elastic straps to attach catheter drainage bag to R27's left lower leg. NA-C positioned the resident lift under R27 and gave R27 the call light. NA-C put on gloves picked up laundry bag and put bath & bed linens in bag, removed one glove, picked up hairbrush from floor with ungloved hand and threw in trash. Without hand hygiene, NA-C left room with dirty linens, carrying in gloved hand. At 7:43 a.m., NA-C returned with NA-F and assisted R27 into the wheelchair. NA-C did not perform hand hygiene or don gloves; NA-F washed hands and put on gloves. NA-C proceeded to remove remaining of bed linens and bag them for laundry without washing hands or donning gloves. NA-C removed sling from under R-27 and finished stripping bed. NA-C moved tray table, gave R-27 a stuffed animal without performing hand hygiene. NA-C unwrapped	F 880		

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F 880	Continued From page 35 toothbrush, placed on tray table and removed lift from R27's room. At 7:58 a.m., NA-C returned to room and did not perform hand hygiene. NA-C brought basin and placed onto tray table, washed hands, and wiped faucet handles. NA-C put toothpaste on toothbrush and gave to R27; then filled water cup. NA-C rinsed basin, toothbrush, and cup. NA-C rearranged R27 hair with bare hand and left room. An interview with NA-C at 10/04/23 8:04 a.m., NA-C stated gloves were not needed when handling or adjusting a residents' catheters. NA-C further explained the catheter and tubing was clean as R27 just came from the shower. "We don't need gloves when handling catheter tubing". Normal hand hygiene during peri care are to leave gloves on till done unless visibly soiled. When interviewed on 10/4/23 at 9:12 a.m., registered nurse (RN)-G stated gloves should be worn when touching or moving the catheter to prevent risk of infection. That staff are to wash hands between cares and before/after cares. They are to wear gloves during procedures. Gloves are needed when handling catheter due to prevent infections. During incontinence cares going from dirty to clean should change gloves. When interviewed 10/4/23 at 10:46 a.m., the Director of Nursing (DON) stated an order was needed for individualized catheter changes that should state the catheter size, change frequency, and catheter cares. Staff are expected to wear gloves when there was potential contact with bodily fluids. HANDWASHING Findings include:	F 880		

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F 880	Continued From page 36 R46's quarterly Minimum Data Set (MDS) dated 9/12/23, identified R46 never/rarely made decisions and had inattention and disorganized thinking. R46 did not reject cares. R46 required total assistance with all activities of daily living, which included bed mobility and toilet use. R46 was incontinent of bowel and bladder. Diagnoses included Parkinson's disease. During observation on 10/4/23 at 8:11 a.m., nursing assistant (NA)-I assisted R46 with peri-cares. NA-I had gloved hands, unfastened R46's incontinent product, washed R46's peri-area and bottom, and removed R46's incontinent product. With the same gloves, NA-I applied R46's clean incontinent product. NA-I removed gloves, repositioned R46, and then washed their hands. During interview on 10/4/23 at 8:30 a.m., NA-I stated they should wash their hands and change their gloves right away after assisting residents with peri-cares. NA-I stated R46 may have had an incontinent episode on the bed if they had washed their hands and changed their gloves before applying R46's incontinent product. The facility's policy Hand Hygiene reviewed 7/24/23, directed staff to perform hand hygiene before and after providing care to resident, after removing gloves, after resident contact, and after handling dressings, catheters, bed pans, specimens or urine.	F 880		

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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 10/03/2023. At the time of this survey, Augustana Chapel View Care Center was found not 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, Health Care Facilities Code. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 10/23/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 100 beds and had a census of 90 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.1,7 and 7.2.1.5.10.1. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 10/03/2023 between 09:30 AM and 12:45 PM, it was revealed by observation that the keypad used to unlock the front exit door after hours was mounted higher than the maximum 48". An interview with the Administrator and the Director of Maintenance verified this deficient finding at the time of discovery.	K 211	POC Life Safety This Plan of Correction constitutes my 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. K211 Means of Egress Detailed description of the corrective action or planned to correct the deficiency: We have contacted a contractor to lower the exit door keypads to be lower than 48 high. Address measures that will be put in place to ensure the deficiency does not reoccur: Exit keypads will be maintained at a	11/30/23

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K 211	Continued From page 3	K 211	height of less than 48 maximum height. How the facility plans to monitor future performance to ensure solutions are sustained: Going forward for any new keypad exit door releases we will ensure that the keypad is installed below a height of 48 Identify who is responsible for the corrective actions and monitoring of compliance: The maintenance director and administrator will be responsible for the corrective actions and monitoring of compliance The actual or proposed date for completion of the remedy: November 30, 2023	
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell access per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, 19.2.2.2.5.2, and 7.2.1.5.10.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 225	K225 Stairways and Smokeproof Enclosures Detailed description of the corrective action or planned to correct the deficiency: We have reviewed all keypads used to unlock doors into emergency exit stairwells and will be getting them lowered below the 48 maximum height	11/30/23

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K 225	Continued From page 4 On 10/03/2023 between 09:30 AM and 12:45 PM, it was revealed by observation that the keypads used to unlock the doors into the emergency exit stairwells were mounted higher than the maximum 48". An interview with the Administrator and the Director of Maintenance verified this deficient finding at the time of discovery.	K 225	Address measures that will be put in place to ensure the deficiency does not reoccur: All keypad work on exits will be maintained at a height of less than 48 How the facility plans to monitor future performance to ensure solutions are sustained: All keypad work will be monitored and maintained to ensure a height of less than 48 Identify who is responsible for the corrective actions and monitoring of compliance: The maintenance director and administrator will be responsible for the corrective actions and monitoring compliance. The actual or proposed date for completion of the remedy: Given the number of keypads that we have to move we estimate the time needed to correct this deficiency will be November 30, 2023.	
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	K 293		11/30/23

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K 293	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain exit signs per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.10.1, 7.10.5.1, and 7.10.5.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/03/2023 between 09:30 AM and 12:45 PM, it was revealed by observation that the exit sign at the bottom of the south stairwell was not illuminated. An interview with the Administrator and the Director of Maintenance verified this deficient finding at the time of discovery.	K 293	K293 Exit Signage Detailed description of the corrective action or planned to correct the deficiency: We are replacing the light in the exit sign at the bottom of the south stairwell Address measures that will be put in place to ensure the deficiency does not reoccur: All exit lights have been reviewed to assure exit lights are always illuminated How the facility plans to monitor future performance to ensure solutions are sustained: Exit light monitoring has been put on a preventative maintenance program to monitor exit lights each month Identify who is responsible for the corrective actions and monitoring of compliance: The director of maintenance is responsible for monitoring compliance with exit lights The actual or proposed date for completion of the remedy: November 30, 2023	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking	K 324		11/24/23

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 _____	**10/03/2023**

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

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K 324	Continued From page 6 Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9) and 19.3.2.5.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/03/2023 between 09:30 AM and 12:45 PM, it was revealed by observation that the lockout device that is installed on the stove in the physical therapy office did not incorporate a timer.	K 324	K324 Cooking Facilities Detailed description of the corrective action or planned to correct the deficiency: A timer was incorporated into the lockout device for the stove in the therapy kitchen Address measures that will be put in place to ensure the deficiency does not reoccur: The therapy stove and timer will be maintained for compliance. How the facility plans to monitor future performance to ensure solutions are sustained: Therapy and maintenance staff will	

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	245493	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/03/2023**

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K 324	Continued From page 7 An interview with the Administrator and the Director of Maintenance verified this deficient finding at the time of discovery.	K 324	monitor stove use and timer to assure a safe area for residents Identify who is responsible for the corrective actions and monitoring of compliance: The maintenance director and therapy manager are responsible for making sure stove shutoff timer is working The actual or proposed date for completion of the remedy: November 24, 2023	
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 and 9.6.1.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.2.1.1.1, 14.2.1.1.2, 14.4.2.2, 14.4.5, 14.4.5.5, 14.4.5.5.1,14.4.5.5.2, 14.4.5.5.3, 14.4.5.5.4, 14.6.2.2, and 14.6.2.4. These deficient findings could have a widespread impact on the residents within the facility.	K 345	K345 Fire Alarm System Detailed description of the corrective action or planned to correct the deficiency: We are making sure that heat detectors, loop resistance for all fixed-temperature, line-type heat detectors are tested appropriately. In addition, annual documentation for fire alarm testing will a count of smoke detectors that were tested.	11/30/23

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	245493	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/03/2023**

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K 345	Continued From page 8 Findings include: 1. On 10/03/2023 between 09:30 AM and 12:45 PM, it was revealed by a review of available documentation that the heat detectors were not being tested and the loop resistance for all fixed-temperature, line-type heat detectors wasn't being tested. 2. On 10/03/2023 between 09:30 AM and 12:45 PM, it was revealed by a review of available documentation that the documentation that was provided for the annual fire alarm testing did not include smoke detectors and a count of what devices were tested. An interview with the Administrator and the Director of Maintenance verified these deficient findings at the time of discovery.	K 345	Address measures that will be put in place to ensure the deficiency does not reoccur: The format for annual fire alarm testing will include heat detectors, loop resistance for all fixed-temperature, line-type heat detectors are tested appropriately. In addition, annual documentation for fire alarm testing will include smoke detectors with a count of what devices were tested. How the facility plans to monitor future performance to ensure solutions are sustained: Fire alarm testing will be monitored to assure appropriate testing and counts are in place including smoke detectors. Identify who is responsible for the corrective actions and monitoring of compliance: The maintenance director is responsible for making sure alarm testing is completed and monitoring for compliance. The actual or proposed date for completion of the remedy: November 30, 2023	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked	K 353		11/24/23

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	245493	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/03/2023**

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K 353	Continued From page 9 b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/03/2023 between 09:30 AM and 12:45 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation for a quarterly sprinkler inspection being completed during the second quarter of 2023. An interview with the Administrator and the Director of Maintenance verified this deficient finding at the time of discovery.	K 353	K353 Sprinkler System □ Maintenance and Testing Detailed description of the corrective action or planned to correct the deficiency: A template will be used to assure that there is a quarterly sprinkler inspection being completed during each quarter of every year. Address measures that will be put into place to ensure the deficiency does not reoccur: A template with quarterly accountability for sprinkler inspections will be utilized to assure compliance How the facility plans to monitor future performance to ensure solutions are sustained: Quarterly sprinkler inspections will be added to our maintenance preventative software to trigger inspection each quarter Maintenance director will be responsible for maintaining quarterly inspection and compliance The actual or proposed date for completion of the remedy: November 24, 2023	

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K 363	Continued From page 10	K 363		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire	K 363		11/24/23

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K 363	Continued From page 11 protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.10. This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 10/03/2023 at 11:32 AM, it was revealed by observation that the door to office 245 Nurse Manager was wedged open with a wooden wedge. 2. On 10/03/2023 at 11:54 AM, it was revealed by observation that the door to office 145 Nurse Manager was wedged open with a rubber wedge. An interview with the Administrator and the Director of Maintenance verified this deficient finding at the time of discovery.	K 363	K363 Corridor Doors Detailed description of the corrective action or planned to correct the deficiency: Appropriate hold open devices that release when the door is pushed or pulled open will be installed to corridor office doors Address measures that will be put in place to ensure the deficiency does not reoccur: Maintenance staff will be the only ones to install hold open devices to office corridor doors How the facility plans to monitor future performance to ensure solutions are sustained: Doors and hold open devices will be monitored quarterly to assure compliance Identify who is responsible for the corrective actions and monitoring of compliance: The maintenance director will be responsible for monitoring and compliance The actual or proposed date for completion of the remedy: November 24, 2023	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		11/24/23

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K 918	Continued From page 12 The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for	K 918	K918 Electrical Systems □ Essential Electric Systems It is the policy of Chapel View to comply with K918. Detailed description of the corrective	

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K 918	Continued From page 13 Emergency and Standby Power Systems, sections 8.4.9, 8.4.9.1, 8.4.9.2, and 8.4.9.5.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/03/2023 between 09:30 AM and 12:45 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that the facility's Emergency Power Supply System (EPSS) was tested for at least four hours within the last 36 months. An interview with the Administrator and the Director of Maintenance verified this deficient finding at the time of discovery.	K 918	action or planned to correct the deficiency: The Emergency Power Supply System (EPSS) will be tested and a schedule maintained to assure appropriate testing including for at least four hours every 36 months. Address measures to be put in place to ensure the deficiency does not reoccur: A schedule will be maintained to assure appropriate testing that includes running four hours every 36 months. Generator testing will be noted in a log book kept in the maintenance director□s office. How the facility plans to monitor future performance to ensure solutions are sustained: The generator log will be monitored to ensure testing is scheduled as required. Identify who is responsible for the corrective actions and monitoring of compliance: The maintenance director is responsible for the corrective action and monitoring compliance The actual or proposed date for completion of the remedy: November 24, 2023	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 6, 2023

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

RE: CCN: 245493
Cycle Start Date: September 19, 2023

Dear Administrator:

On October 16, 2023, we notified you a remedy was imposed. On December 5, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 30, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 19, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 16, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 19, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 30, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us