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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 8VO3

Facility ID: 00979

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245264**
2.STATE VENDOR OR MEDICAID NO.
(L2) **176622800**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HCC OF APPLE VALLEY**
(L4) **14650 GARRETT AVENUE**
(L5) **APPLE VALLEY, MN** (L6) **55124**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/25/2006**
6. DATE OF SURVEY 01/13/2014 (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **178** (L18)
13.Total Certified Beds **178** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC
And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room
B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	178			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 01/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/20/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/10/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/25/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5264

The facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on 11/21/13. On 01/13/14, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction. Based on the PCR. it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on 11/21/13, effective 01/13/14. Refer to the CMS-2567B for both health and life safety code.

Effective 01/13/14, the facility is certified for 178 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5264

March 20, 2014

Mr. David Shaw, Administrator
Augustana Healthcare Center of Apple Valley
14650 Garrett Avenue
Apple Valley, Minnesota 55124

Dear Mr. Shaw:

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

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

Effective January 13, 2014, the above facility is certified for:

178 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 178 skilled nursing facility beds.

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

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 22, 2014

Mr. David Shaw, Administrator
Augustana HCC Of Apple Valley
14650 Garrett Avenue
Apple Valley, MN 55124

RE: Project Number S5264023

Dear Mr. Shaw:

On December 13, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 21, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On January 13, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 21, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 13, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 21, 2013, effective January 13, 2014 and therefore remedies outlined in our letter to you dated December 13, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Gayle Lantto

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Telephone: 651-201-3794 Fax: 651-201-3790

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245264	A. Building B. Wing	1/13/2014

Name of Facility	Street Address, City, State, Zip Code
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 01/13/2014	ID Prefix F0364 Reg. # 483.35(d)(1)-(2) LSC	Correction Completed 01/13/2014	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 01/13/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By 16022	Date: 1-22-14	Signature of Surveyor: 15507	Date: 1-13-14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 11/21/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8VO3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00979

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245264**
2.STATE VENDOR OR MEDICAID NO.
(L2) **176622800**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HCC OF APPLE VALLEY**
(L4) **14650 GARRETT AVENUE**
(L5) **APPLE VALLEY, MN** (L6) **55124**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/25/2006**

6. DATE OF SURVEY **11/21/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **178** (L18)

13.Total Certified Beds **178** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	178			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Elizabeth Nelson, HFE NE II 12/24/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/23/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN-245264

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7031

December 13, 2013

Mr. David Shaw, Administrator
Augustana Healthcare Center of Apple Valley
14650 Garrett Avenue
Apple Valley, Minnesota 55124

RE: Project Number S5264023 and H5264047

Dear Mr. Shaw:

On November 21, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the November 21, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5264047. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the November 21, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5264047 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 31, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 21, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 21, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Complaint investigations were completed at the time of the standard recertification survey. Complaint H5264047 and H5264045 were both unsubstantiated.	F 000		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329	It is the policy of Augustana Health Care Center of Apple Valley to ensure that each resident's drug regimen is free from unnecessary drugs. R89 Seroquel was discontinued on 11/25/13. For R89, Sleep log was completed 12/18-12/20/13 and summary of sleep will be completed on 12/23/13.	

Accepted 12-24-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Shaw | TITLE: Administrator | (X6) DATE: 12-20-13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

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F 329	Continued From page 1 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed ensure necessary medication was not prescribed for 1 of 5 residents (R89) reviewed for unnecessary drug use. Findings include: R89 was prescribed antipsychotic medication without attempts at a gradual dose reduction or documented justification as to why a dose reduction was contraindicated, as well as medication to promote sleep without a comprehensive assessment of sleep patterns and effectiveness of non-pharmacological interventions. R98 was prescribed Seroquel (antipsychotic) 12.5 mg daily (since 9/26/12) for adjustment disorder with anxiety, and dementia with behavioral disturbance. No evidence of a dose reduction attempt was found since the initiation of the antipsychtoic medication was initiated more than 13 months prior. Physician and NP notes lacked justification for the continued need (benefit versus risk) for the medication or documentation why a dose reduction was contraindicated. Notes by both the physician and NP consistently indicated Seroquel was ordered "per demand of daughter." Notes were dated 5/2/13, 6/20/13, 7/9/13,	F 329	Psychotropic drug monitoring policy was reviewed and updated and given to nurses to include appropriate indications for use of psychotropic meds, gradual dose reductions when appropriate and use of non-pharmacological interventions. In-services regarding the updated policy will be held the week of Jan 6th, 2014. Random audits of 20% of residents admitted on or newly started on sleep medications will be completed monthly X 3 months to ensure compliance with this policy. Unit manager or designee is responsible for compliance. Random audits of 20% of residents on anti-psychotic medications will be completed monthly X 3 months to ensure that gradual dose reductions have been attempted per consultant pharmacist recommendations or that there is adequate documentation of contraindication of a gradual dose reduction.	

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F 329	Continued From page 2 7/17/13, 8/9/13, 9/3/13, 9/12/13, 9/16/13, 9/26/13, and 10/9/13. Review of pharmacist recommendation revealed a note on 4/15/13 "Reviewed at MED [committee related to resident minimal effective doses] plan: discontinue Seroquel due to patient no longer hallucinating or stating suicidal statements." MED meeting notes for 4/15/13, indicated the resident's behaviors were stable for verbal abuse, refusal of cares, history of suicidal ideation/ hallucinations. "Recommend to discontinue Seroquel". A subsequent NP note dated 4/29/13, however, read "Chronic anxiety cont [continue] with current treatment...dementia with behavioral disturbance...craves attention and misinterprets physical sx [symptoms]. Decrease of Seroquel may cause emotional harm. No change in treatment." Prior to the initiation of sleep medication, R89's medical record lacked evidence of an assessment of sleep patterns, identification of potential causal factors for sleep disturbance, and documentation of non-pharmacological interventions and the effectiveness of interventions tried. Physician progress notes revealed a note by the nurse practitioner (NP) on 8/9/13, "Insomnia, has days and night mixed up, sleeps most of the day...deep asleep at 9 a.m." Desyrel (medication commonly used for sleep) 25 milligrams (mg) was ordered on 8/9/13. A nursing note on 10/1/13, "Message left for NP regarding res [resident] not sleeping well on	F 329	Unit manager or designee is responsible for compliance. Results of the audits will be reviewed at the facility QI meetings to determine compliance and any recommended changes to the POC based on those results. Date of Completion 1/13/14	

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F 329	Continued From page 3 overnights. During medication committee it was discussed to increase Trazodone (desyrel). Res currently receives Trazodone 25 mg at HS" (hours of sleep). The desyrel was increased on 10/1/13 to 50 mg at bedtime. R89's care plan dated 2/20/13, identified a risk for sleep pattern disturbance per history of trouble sleeping, anxiety and agitation at times, and orders for sleep mediation were noted. Interventions directed staff to administer sleep medication as ordered by physician, monitor for pain and intervene as needed, maintain consistent environment and routine, decrease stimulation by providing calm and quiet environment. The director of nursing (DON) stated in an interview on 11/21/13, at 10:04 a.m. that a sleep assessment for all shifts for seven days should have been completed prior to the initiation of mediation for R89 and confirmed that this was not completed. The DON further stated quarterly documentation of resident sleep pattern was to be completed by the night shift, but she was unable to locate documentation to that effect. The DON explained that although non-pharmacological interventions for R89 included warm blankets and orange juice, the interventions had not been and their effectiveness had not been consistently documented. In addition, the DON stated she was unable to find documentation of the justification for the continued use of the Seroquel by the physician. The consulting pharmacist reported in an interview on 11/21/13, at 3:33 p.m. that that during the 9/13 MED committee meeting, they had discussed trying to improve R89's sleep with	F 329		

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F 329	Continued From page 4 the use of desyrel, and then again attempt to reduce the Seroquel. Policies for sleep hygiene assessment and psychotropic drug reductions were requested, but were unavailable.	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served at temperatures to the residents' satisfaction in 1 of 3 serving kitchens, potentially affecting the residents served from the steam table. Findings include: Food temperatures were measured on 11/18/13, at 12:30 p.m. by dietary aide (DA)-A and the food was 120 degrees Fahrenheit (F). At 12:36 p.m. the first resident was served. At 1:05 p.m. as the last three residents were about to be served meals in their rooms, a test tray was requested. DA-A stated she knew the food was not going to be at the proper holding temperature when she	F 364	It is the policy of the Augustana Health Care Center to serve food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive and at the proper temperature. Policy and Procedure for Food Temperatures (#5561) was reviewed and is current. All Food Service staff will be re-educated on Policy and Procedure for Food Temperatures (#5561) at staff in-service on 12/26/13 or 1/7/14. New Induction System purchased 12/19/13 and will be utilized for room trays to ensure proper food temperatures. The Manufacture will educate Food Service Staff on use of Induction System.	

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F 364	Continued From page 5 brought the food to the dining room, as it had not had the proper time to be reheated prior to serving. At 1:18 p.m. the last resident on the second floor was served her meal in her room. Temperatures of the food on the test tray measured 120 degrees F which was confirmed by a nursing assistant (NA)-A. R426 stated in an interview on 11/18/13 at 7:30 p.m. that the food was never really served hot. R27 was interviewed the following morning at 9:34 a.m. and stated the food was sometimes served cold, depending on the cook. The resident also did not find the food looked good and tasted appetizing. R143 was then interviewed at 1:43 p.m. stated that the food was not always served hot. The director of food service (DFS) was interviewed on 11/21/13, at 2:00 p.m. She stated she had not received any complaints of food temperatures for a long time. She explained that the facility procedure directed staff to take the temperature of the food when it was placed into the steam tables in the serving kitchen. If the food was not at the proper temperature at that time, it was supposed to be brought back to the kitchen to be heated to the proper temperatures before serving. Serving kitchen temperature logs were reviewed from the previous several months and revealed numerous days lacked measurements of food temperatures for all three meals. Some of the temperature ranged from 100-130 degrees. If the food was returned to the kitchen and reheated, temperatures were not again measured after the food was re-warmed to ensure it had reached the proper temperature.	F 364	Food Temperature logs will be monitored 3 times per week by Food Service Director and/or Registered Dietitian. Results of audits will be reviewed by the Quality Improvement/Assurance Committee for the next 90 days. Food Service Director is responsible for compliance. Date of completion 1/10/14	

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F 364	Continued From page 6 The facility's policy and procedure for food temperatures (revised 8/10) noted it was the dietary staffs' responsibility to take temperatures and properly record for each meal. "All hot food items must be cooked to appropriate internal temperatures and held at a temperature of at least 150 degrees Fahrenheit per Minnesota food code. Food that is not at 150 degrees must be returned to the kitchen and reheated to 165 degrees Fahrenheit."	F 364		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	It is the policy of Augustana Health Care Center of Apple Valley to ensure that medications are labeled and stored in accordance with MN Board of Pharmacy regulations. R203 insulin was removed from the med cart on 11/20/13. R236 liquid Certavite was removed from the med cart on 11/20/13. TMA and Licensed staff were educated on importance of removing medications from the cart after they are expired and checking dates on insulin bottles prior to administering. They were also educated regarding ensuring labels are clear and legible prior to administering medications.	

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F 431	Continued From page 7 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired medication was not administered for 1 of 1 resident (R203) who received expired insulin, and ensure medication labels were legible for 1 of 1 resident (R236) whose medication label was illegible. Findings include: R203's order for Lantus insulin (for diabetes) and had an open date of 10/12/13. The staff continued to administer the insulin after it had expired on 11/9/13. Licensed practical nurse (LPN)-A verified the Lantus was expired. R236's medication administration was observed on 11/20/13, at 9:00 a.m. The resident was administered Certavite liquid (multivitamin) from a bottle where the pharmacy label was heavily stained with the brown liquid medication and was illegible. LPN-A verified R236's Certavite label was illegible, and the staff should have requested the medication be re-labeled by the pharmacy. The facility's Pharmaceutical Administration Policy dated 1/13, directed staff to date insulin	F 431	Audits of the medication carts for improperly labeled and expired medications will be completed weekly X 4 and then monthly X 3 to ensure compliance. Results of the audits will be reviewed at the facility QI meetings to determine compliance and any recommended changes to the POC based on those results. Unit manager or designee is responsible for compliance. Date of completion 1/13/14	

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F 431	Continued From page 8 vials when opened, and to replace 28 days from the date opened. "Expired meds [medications] will be removed from storage area and destroyed according to policy." In addition, the policy indicated medications "will be labeled in accordance with Minnesota Board of Pharmacy regulations."	F 431		

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	245264	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2013**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Augustana Health Care Center of Apple Valley, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Augustana Health Care Center of Apple Valley is a 3-story building with a full basement. The building was constructed in 1983, and was determined to be of Type II(222) construction. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility chooses to have battery operated single station smoke alarms in all resident rooms. The facility has a licensed capacity of 178 beds and had a census of 152 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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