DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: NSAF

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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1. 1. 1. 1. 1. 1. 1. 1.	(L1) 245493		(L3) AUGUSTAN	IA CHAPEL V	IEW CAI	RE CENTER		ON: <u>7 (</u> L8)
S. FIFT CHATCH CHANCE IN SURVEY		NO.	1 1		LS ROAD	(L6) 55343	5. Validation	6. Complaint
S. ACCEPITATION STATUS: C. 1.0 O SNN-NY-PROFISE O SNN-NY-PROFI		OWNERSHIP				` '		
From (a):	8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC		03 SNF/NF/Distinct	07 X-Ray	11 ICF/III) 15 ASC		ING DATE: (L35)
12 Total Facility Reds	11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	' IS CERTIFIED	AS:			
12. Total Facility Beds	From (a):		X A. In Complia	nce With				ments:
12.Total Facility Beds	To (b):							
14. LIC CERTIFIED BED BREAKDOWN	12.Total Facility Beds	118 (L18)	•			4. 7-Day RN (Rural SN	NF) 8. Patient Roo	om Size
18 SNF	13.Total Certified Beds	118 (L17)				* Code: A *	(L12)	
118	14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
CL37		19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL Date:		(L39)	(L42)	(L43)				
Anne Kleppe, Enforcement Specialist O1/23/2015	16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):			
PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY **L** 1. Facility is Eligible to Participate** **L** 20. COMPLIANCE WITH CIVIL RIGHTS ACT:** **L** 21. 1. Statement of Financial Solvency (HCFA-2572)* 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 0F PARTICIPATION BEGINNING DATE ENDING DATE (L24) (L41) (L25) 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS **A. Suspension of Admissions:** (L27) B. Rescind Suspension Date: (L44) 28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 03001 (L28) (L28) (L31) 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE 01/08/2015	17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 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 23. LTC AGREEMENT OF PARTICIPATION BEGINNING DATE (L24) (L41) (L25) 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45) 28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 03001 (L28) 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE 01/08/2015	Gloria Derfus, Supervsion	?		01/23/2015	(L19)	Anne Kleppe, Enforce	ment Specialist	01/23/2015
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01/08/2015		(L28)	03001		(L31)			
(L32) DETERMINATION APPROVAL	31. RO RECEIPT OF CMS-1539	32		OF APPROVAL	DATE			
		(L32)	01/00/2015		(L33)	DETERMINATION APP	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5493

Electronically Delivered: January 23, 2015

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

Dear Ms. Sparling:

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, 2015 the above facility is certified for:

118 - Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Dre Kleese

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program

Health Regulations Division

Minnesota Department of Health Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: January 23, 2015

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

RE: Project Number S5493025

Dear Ms. Sparling:

On December 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 4, 2014. 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 21, 2015, 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 December 4, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 13, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 4, 2014, effective January 13, 2015 and therefore remedies outlined in our letter to you dated December 18, 2014, 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. Please feel free to call me with any questions about this electronic notice.

Sincerely,

Dire Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Health Regulations Division

Minnesota Department of Health Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124 Fax: (651) 215-9697

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 245493	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/21/2015
Name of Facility		Street Address, City, State, Zip Code	
AUGUSTANA CHAPEL VIEW CARE C	ENTER	615 MINNETONKA MILLS ROA	D

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 Reg. # LSC	F0246 483.15(e)(1)		Correction Completed 01/13/2015	ID Prefix Reg. # LSC	F0278 483.20(g) - (j)		Correction Completed 01/13/2015			483.20(d), 483		Correction Completed 01/13/2015
ID Prefix	F0282 483.20(k)(3)(ii)		Correction Completed 01/13/2015	ID Prefix	F0309 483.25		Correction Completed 01/13/2015		ID Prefix Reg. #	F0312 483.25(a)(3)		Correction Completed 01/13/2015
ID Prefix Reg. # LSC	F0314 483.25(c)		Correction Completed 01/13/2015	ID Prefix Reg. # LSC	F0329 483.25(I)		Correction Completed 01/13/2015			F0428 483.60(c)		Correction Completed 01/13/2015
	F0431 483.60(b), (d),	(e)	Correction Completed 01/13/2015		492 GE		Correction Completed 01/13/2015					
ID Prefix Reg. # LSC												
Reviewed E State Agen		eviewed GD/AK	=	Date: 01/23/20	Signature	of Sur	veyor:		1862	3	Date: 01/2	1/2015
Reviewed E	Ву В	eviewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
Followup t	o Survey Comp 12/4/2		:		Check for any Uncorrecte					Summary of the Facility?	YES	NO

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: NSAF Facility ID: 00727

		10 22 00			I B S C I (E I I I G E I C I	1 weinty 15: 00/2/
1. MEDICARE/MEDICAID PROVID (L1) 245493 2.STATE VENDOR OR MEDICAID I (L2) 470843100		3. NAME AND AL (L3) AUGUSTAN (L4) 615 MINNE (L5) HOPKINS, I	IA CHAPEL V TONKA MILI	IEW CAF	(L6) 55343	4. TYPE OF ACTION: 2(L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 12/04	OWNERSHIP //2014 (L34)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual		GORY 09 ESRD 10 NF	02 (L7) 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit 9. Other 8. Full Survey After Complaint
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/III 12 RHC	D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	' IS CERTIFIED	AS:		
From (a):		A. In Complia	nce With equirements		And/Or Approved Waivers Of 2. Technical Personne	f The Following Requirements: 6. Scope of Services Limit
To (b):		Complianc	e Based On:		3. 24 Hour RN	7. Medical Director
12.Total Facility Beds	118 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural Sl 5. Life Safety Code	NF)8. Patient Room Size 9. Beds/Room
13.Total Certified Beds	118 _(L17)		npliance with Prog ents and/or Appli		* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
118						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION :	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL Date:
Kathy Sass, HFE NE II		1	2/30/2014	(L19)	Anne Kleppe, Enforce	ment Specialist 01/06/2015 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY
19. DETERMINATION OF ELIGIBI	LITY		IPLIANCE WITI HTS ACT:	H CIVIL		nncial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513)
1. Facility is Eligible to	-				3. Both of the Abov	,
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREED	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 0	
08/01/1987					01-Merger, Closure 02-Dissatisfaction W/ Reimburs	05-Fail to Meet Health/Safety sement 06-Fail to Meet Agreement
(L24)	(L41)		(L25)		03-Risk of Involuntary Terminati	on
25. LTC EXTENSION DATE:		VE SANCTIONS n of Admissions:			04-Other Reason for Withdrawal	UTHEK
(- - -	71. Suspension	or rumissions.	(L44)			00-Active
(L27)	B. Rescind St	aspension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APP	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5421

December 26, 2014

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

RE: Project Number S5493025 and Complaint Number H5493035. Please note, this letter includes a revision to the correspondence originally mailed December 18, 2014

Dear Ms. Sparling:

On December 4, 2014, 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 December 4, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5493035. 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 December 4, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5493035 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;

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

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

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

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

DEPARTMENT CONTACT

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

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

Email: gloria.derfus@state.mn.us Telephone: (651) 201-3792 Fax: (651) 201-3790

Fax: (651) 201-3/90

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 January 13, 2015, 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 March 4, 2015 (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

Augustana Chapel View Care Center December 26, 2014 Page 5 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 June 4, 2015 (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_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 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0525

Email: pat.sheehan@state.mn.us

Feel free to contact me if you have questions.

Sincerely,

Dre Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Health Regulations Division Minnesota Department of Health

Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STEMENT (DE DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	COMP	SURVEY LETED
		245493	B. WING			4/2014
	ROVIDER OR SUPPLIER	CARE CENTER	61	REET ADDRESS, CITY, STATE, ZIP 5 MINNETONKA MILLS ROAD OPKINS, MN 55343	CODE	
	CURALADY CT	ATEMENT OF DESIGIENCIES	ID I	PROVIDER'S PLAN OF C	ON SHOULD BE	(X5) COMPLETION
(X4) ID PREFIX TAG	JE KOLL DESIGNENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE	1E APPROPRIATE	DATE
F 000	INITIAL COMMEN	TS	F 000			
	as your allegation Department's accomposition bottom of the first be used as verific	of correction (POC) will serve of compliance upon the eptance. Your signature at the page of the CMS-2567 form wation of compliance.	111			
	revisit of your fact	n acceptable POC an on-site lity may be conducted to tantial compliance with the een attained in accordance wit	h	F246		1 12
F 246 SS=D	#H5493035 and 1 483.15(e)(1) RE/	stigation was conducted for ound unsubstantiated. ASONABLE ACCOMMODATIC FERENCES	F 240	received wheelchair-	dent R64 height 12/4/14.	1-13-
	services in the fa	e right to reside and receive scility with reasonable s of individual needs and ept when the health or safety o other residents would be	1030	Permanent mirror ore received and installe Two additional adap were received for fur Audit was complete.	dered 12/5/14, d on 12/9/14. tive mirrors ture residents. d to identify	
	This REQUIREM	MENT is not met as evidenced	X	any other residents respecial height mirro Social services and/will continue to init	requiring r installation. or nursing staf	f
	review, the facili	rvation, interview, and docume ty failed to assure bathroom cessible for 1 of 1 resident (R6 pelchair and required a bathroo out activities of daily living (ADL	(4) S	to maintenance whe require adaptive mi Maintenance Engin responsible for mor	en residents rrors. eer will be	
	Findings include	•		assuring timely cor	npletion of wo	rk
	R64's annual M	inimum Data Set (MDS) dated		Offices.		(X6) DAT

Any deficiency statement ending with an asterisk (*) dendess a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient prefection 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 O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		245493	B. WING			12/0	4/2014
	NOVIDER OR SUPPLIER			615 MINNETONKA HOPKINS, MN 5	5343		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CO	ER'S PLAN OF CORREC RRECTIVE ACTION SHO ERENCED TO THE APPI DEFICIENCY))ULD RE I	(X5) COMPLETION DATE
	Continued From p 10/29/14, identifie and required exte with personal hyg On 12/2/14, at 10 expressed there with bout one month outside the room time, so he know times. I can't sha shaving by feel ri On 12/4/14, at 3: completed with bour director of house the tour the BE a mirror was missi indicated he did expected staff to problems. Wher mirror missing E mirror here, we tape a mirror in When asked if to to the mirror bei stated "We don' am more than h asked how the department abounceded repairs orders were in would fix things On 12/4/14, at	d the R64 had intact cognition insive physical assist of one staffiene. :06 a.m. during interview R64 was no mirror at wheelchair leve R64 stated it fell off the wall ago. R64 further stated "I was with maintenance guy at the s. I have asked for it many ve without it. I have been	s	246			
	/	M)-A) by name and then stated when the mirror fell with me and	he	Facility ID: 00727	1f	continuation s	heet Page 2

F 246 Continued From page 2 knew about it." At 3:39 p.m. M-A stated he knew about the mirror but did not have a good re-collection of what date it had happened and he was there when it fell. He further stated the BE was aware of it and there was a work order for it, and the mirror had been ordered but not delivered. M-A further indicated he would provide the work order. At 3:42 p.m. surveyor approached BE and Informed him M-A knew about the mirror missing. BE indicated "There is so much I don't know, I don't go through all the work orders." BE stated he would provide the invoice and work orders. On 12/4/14, at 4:01 p.m. BE brought a work order dated 1/11/11/4, and stated he had not seen that work order as he did not see them all. BE further stated "This will be ordered as soon as I get the measurements from [M-A] and will get it corrected." When asked if the facility had a maintenance/repair policy BE stated "There is nothing on paper but we work together in the department and communicate. F 278 483.20(g) < 1) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	STATEMENT (AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY MPLETED	
AUGUSTANA CHAPEL VIEW CARE CENTER SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFOISE) CHART DEFOISE (EACH DEFOISE) CHART DEFOISE (EACH DEFOISE) CHART DEFOISE (EACH DEFOISE) CHART DEFOISE CHART DEFOISE) CHART DEFOISE CHART DEFOIS			245493	B. WING			/04/2014	
PREFIX TAG F 246 Continued From page 2 knew about it." At 3:39 p.m. M-A stated he knew about the milror but did not have a good re-collection of what date it had happened and he was there when it fell. He further stated the BE was aware of it and there was a work order for it, and the milror had been ordered but not delivered. M-A further indicated he would provide the work order. At 3:49 p.m. surveyor approached BE and informed him M-A knew about the mirror had been ordered but not delivered. M-A further indicated "There is so much I don't know; I don't go through all the work orders." BE stated he would provide the invoice and work orders. On 12/4/14, at 4:01 p.m. BE brought a work order dated 11/11/1/4, and stated he had not seen that work order, as he did not see them all. BE further stated "This will be ordered as soon as I get the measurements from [M-A] and will get it corrected." When asked if the facility had a maintenance/repair policy BE stated "There is nothing on paper but we work together in the department and communicate. F 278 \$S=D The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.					615 MINNETONKA MILLS ROAD HOPKINS, MN 55343	**:		
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Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278	knew about it." -At 3:39 p.m. M-A mirror but did not what date it had h when it fell. He fur of it and there was mirror had been of turther indicated had 3:42 p.m. survinformed him M-A BE indicated "The don't go through a he would provide On 12/4/14, at 4:0 dated 11/11/14, a work order, as he stated "This will be measurements from thing on paper department and (483.20(g) - (j) AS ACCURACY/CO The assessment resident's status. A registered nurse each assessment is considered individual wassessment is considered in the consider	stated he knew about the have a good re-collection of appened and he was there ther stated the BE was aware as a work order for it, and the ordered but not delivered. M-A ne would provide the work order reyor approached BE and a knew about the mirror missing. For it is so much I don't know; I wall the work orders." BE stated the invoice and work orders. In p.m. BE brought a work orders and stated he had not seen that a did not see them all. BE further the ordered as soon as I get the form [M-A] and will get it asked if the facility had a fair policy BE stated "There is but we work together in the communicate. SSESSMENT ORDINATION/CERTIFIED must accurately reflect the see must conduct or coordinate at with the appropriate ealth professionals. See must sign and certify that the completed.	F				

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
AND PLAN O	F CORRECTION	выдати южизента	•		12/04/2014
		245493	B. WING	STREET ADDRESS, CITY, STATE,	
	PROVIDER OR SUPPLIER	CARE CENTER		615 MINNETONKA MILLS ROA HOPKINS, MN 55343	
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		O THE APPROPRIATE
	willfully and know false statement in subject to a civil r \$1,000 for each a willfully and know to certify a materized resident assessment. Clinical disagree material and fals This REQUIREM by: Based on observeiew, the facility the Minimum Da (R226) who had Findings include R226's pressured dressing change performed by the (LPN-C). The performed by the control of the control	assessment. and Medicaid, an individual who ingly certifies a material and a resident assessment is money penalty of not more than issessment; or an individual who ingly causes another individual all and false statement in a ment is subject to a civil money ore than \$5,000 for each ment does not constitute a e statement. MENT is not met as evidenced vation, interview and document by failed to ensure the accuracy of the set (MDS) for 1 of 3 residents an unstageable pressure ulcer.	d, to	team. All MDS that includes assessment will b	ssion. The ulcer a wound flow ated. Wound one as ordered A wound flow ad wound cares as ordered and MDS was coded nation available at RN's. An as submitted to ling. This was an lue to missing ence, MDS eviewed with RAI lude wound a audited for 3 ongoing accuracy Outcomes by QAPI team

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	COMPI	
		245493	B. WING			12/0	4/2014
	PROVIDER OR SUPPLIER			61	REET ADDRESS, CITY, STATE, ZIP CODE 5 MINNETONKA MILLS ROAD OPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	;	(X5) COMPLETION DATE
F 278	Record review inda- The undated Re indicated R226 wa 11/18/14, with diadisease and cong The Admit/Weel- 11/18/14, indicated body diagram indinowever the stagemeasurements wasurrounded by no ulcer 100% sloug clean base." The physician of "Wound care: bas saline (salt water (an absorbant drecomposite dressiday." The order to (antibacterial hordiscontinued on The Admission 12/1/14, indicated thickness loss of open ulcer with a slough [non viable ulcers, R226 was needed two staff and personal hygadmission MDS had two stage 2 presenting as a serior of the control of the cont	licated the following information: sident Admission Record as admitted to the facility on gnoses including Alzheimer's estive heart failure. kly skin check tool dated d circled area on mid back of a icating "pressure ulcer", e of the wound or ere not documented. progress notes dated 11/19/14 mission), noted presence of re ulcer- 2 small ulcerations in blanchable redness-proximal h in base, distal shallow with re was no detailed description of rder dated 11/24/14, indicated ck-clean wound with normal 14x4. Cover with 4x4 Mepilex essing) border or other ng. Once a day Every other or "Apply Medihoney ney) gel to wound bed" was		278			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION	COMF	PLETED
		245493	B. WING			12/0	14/2014
	ROVIDER OR SUPPLIER	CARE CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE IS MINNETONKA MILLS ROAD OPKINS, MN 55343		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 278	white/yellow tissue unstageable press on the MDS which midback. The registered nur nurse who comple was interviewed or stated she got the manager via phonacknowledged she record, and did no back pressure ulcomediate the physician progacknowledged R2 inaccurate, and sthave been coded. According to the L Resident Assessment according unhealed passessment were record review. Review the messheets or other skeets	I) pressure ulcer, R226 had an ure ulcer that was not coded was located on the spine and rese (RN)-H (also medicare sted R226's admission MDS) in 12/3/14, at 9:57 a.m., and information from the nurse e conversation. The RN-H edid not review R226's medical texamine R226 to assess the ers to ensure coding accuracy. It was a did not review R226's medical texamine R226 to assess the ers to ensure coding accuracy. It was a did not review R226's record including gress notes dated 11/19/14, 26's admission MDS was ated the pressure ulcer should as unstageable. Long Term Care Facility nent Instrument (RAI) User's 0 dated October 2013, when pressure ulcer(s) "Steps for e: edical record, including flow kin tracking forms. ect care staff and the treatment conclusions from the medical esident and determine whether		278			
	or brown) or sloug	gh (yellow, tan, gray, green or sent such that the anatomic					

STATEMENT C AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMPL	
		245493	B. WING			12/04	/2014
	ROVIDER OR SUPPLIER		·	615	EET ADDRESS, CITY, STATE, ZIP CODE MINNETONKA MILLS ROAD PKINS, MN 55343		
(X4) ID PREFIX TAG	/EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE !	- (X5) COMPLETION DATE
F 278 F 279 SS=D	palpated in the w as unstageable." 483.20(d), 483.2 COMPREHENSI	amage cannot be visualized or ound bed, should be classified D(k)(1) DEVELOP VE CARE PLANS		278	F279 R35 has a diagnosis of COP	D and	- - 3- 5
	to develop, revie comprehensive p The facility must plan for each res objectives and ti	e the results of the assessment w and revise the resident's plan of care. develop a comprehensive care sident that includes measurable metables to meet a resident's and mental and psychosocial dentified in the comprehensive			this is addressed on his care Parameters for use for PRN inhalers and nebulizers were received from the Physician added to the orders. Review of other residents w PRN inhalers and nebulizers	and ith	
	The care plan m to be furnished highest practica psychosocial we §483.25; and ar be required und	nust describe the services that are to attain or maintain the resident's ble physical, mental, and ell-being as required under by services that would otherwise er §483.25 but are not provided ent's exercise of rights under ing the right to refuse treatment	5		be done to ensure parameter use were included in orders. Education provided to all Li Nursing Staff and Health Use Coordinators regarding this 2 chart audits will be done to week to ensure ongoing corfor 3 months. Audit outcom be reviewed monthly by face QAPI committee.	icensed nit . per npliance les will	
	by: Based on obserview, the faci	MENT is not met as evidenced ervation, interview and document lity did not ensure a careplan was ly developed for respiratory f 5 residents (R35) reviewed for edications.	5		Clinical Manager and DON responsible.	[;	
	Findings includ	e: —					-

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION		E SURVEY IPLETED
		245493	B, WING		· .	12/	04/2014
	PROVIDER OR SUPPLIER			STREE 615 M	T ADDRESS, CITY, STATE, ZIP CODE INNETONKA MILLS ROAD KINS, MN 55343		
(X4) ID PREFIX TAG	/EACH DESIGIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	On 12/03/14, at 9: sitting in his whee coughing with his and R35 could not Licensed practica." I will get you a neproceeded to assischeck his [R35's] R35's 14 day Min 11/13/14, indicate modified indepennew situations on regarding tasks of Admission Record (Dx) included: ad chronic airway of Physician Order R35 also had a description of R35's Care Area 11/14/14, for R35 living (ADLs) Fur Potential. Analys [R35] recently accept the due to Pneumonia. Cur assistance with a Non-ambulatory bowel and bladd above listed risk environment, ep breath], occasio [night]." The CA triggered for De indicated "Infect	25 a.m. R35 was observed Ichair (w/c) near nurse's station face color getting reddened, it speak due to coughing. I nurse (LPN)-C stated to R35, solulizer treatment" and st R35. LPN-C also stated, "I		279			short Page 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMI	(X3) DATE SURVEY COMPLETED	
		245493	B. WING				04/2014	
	PROVIDER OR SUPPLIER			61	REET ADDRESS, CITY, STATE, ZIP CO 5 MINNETONKA MILLS ROAD DPKINS, MN 55343	ODE		
(X4) ID PREFIX TAG	/EACH DESCIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 279	11/21/14, lacked of Pulmonary/Respir interventions which treatments as new nebulizers, assess ordered and check levels) which nurse care plan "Care Finages numbered under "Nutritional and lung sounds. During an interview stated, "I would go nebulizer treatment SOB or if his oxy RN-D also stated COPD [chronic of we can give the treatment." RN-Edid not indicate woor PRN nebulize having SOB or care and the core of the stated of the st	evidence of any ratory diagnoses and sh would have included eded (PRN) inhaler, PRN sing lung sounds as physician king O2 sats (oxygen saturation sing routinely did for R35. R35's Plan [computerized careplan, "dated 11/17/14, indicated Status, Assess bowel sounds q. [every] shift. Nursing" ew on 12/4/14, at 2:11 p.m. RN-five R35 his PRN inhaler or PRN ent when R35 was wheezing, gen sats gets low, 89-90%." d, "Since R35 has a diagnosis of obstructive pulmonary disease] PRN inhaler or PRN nebulizer everified R35's physician orders whether to give the PRN inhaler respiratory concerns. N-i when asked stated, "I would nebulizer treatment when R35 foreath or if R35 requested one, "I have never given R35 a PRN inhave never given R35 a P		279				

DENTIFICATION AND RADED.		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245493	B, WING			12/0	4/2014
	PROVIDER OR SUPPLIE			615 M	T ADDRESS, CITY, STATE, ZIP CODE INNETONKA MILLS ROAD KINS, MN 55343	·	
(X4) ID PREFIX TAG	/FACH DEFICIEN	TATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	sulfate) HFA aero (micrograms)/act Special Instruction Interventions: 1) relax; 2) Encoura applicable) 3) Off Hours - PRN; and Ipratropium-albuting - 3 milligrams (ml); amt: 3 mls; Dx: reactive airw physician order of solution; 100 mg 10 ml; inhalation PRN. The Medication of 11/1/14 through at 2:42 a.m. R35 (albuterol sulfate mcg/actuation 2 the inhaler was 6 Medication Adm R35 received a land was effective Administration breceived a PRN 11/26/14, at 13:5 effective. The M dated 12/1/14 through at 13/1/16/14, at 13:5 effective. The M dated 12/1/14 through at 13/1/16/14, at 13:5 effective. The M dated 12/1/14 through at 13/1/16/14, at 13:5 effective. The M dated 12/1/14 through at 13/1/16/14, at 13:5 effective. The M dated 12/1/14 through at 13/1/16/14, at 13:5 effective. The M dated 12/1/14 through at 13/1/16/14, at 13:5 effective. The M dated 12/1/14 through at 13/1/16/14, at 13:5 effective. The M dated 12/1/14 through at 13/1/16/14, at 13:5 effective. The M dated 12/1/14 through at 13/1/16/14, at 13:5 effective. The M dated 12/1/14 through at 13/1/16/14, at 13:5 effective. The M dated 12/1/14 through at 13/1/16/14, at 13:5 effective. The M dated 12/1/14 through at 13/1/16/14, at 13:5 effective. The M dated 12/1/14 through at 13/1/16/14, at 13:5 effective. The M dated 12/1/14 through at 13/1/16/14, at 13:5 effective. The M dated 12/1/14 through at 13/1/16/14, at 13:5 effective. The M dated 12/1/14 through at 13/1/16/14, at 13:5 effective.	ustion; amt: 2 puffs; inhalation uns: Non pharmacological Encourage deep breathing to the incentive spirometer (iffer emotional support Every 3 dephysician order dated 11/19/14, terol solution for nebulization; 0.5 (mg) (2.5 mg base)/3 milliliters inhalation Special Instructions: ays Once A Day PRN. R35's dated 11/19/14, Acetylcysteine /ml (10%) Amount to administer: miscellaneous Once A Day - Administration History dated 11/30/14, indicated on 11/18/14, is was given a PRN Ventolin HFA (in		279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION (C	(X3) DATE SURVEY COMPLETED	
		245493	B, WING			12/04/	2014
l	ROVIDER OR SUPPLIER	CADE CENTER		615	EET ADDRESS, CITY, STATE, ZIP CODE MINNETONKA MILLS ROAD PKINS, MN 55343		
AUGUSTA	NA CHAPEL VIEW		ID	HU	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE (DATE
F 279	Continued From prebulizer treatment parameters for use to determined. The Treatment Addated 11/01/14 the lung sounds were shift. Progress notes be indicated "He [R3 of aspiration pnecare. He [R35] he yellow sputum and eating. Denies a shortness of breepistaxis noted of the provide a written the resident to neare, and psychology (18) (19) (19) (19) (19) (19) (19) (19) (19	age 10 Ints were effective. The age for R35's PRNs could not seem of the age for R35's PRNs could not seem of the age for R35's PRNs could not seem of the age for R35's passessed by nursing every seem of the age age of the age of	9	279 F 282	F282 Residents R11 and R14 are shaved daily as needed. Nu Assistants involved have be educated on grooming need requirements.	irsing een	1-13-15
SS=I	The services prediction must be provided accordance with care. This REQUIRE by:	his REQUIREMENT is not met as evidenced			To prevent recurrence, Shapolicy has been reviewed when Nursing Department staff. 5 audits will be done week months to ensure ongoing compliance. Audit outcombe reviewed by facility QA committee.	vith ly for 3 nes will PI	
	I were followed	for 2 of 4 residents (R11, R14) ctivities of daily living (ADLs).			Nurse Managers and DON responsible.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245493	B. WING			12/0	4/2014	
	PROVIDER OR SUPPLIER			615	REET ADDRESS, CITY, STATE, ZIP CODE MINNETONKA MILLS ROAD PKINS, MN 55343			
(X4) ID PREFIX TAG	/EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFIGIENCY)	DBE Ì	(X5) COMPLETION DATE	
F 282	Findings Include: R11 was observed seven, white 1/2 is chin. R11 stated, R11 also stated, "just plucks them." received my show R11's quarterly M was cognitively in assist with activity personal hygiene the undated resid malaise, fatigue, On 12/3/14, at 8: in bed with seven hairs on her chin assistant (NA)-B asked R11 what answered. NA-B gloves on and gaproceeded to wa face with the tow R11's socks and up on side of bed upper half and R NA-B finished as applied transfer stand, turn and s NA-B then whee then took off the stand nearby, R toileting NA-B w	d on 12/1/14, at 6:24 p.m. with nch length facial hairs on her "My chin hairs are not all right." Which ever staff notices them 'R11 further stated, "I just ver this morning." DS dated 9/3/14, indicated R11 stact and needed extensive staff y of daily living (ADLs) including R11's diagnoses indicated on lent admission record included: weakness and dementia. O0 a.m. R11 was observed lying to get her up from bed. NA-B she wanted to wear and R11 pulled privacy curtain, put his ave R11 wet wash cloth and R11 sh her face and then dried her rel NA-B provided. NA-B put slacks on and assisted R11 to stated, "That feels good." sisting R11 with dressing, belt to R11 and assisted R11 to sit in R11's wheelchair (w/c). led R11 to the bathroom. NA-B soiled gloves. NA-B stated, "I prefers it." After R11 finished ith new gloves on assisted R11	it	282				
	nulling up R11's	d drying R11's backside and pants up and assisted R11 to th sfer belt applied to R11.	е				10-146	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DAT	(X3) DATE SURVEY COMPLETED	
•		245493	B. WING				/04/2014
	PROVIDER OR SUPPLIER			615	EET ADDRESS, CITY, STATE, ZIP CO MINNETONKA MILLS ROAD PKINS, MN 55343	DDE	
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	-At 8:24 a.m. NA-linto her room. NA and put on R11. No brush her teeth not. At 8:44 a.m. while seven, white 1/2 in observed on R11's she wanted her classist R11. NA-B go to breakfast. R11's care plan de Potential Alteration Grooming, R11 we staff assist daily, with grooming as undated care care be checked for fagreen bath book residents are to be considered to the care part of	3 wheeled R11 from bathroom -B cleaned R11's eye glasses IA-B asked R11 if she wanted to be and R11 stated, "No." a R11 and NA-B still in her room inch length facial hairs were is chin. NA-B did not ask R11 if inin hairs shaved nor did her then asked R11 if she wanted to ated 9/17/14, indicated: in in ADL Self Performance of rould groom self with Mod-Max R11 required extensive assist sist of one staff to shave. NAs d for R11 indicated R11 was to roial hair and shaved daily. The indicated: "ATTENTION, All be shaved on a daily basis." 21 p.m. registered nurse (RN)-A e cards for the residents are a rolans, and the NAs carry them them." 224 a.m. RN-B stated, "We of follow the residents' care 2:11 p.m. NA-F stated, "Every sidents' facial hair, we make sur and there is no facial hair." 2:00 p.m. director of nursing the expected nursing staff to follow	е	282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				É SURVEY IPLETED
	245493	B. WING			12/	04/2014
NAME OF PROVIDER OR SUPPLIER AUGUSTANA CHAPEL VIEW CA	ARE CENTER		615 MJ	FADDRESS, CITY, STATE, ZIP O NNETONKA MILLS ROAD INS, MN 55343	CODE	
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
on 12/3/14, at 2:38 pfacial hairs approximobserved on upper liwas never offered as R14's activities of daplan dated 11/14/14, for self performance grooming related to impaired functional reloss, and weakness required assistance and upper body, dredid not address R14 included facial hair ron On 12/3/14, at 8:07 (OT)-E stated the ailed, to the toilet and she could as she way what grooming need R14 brushed her ow pericares and brush what she had assist cares, OT-E indicate pericares. On 12/3/14, at 2:09 gotten R14 dressed gone back to the robrushed teeth and for the could as she way what she had assist cares, OT-E indicate pericares. On 12/3/14, at 2:09 gotten R14 dressed gone back to the robrushed teeth and for the could as she way what she had assist cares, OT-E indicate pericares.	on 12/1/14, at 3:30 p.m. and o.m. to have multiple white nately one-half (1/2") inch ip and jaw below mouth and ssistance to remove them. ally living (ADL) function care, identified R14 had alteration of bathing, dressing, diagnoses of arthritis, mobility, short term memory. The care plan directed R14 of one, staff to wash lower as lower and upper body but it's grooming needs which removal. a.m. occupational therapist ides help R14 to get out of dicued her to do as much as as improving. When asked as R14 required OT-E stated on teeth, did get help with led hair herself. When asked that her her assisted her with p.m. NA-C stated OT-E had a that morning and NA-C had om to makes sure R14 had NA-C would assisted her with led what she reports to the abnormal vitals, if the resident rer is unusual, breathing we something happen that export, skin check/changes and		282			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245493	B. WING			12/0	4/2014
	ROVIDER OR SUPPLIER			615 N	ET ADDRESS, CITY, STATE, ZIP CODE MINNETONKA MILLS ROAD PKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	(LPN)-B verified F When asked who residents were pr "the nursing assis On 12/3/14, at 3: hairs RN-C indicathe nurse should grooming to make groomed." On 12/4/14, at 2 "Women should I men" when asked assisting female removal. Augustana Chap Policy Subject Co "Provide a writter the resident to m care, and psycholindividualization resident's plan of 483.25 PROVID HIGHEST WELL Each resident m provide the necession mental and psycholindividualization resident's plan of 483.25 PROVID HIGHEST WELL Each resident m provide the necession mental and psycholindividualization resident's plan of 483.25 PROVID HIGHEST WELL Each resident m provide the necession mental and psycholindividualization resident m provide the necession m provide the necession m provide the necession m provident m provi	38 p.m. licensed practical nurse R14 had multiple facial hair. was responsible to ensure operly groomed LPN-B stated stants are." 22 p.m. when asked about facial ated "the nursing assistant and be looking out for residents' esure they were properly 24 p.m. the DON stated be asked to be shaved, same as down her expectation of staff with residents with facial hair el View Health Care Center are Plans dated 1/14, directed an guide for intervention, assisting eet their needs for ADLs, health associal needs, to provide for (choice/preferences) of the ficare." E CARE/SERVICES FOR BEING ust receive and the facility must essary care and services to attain highest practicable physical, chosocial well-being, in the comprehensive assessment	· F	309			
		ガENT is not met as evidenced					

CLIVILI	10 1 OIT WILDIOATTE					VOLDATE	CLIDVEV
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245493	B. WING			12/0	4/2014
	PROVIDER OR SUPPLIER TANA CHAPEL VIEW	CARE CENTER		61	REET ADDRESS, CITY, STATE, ZIP CODE 5 MINNETONKA MILLS ROAD DPKINS, MN 55343		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 309	by: Based on observareview, the facility medication and ox manner to 1 of 1 re hospice care. In acidentify a non-pressures to preve (R14) reviewed for Findings include: Hospice care: On 12/4/14, at 7:5 in bed and was can understand natwice, no staff resures assistant across R59's roor overheard talking -At 7:55 a.m. NA-and went back to -At 7:58 a.m. R59 on the door, and was nostrils. Oxygen tank was nostrils. Oxygen tank was nostrils. Oxygen to observed on top of hand was also hot top of her abdomi with moist but nor R59 was observe coughing and with also showed sign body as she adjuing R59 stated to have	ation, interview and document failed to ensure pain ygen was provided in timely esident (R59) reviewed for ddition, the facility failed to sure skin condition (bruise), use and provide preventative ent bruising for 1 of 3 residents r non-pressure skin condition. O a.m. R59 was observed lying alling out "will somebody call [did me] to come!?" R59 called out bonded to the call. called out for the third time, (NA)-D came out from the room, entered R59's room and was		809	R59 did receive her pain medication as requested and oxygen cannula properly place. Nurse and Nursing Assistant involved were educated on importance of timely medical administration and ensuring padministration of oxygen. R14 bruise of unknown origing right hand was assessed. Resunsure how this bruise occur was able to participate in into Nurses involved were educated importance of completing increports and follow up investing timely for skin alterations. Timely medication administry placement of oxygen tubing appropriate follow up for skin alterations was included in a education. Clinical Managers and DON responsible.	tion proper n on sident red but erview. ted on cident gations ration, and in all staff	-13-15

STATEMENT OF BETTOLEN		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245493	B. WING	· · · · · · · · · · · · · · · · · · ·		/04/2014
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP C 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343	ODE	
(X4) ID PREFIX TAG	LEACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE
F 309	angina and heart having wanted to nobody could hel nor any fluid con-At 7:59 a.m. NA R59 she was goi NA-D verified the R59's bedside ar for a drink when 7:54 a.mAt 8:01 a.m. NA small pitcher of while cartons, ho so R59 was still -At 8:03 a.m. reg R59's room, was to hook R59's ox RN-B increased three liters per n needed medicat drink and wanter RN-B told R59 hoain medication straws for R59's telephone numb determined how oxygen prior to 1-At 8:07 a.m. the oximeter read a 90% at 8:10 a.mAt 8:11 a.m. RN one carton of th handed it to R55 written on a piec gave the telephotalk to F-B, put one was answe signs of discom	failure) for pain. R59 added drink since "last night" but pher. There was neither fluid tainer on R59's bedside table. -D entered R59's room and tolding to get her something to drink. Bre was no fluid available at and confirmed R59 asked NA-D NA-D first entered R59's room with a water and fluids contained in two owever, NA-D did not bring straws unable to drink. Bistered nurse (RN)-B entered shed his hands and went ahead sygen through R59's nostrils, the oxygen to be delivered at ninute. R59 told RN-B that she ion for pain, wanted to have a did to call family member (F)-B. Be would find the nurse to give the RN-B also stated he would bring drinks and would get the long R59 laid in bed without the che observation. By oxygen saturation per pulse to 77% then gradually increased to		309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245493	B. WING		12	04/2014
,,,,,,	ROVIDER OR SUPPLIER ANA CHAPEL VIEW			STREET ADDRESS, CITY, STATE, ZIP C 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 309	would attempt bood-At 8:31 a.m. R59 R59's room that not medication as of the would go look for a stepped out of R5-At 8:33 a.m. RN-I gown, asked for Nothern went on to chood the word her in bed. At 8:35 a.m. RN-I R59's pain medicated at RN-B who was fear of dying, and be on Hospice and they would talk abdialed F-B's number and the word her in bed. R59's quarterly Modified 11/19/14, indicated decision making. Indicated deci	s were still noted when R59 y shifting. told RN-B who re-entered obody had given R59's pain he time. RN-B told R59 that he the nurse, and then RN-B 9's room. B returned to R59's room with a A-D's help to boost R59 in bed, lange R59's gown which spilled drink. R59 reacted with unds when RN-B and NA-D	and printing and an artist of the state of t	09		

PRINTED: 12/18/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

TATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		MPLETED
		245493	B. WING			/04/2014
	OVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, Z 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343		OJE:
(X4) ID PREFIX TAG	ALYON DESIGNATIONS	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	It was further note as needed (PRN) The care plan date alteration in comfo complaints of pair as generalized. Rechest pain. The caimplement interve anticipating reside non-verbal indicate medications as of (NP) or the physic medicated cream ordered by NP or to legs for 20 min A review of the m (MAR) dated 11/4 never had PRN E (topical medicated doses of Dilaudic (mg) and PRN N days ago on 11/2 that R59 request complained of choxygen saturation complaint of chemals. The Physician C directed staff to while awake and Nitrostat 0.4 mg pain; Lyrica 75 r Dilaudid liquid 3 pain every 4 hor mouth every hor as general plant of chemals.	d to severe degree of pain daily. d R59 was on scheduled and pain medications. ed 8/13/14, indicated R59 had both with mild to severe in daily. Pain was characterized 59 was also identified to have are plan directed staff to entions which included entions of pain; giving PRN pain redered by the nurse practitioner cian (MD; applying topical as for pain; giving Nitrostat as MD; and applying warm packs and applying warm packs and the second second with the pain in the PRN defence of the pain in the pain; giving Nitrostat were last given eight 26/14. It was noted in the MAR the the dilaudid and also the pain on 11/26/14. R59's on was noted as 60% with the	st in;	309		

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245493	B. WING			/04/2014
	PROVIDER OR SUPPLIE ANA CHAPEL VIEW			STREET ADDRESS, CITY, STATE, ZIP CO 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343	DE	
(X4) ID PREFIX TAG	/EACH DESIGIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL I LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	nasal cannula ev On 12/4/14, at 8: received PRN Di Nitrostat medicat -At 1:15 p.m. the she expected sta complaints of pa according to care The facility's poli Management/As provided for staf medications for I receive the hosp manner to maint to ensure the ox maintain the oxy Bruise: R14's diagnoses (generalized), ri ulcer, and chron admission MDS daily living (ADL potential CAA di severe impairm physical assist v dressing, groom R14's skin care R14 was at risk "will remain inta care plan direct assisting reside not slide and to	ery shift for comfort. 49 a.m. RN-D verified R59 last audid pain medication and ion on 11/26/14. director of nursing (DON) stated if to assess any resident's in and implement interventions e plan. cy on Pain sessment last reviewed on 8/14, it to administer ordered PRN breakthrough pain. R59 did not ice related services in a timely ain and /or control the pain and ygen was being delivered to	al			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY APLETED
		245493	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CO		/04/2014
NAME OF PROVIDER OR SUPPLIER AUGUSTANA CHAPEL VIEW CARE CENTER						
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	On 12/1/14, at 4:00 wheelchair in her rr RN-G in room obs wheelchair slightly anything about the thumb that was vision 12/2/14, at 8:2 hand between thur asked how the brustated "I bruise ear On 12/3/14, at 7:1 R14's room. Upon occupational there and R14 was observed and R14 was observed wheelchair, door was a man of the slightly open, there and R14 seated on the slightly open, there are resulting to the s	9 p.m. observed R14 seated on oom with husband visiting. erved moving resident, then briefly, never discussed dark purple bruise to right sible. 8 a.m. observed bruise on right mb and second finger. When hise may have occurred R14 sily." 8 a.m. observed door shut to entering room observed upist (OT)-E making the bed erved seated on the toilet. erved OT-E come out of room contents, R14 was seated on		09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY MPLETED
		245493	B. WING			12	04/2014
NAME OF PROVIDER OR SUPPLIER AUGUSTANA CHAPEL VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 309	-At 9:12 a.m. NA-I holding blanket an had brought a war get wrapped with I -At 9:17 a.m. obset therapist (PT)-G ethe doorAt 9:19 a.m. PT-G getting an oximeted oxygen level) and back and said shet then stated it was percent (%) PT-G and push seat upwalker and was oldark purple bruise was visible to PT-On 12/3/14, at 12 would report to the would report abused what she was abnormal vitals, runusual, breathin redness. On 12/3/14, at 2:0 occupational therasked what she was abnormal vitals, runusual, breathin redness. On 12/3/14, at 2:0 had gotten the bruise. LP had gotten the bruise. LP had gotten the bruising. LPN-B for the purple bruising. LPN-B for the purple bruising. LPN-B for the purple provising. LPN-B for the purple provision and methal purple provision.	E came back to room observed d overheard telling R14 she m towel. NA-E assisted R14 to blanket and left room briefly. erved NA-C and physical nter room. NA-C left and shut a left room stated she was er (a machine used to measure would be back. PT-G came would test the oxygen level, spell this out ninety four (94) got R14 to push up from chair R14 was resting arms on observed walking in room. R14's between thumb and first finger G but nothing was said about it.		309			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245493	B, WING		12/	04/2014	
NAME OF PROVIDER OR SUPPLIER AUGUSTANA CHAPEL VIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 309	was aware of R14 thumb and first fine been informed by further stated he w had cared for resid to nurses and to a usually the nurse w and he would revie On 12/04/14, at 2: when asked about discover it should anybody who sees During review of In Notes dated 10/28 revealed the dark between the thum identified nor dock Notes it was revea nursing note dated been brought to the Skin Care Program staff "Residents at Residents at risk if have interventions Plan, computer	2 p.m. RN-C was asked if he I's bruise to right hand between ger. RN-C stated he had just LPN-B about the bruise. RN-C would have expected staff who dents to have reported bruises ssess it. RN-C also indicated would fill out an incident report	F3				
F 312 SS=D	: - ' - ' -	CARE PROVIDED FOR SIDENTS	F	312			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
THE LANG	, 10	245402	B. WING			10/0	4/2014
		245493	B. W119C		REET ADDRESS, CITY, STATE, ZIP CODE	1 12/0	4/2014
NAME OF PROVIDER OR SUPPLIER AUGUSTANA CHAPEL VIEW CARE CENTER			615 MINNETONKA MILLS ROAD HOPKINS, MN 55343				
(X4) ID PREFIX TAG	/CACH DEFICIENC	ATEMENT OF DEFICIENCIES YY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 312	daily living received maintain good nut and oral hygiene. This REQUIREMI by: Based on observative review, the facility for 1 of 3 resident incontinence care provide assistant 2 of 4 residents (on staff. Findings include: R226 did not recorders for bowel in The undated Resindicated was adwith diagnoses in disease, Congest The care plan dawas on hospice of the Admission of 12/1/14, indicated incontinent with with bowel move R226 needed two hygiene and tolk. The Nursing Admission Admission of the Nursing Admission and tolk.	unable to carry out activities of as the necessary services to crition, grooming, and personal ation, interview and document of failed to provide perineal care as (R226) reviewed for bowel and addition, the facility failed to be with facial grooming cares for R11, R14) who were dependent as general area cares during an acontinence. Sident Admission Record mitted to the facility on 11/18/14, including dementia, Alzheimer's tive heart failure. Minimum Data Set (MDS) dated a R226 was frequently urine and was always incontinent and memors. The MDS also indicated to staff assistance with personal	t	312	Peri-care protocol was review with Nursing Assistants invocare of R226. Residents R11 and R14 are to shaved daily as needed. Nurses Assistants involved have been educated on grooming needs requirements. To prevent recurrence, Shave Peri-Care policies have been reviewed with Nursing Depastaff. 5 audits of resident shaving audits of peri care practices done weekly for 3 months to ongoing compliance. Audit outcomes will be shared with facility QAPI committee or Nurse Managers and DON responsible.	peing resing en s and artment and 2 will be o ensure	/-/3-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		RECTION IDENTIFICATION NUMBER:		TIPLE C	CONSTRUCTION	COMPLETED		
		245493	B, WING			12/	04/2014	
NAME OF PROVIDER OR SUPPLIER AUGUSTANA CHAPEL VIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 312	- R226 was alert and time R226 was incor- R226 needed a bathing and hygic with bed mobility The undated TCl card also indicate staff with groomi R226 was observed to the staff with groom of the staff washeloths and however did not provide genital approached to the staff with groom of the staff washeloths, however thighs were not incontinence particular and completed the staff washeloths, sepperineal cleanling washeloths, seppenital area car with dark green five additional washeloths.	and oriented to person, place attinent bowel and bladder ssist of one staff with toileting, ene, and assist of one/two staff U (transitional care care) Care ed R226 needed assist of one		312				

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMP	LETED
		245493	B. WING			12/0	4/2014
	PROVIDER OR SUPPLIER	CARE CENTER		615	REET ADDRESS, CITY, STATE, ZIP CODE MINNETONKA MILLS ROAD PKINS, MN 55343		
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	LPN-C was interviand stated that wharea cleanliness Figenital area and the nursing assistants resident's genital alegs separated. During interview of stated NA-F "was when she was turning interview of the infection congression of the infection congression of the "Female Orange". Use wipes, but on special soap to pexpected to clean skin clean. The facilities Perdated revised on waterproof padulegs and lift the bed." The policy of the "Female Orange in one motogen and sin one motogen and sin one motogen and sin one motogen."	ewed on 12/3/14, at 8:28 a.m. len she checked R226's genital. R226 was dirty with stool on her nighs. LPN-C also stated the were expected to clean area while on back and with an 12/3/14, at 9:18 a.m. NA-B supposed to clean resident ned to the left side", and that completed the genital area on 12/3/14, at 10:13 a.m. NA-F ht" NA-C "cleaned resident". It of nurse (ICN) who was also aff development was 2/3/14, at 2:46 p.m. The ICN wed extensive training upon hire; or, and also watched videos on The ICN also stated staff did not hely wet washcloths, towels and erform pericare, and staff was an until washcloths came off the ineal Care policy and procedure 10/14, indicated "Place a under the resident's hips. Spread the side of the neurethral opening towards the ineurethral opening towards the ineurethral opening towards the repeat until the area is clean."	9	312			

PRINTED: 12/18/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		ONSTRUCTION		PLETED
		245493	B. WING			12/	04/2014
	PROVIDER OR SUPPLIE ANA CHAPEL VIEW			615	EET ADDRESS, CITY, STATE, ZIP CODE MINNETONKA MILLS ROAD PKINS, MN 55343		.
(X4) ID PREFIX TAG	(FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL B LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 312	R11 and R14 were free from unwant free from unwant R11 was observed length facial hairs p.m. R11 stated, R11 also stated, just plucks them received my shown R11's quarterly for was cognitively in assist with activity personal hygienes the undated resimalaise, fatigue, On 12/3/14, at 8 in bed with seven hairs on her chircher up from bed wanted to wear privacy curtain, yet wash cloth a face and then disprovided. NA-B and assisted R1 washed and driestated, "That fee R11 with dressin and assisted R1 wheelchair (w/c) bathroom. NA-B stated, "I After R11 finished on assisted R11 backside and provided and provided and provided R11 backside R11 backside and provided R11 backside R1	re not provided services to be		312			

F 312 Continued From page 27 -At 8:24 a.m. NA-B wheeled R11 from bathroom into her room. NA-B cleaned R11's eye glasses and put on R11. NA-B asked R11 if she wanted to brush her tech now and R11 stated, "No." -At 8:44 a.m. while R11 and NA-B still in her room seven, while 1/2 inch length facial hairs were observed on R11's chin. NA-B did not ask R11 if she wanted her chin hairs shaved nor did her assist R11. NA-B then asked R11 if she wanted to go to breakfast. R11's care plan dated 9/17/14, indicated: Potential Alteration in ADL Self Performance of Grooming, R11 would groom self with Mod-Max staff assist daily. R11 required extensive assist with grooming assist of one staff to shave. NAs undated care card for R11 indicated R11 was to be checked for facial hair and shaved daily. The green bath book indicated: "ATTENTION, All residents are to be shaved on a daily basis." On 12/2/14, at 3:21 p.m. registered nurse (RN)-A stated, "The care cards for the residents are a part of the care plans, and the NAs carry them and are to follow them." On 12/3/14, at 7:24 a.m. RN-B stated, "We expect the NAs to follow the residents' care cards." On 12/4/14, at 12:11 p.m. NA-F stated, "Every day we shave residents' facial hair, we make sure they are clean and there is no facial hair," on 12/4/14, at 12:00 p.m. director of nursing (DON) stated she expected nursing staff to follow		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SLIPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION		E SURVEY MPLETED
AUGUSTANA CHAPEL VIEW CARE CENTER Maj ID			245493	B, WING				/04/2014
F 312 Continued From page 27 At 8:24 a.m. NA-B wheeled R11 from bathroom into her room. NA-B cleaned R11's eye glasses and put on R11. NA-B asked R11 if she wanted to brush her teeth now and R11 stated, "No." At 8:44 a.m. while R11 and NA-B still in her room seven, white 1/2 inch length facial hairs were observed on R11's chin. NA-B did not ask R11 if she wanted to go to breakfast. R11's care plan dated 9/17/14, indicated: Potential Alteration in ADL Self Performance of Grooming, R11 would groom self with Mod-Max staff assist daily. R11 required extensive assist with grooming assist of one staff to shave. NAs undated care card for R11 indicated R11 was to be checked for facial hair and shawed daily. The green bath book indicated: "ATTENTION, All residents are to be shaved on a daily basis." On 12/2/14, at 3:21 p.m. registered nurse (RN)-A stated, "The care cards for the residents are a part of the care plans, and the NAs carry them and are to follow them." On 12/3/14, at 7:24 a.m. RN-B stated, "We expect the NAs to follow the residents' care cards." On 12/4/14, at 12:11 p.m. NA-F stated, "Every day we shave residents' facial hair, we make sure they are clean and there is no facial hair, we make sure they are clean and there is no facial hair, we make sure they are clean and there is no facial hair, we make sure they are clean and there is no facial hair."					615	MINNETONKA MILLS ROAD	E	,
-At 8:24 a.m. NA-B wheeled R111 from bathroom into her room. NA-B cleaned R111's eye glasses and put on R11. NA-B asked R11 if she wanted to brush her teeth now and R11 stated, "No." -At 8:44 a.m. while R11 and NA-B still in her room seven, white 1/2 inch length facial hairs were observed on R11's chin. NA-B did not ask R11 if she wanted her chin hairs shaved nor did her assist R11. NA-B then asked R11 if she wanted to go to breakfast. R11's care plan dated 9/17/14, indicated: Potential Alteration in ADL Self Performance of Grooming, R11 would groom self with Mod-Max staff assist daily. R11 required extensive assist with grooming assist of one staff to shave. NAs undated care card for R11 indicated R11 was to be checked for facial hair and shaved daily. The green bath book indicated: "ATTENTION, All residents are to be shaved on a daily basis." On 12/2/14, at 3:21 p.m. registered nurse (RN)-A stated, "The care cards for the residents are a part of the care plans, and the NAs carry them and are to follow them." On 12/3/14, at 7:24 a.m. RN-B stated, "We expect the NAs to follow the residents' care cards." On 12/4/14, at 12:11 p.m. NA-F stated, "Every day we shave residents' facial hair, we make sure they are clean and there is no facial hair." On 12/4/14, at 12:00 p.m. director of nursing (DON) stated she expected nursing staff to follow	PREFIX	(FACH DEFICIENC	BY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCED TO THE AP	IOULD BE	(X5) COMPLETION DATE
R14 was observed lying in bed on her back in her room on 12/1/14, at 3:30 a.m. R14's family	F 312	-At 8:24 a.m. NA-into her room. NA and put on R11. Norush her teeth norush her value observed on R11's she wanted her of assist R11. NA-B go to breakfast. R11's care plan of Potential Alteration Grooming, R11 which with grooming assundated care care be checked for fall green bath book is residents are to both the care part of the care part of the care pand are to follow. On 12/2/14, at 3:3 stated, "The care part of the care pand are to follow. On 12/3/14, at 7:3 expect the NAs to cards." On 12/4/14, at 12 day we shave residents are clean and the care part of the care part of the care pand are to follow.	B wheeled R11 from bathroom B cleaned R11's eye glasses IA-B asked R11 if she wanted to be R11 and NA-B still in her room the R11 and NA-B still in her room the R11 and NA-B did not ask R11 if she chin. NA-B did not ask R11 if she chin. NA-B did not ask R11 if she wanted to the asked R11 if she wanted to the asked R11 if she wanted to the asked R11 if she wanted to the asked R11 if she wanted to the asked R11 if she wanted to the asked R11 if she wanted to the asked R11 if she wanted to the asked R11 if she wanted to the asked R11 indicated: the asked R11 indicated R11 was to cial hair and shaved daily. The indicated: "ATTENTION, All the shaved on a daily basis." 21 p.m. registered nurse (RN)-A cards for the residents are a thans, and the NAs carry them them." 24 a.m. RN-B stated, "We to follow the residents' care 2:11 p.m. NA-F stated, "Every sidents' facial hair, we make sure that there is no facial hair." 2:00 p.m. director of nursing the expected nursing staff to follow thans. the diving in bed on her back in her the asked lying in bed on her back in her the asked lying in bed on her back in her		312			

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
AND PLAN O	F CORRECTION	DENTIFICATION NUMBER:	A. BUILD	ING _			
		245493	B, WING			12/0	4/2014
	PROVIDER OR SUPPLIER TANA CHAPEL VIEW			61	REET ADDRESS, CITY, STATE, ZIP CODE 5 MINNETONKA MILLS ROAD OPKINS, MN 55343		
(X4) ID PREFIX TAG	! /EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULI. LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.DBE	(X5) COMPLETION DATE
.F 312	member (F)-A was room. Multiple whi one-half (1/2") incl below mouth. On 12/2/14, at 4:0 wheelchair in her was observed in the wheelchair slightly remove the facial On 12/3/14, at 7:1 therapist (OT)-E respectively the toilet. At 7:32 a.m. obsection of the wish bag of soiled wheelchair, door wheelchair on wheelchair on wheelchair staff in the dining that stayed in the visible then came at 8:12 a.m. obstable with three cand at 8:12 a.m. obstable with three cand at 8:51 a.m. R1 completed eating staff in the dining at 9:08:08 a.m. R14 from breakf at 9:09 a.m. NA R14, and put telein her wheelchair	s seated in chair in corner of the te facial hairs approximately nobserved on upper lip and jaw 9 p.m. observed R14 seated on room with F-A visiting. RN-G ne room moving resident 4, then briefly, never offered to hairs. 8 a.m. observed occupational making bed, R14 was seated on contents, R14 was seated on was slightly open. E went back to room. Observed eelchair by sink, door was E shut the door. erved R14 leaving her room with erapist (OT)-E wheeling her weng room and took elevator to the therapy room was located	g	312			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		re survey MPLETED
		245493	B. WING		12	/04/2014
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 312	-At 9:12 a.m. R14 wheelchair watchir openAt 9:12 a.m. NA-E holding blanket and had brought a warn get wrapped with band left room briefi facial hairsAt 9:17 a.m. both (PT)-G entered roodoorAt 9:19 a.m. PT-G getting an oximete came back and sa level, and then sta percent (%). PT-G and push seat up. walker and was wastandby assist as I chair by window. F without assistance multiple white facial were not acknowle offered to remove R14's diagnoses in (generalized), rhet ulcer, and chronic admission MDS di MDS indicated R1 required extensive dressing, tollet use R14's ADLs functi potential Care Are 11/4/14, identified impairment with or	was observed seated in a TV with door to room wide a Came back to room observed doverheard telling R14 she are towel. NA-E assisted R14 to blanket around R14 upper body by never offered to remove the NA-C and physical therapist om. NA-C left and shut the a left room stated she was ar and would be back. PT-G id she would test the oxygen ted it was ninety four (94) got R14 to push up from chair R14 was resting her arms on alking in room. PT-G was R14 walked in room to sit in R14 was able to sit in chair at R14 was still observed with all hairs above lip and on chinedged, and no assistance was	F	812		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• '	TIPLE CONSTR			re survey MPLETED
		245493	B. WING			12	/04/2014
	PROVIDER OR SUPPLIEF			615 MINNE	DRESS, CITY, STATE, ZIP CO TONKA MILLS ROAD , MN 55343	DDE	
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR EACH CORRECTIVE ACTION DSS-REFERENCED TO THE A DEFIGIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 312	grooming and toil dated 11/14/14, 14 is self-performance related to diagnost functional mobility weakness. The cassistance of one body, dress lower address R14's gradial hair removal on 12/3/14, at 8:0 her to do as muclimproving. When R14 required OT teeth, did get help herself. When as during morning coindicated she had on 12/3/14, at 2: gotten R14 dress gone back to the brushed teeth and toileting. When a NA-C stated abn was in pain, what problems, if she should not would redness among on 12/3/14, at 2: multiple facial had responsible to er groomed LPN-B are."	eting. ADL function care plan lentified R14 had alteration for of bathing, dressing, grooming ses of arthritis, impaired y, short term memory loss, and are plan directed R14 required y, staff to wash lower and upper and upper body but did not coming needs which included al. 27 a.m. OT-E stated the aides ut of bed, to the toilet and cued h as she could as she was asked what grooming needs asked what grooming needs but he pericare and brushed hair ked what she had assisted R14 ares as observed OT-E diassisted her with pericare. 29 p.m. NA-C stated OT-E had sed that morning and NA-C had room to makes sure R14 had d NA-C would assisted her with sked what she reported to nurse ormal vitals, reported if resident tever was unusual, breathing saw something happen that I report, skin check/changes and		312			

		WINDOWN CENTRAL	0.00 3.00 7.00	CONCEDUCTION	(X3) DATE SURVEY	- 1
	OF DEFICIENCIES FORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	COMPLETED	
		245493	B. WING		12/04/2014	_
	ROVIDER OR SUPPLIER ANA CHAPEL VIEW	CARE CENTER	6	TREET ADDRESS, CITY, STATE, ZIP CODE 15 MINNETONKA MILLS ROAD OPKINS, MN 55343		
(X4) ID PREFIX TAG	ARACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROID DEFICIENCY)	D BE COMPLETION	1
F 314 SS=D	hairs RN-C indicate the nurse should be grooming to make groomed." On 12/4/14, at 2:2 "Women should be men" when asked assisting female removal. Augustana Chape Policy Subject Ca "Provide a written the resident to me care, and psycholindividualization (resident's plan of 483.25(c) TREAT PREVENT/HEAL Based on the corresident, the facility who enters the fadoes not develop individual's clinicately were unavoid pressure sores reservices to promiprevent new sore this REQUIREM by: Based on obserview, the facility assess a pressure soresure soresure soresure the facility assess a pressure soresure sore	ed "the nursing assistant and be looking out for residents' sure they were properly 4 p.m. the DON stated e asked to be shaved, same as her expectation of staff with esidents with facial hair el View Health Care Center re Plans dated 1/14, directed guide for intervention, assisting set their needs for ADLs, health social needs, to provide for choice/preferences) of the care."	0	F314 As stated above, R226 had a pressure ulcer on spine at the of admission. The ulcer was measured but a wound flow was not initiated. Wound care being done as ordered physician with the exception. The exception noted was rewith the nurse involved and return demonstration was performed. A wound flow sheet is in playound cares continue to be ordered and ulcer is healing.	se time s sheet ares by the n noted. viewed a ace and done as	15

	4/2014
240430	4/ZU14
NAME OF PROVIDER OR SUPPLIER AUGUSTANA CHAPEL VIEW CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314 Continued From page 32 to monitor effectiveness of the treatments to promote wound healing for 1 of 3 residents (R226) reviewed for pressure ulcer. Findings include: R226's pressure ulcer was not assessed upon admission (11/18/14) and/or since admission, until surveyor observed it on 1 2/3/14. The facility staff did not provide ulcer treatment as ordered by the physician. R226's pressure ulcer was observed during dressing change on 12/3/14, at 8:04 a.m. performed by the licensed practical nurse (LPN)-C. The pressure ulcer was on the spine, mid back, and was approximately dime sized, with 100 percent (%) pale yellowish slough. The LPN-C washed hands, set up the dressing change supply, applied clean gloves, removed the old dressing, and washed the wound bedusing a folded 4x4 gauze. Applied Mepilex dressing on the wound, dated and signed it. During interview on 12/3/14, at 8:28 a.m. the LPN-C stated the pressure ulcer was dime sized, and stated the wound bed by slough or eschar), and there was 100 % "slough" in the wound bed." After verifying the physicians order, the LPN-C stated she was suppose to use normal saline to clean the wound instead of the Dermal wound cleanser, and was not to apply Medihoney gel, since it was discontinued. LPN-C interview.	cont'd 1-13-15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[' '			ATE SURVEY OMPLETED	
		245493	B. WING		12	/04/2014	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIR 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343	CODE		
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F 314	Continued From p	age 33	F3	114			
	the previous week	nembered using the Medihoney when she worked, and erify physician order prior					
	indicated was adm with diagnoses ind and congestive he	dent Admission Record nitted to the facility on 11/18/14, cluding Alzheimer's disease, eart failure. The care plan dated d resident was on hospice care.					
	"Wound care: bac saline (salt water) (an absorbent dre composite dressir day." The order to wound dressing u	ler dated 11/24/14, indicated, ock-clean wound with normal 4x4. Cover with 4x4 Mepilex essing) border or other ng. Once a day Every other o "Apply Medihoney gel (a sed to speed up healing) to discontinued on 11/24/14.					
	and contradicting - The Admit/Weel 11/18/14, indicate body diagram ind however the stage measurements w - The progress neacked evidence to assessed upon and admission to ensity - The physician's noted presence of small ulcerations redness- proximal distal shallow with - The Tissue Tole 11/19/14, noted "	kly skin check tool dated of circled area on mid back of a icating "pressure ulcer", e of the wound or ere not documented. otes dated from 11/18/14, also the pressure ulcers were dmission or any time after ure monitoring. progress notes dated 11/19/14, if "Thoracic pressure ulcer- 2 surrounded by non blanchable all ulcer 100% slough in base,					

F 314 Continued From page 34 described as being assessed. The Assessment indicated intervention plan for one hour repositioning schedule The Skin Risk assessment w[with]/ Braden scale dated 11/27/14, (tool used to determine risk for developing pressure ulcers had a score of 13 (moderate risk), interventions included pressure reducing devices for chair and bed, pressure ulcer care and turning and repositioning program. However, there was no documentation the	URVEY
AUGUSTANA CHAPEL VIEW CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG F 314 Continued From page 34 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 314 Continued From page 34 F 314 described as being assessed. The Assessment indicated intervention plan for one hour repositioning schedule -The Skin Risk assessment w[with]/ Braden scale dated 11/27/14, (tool used to determine risk for developing pressure ulcers had a score of 13 (moderate risk), interventions included pressure reducing devices for chair and bed, pressure ulcer care and turning and repositioning program. However, there was no documentation the	ETED
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indicated intervention plan for one hour repositioning schedule -The Skin Risk assessment w[with]/ Braden scale dated 11/27/14, (tool used to determine risk for developing pressure ulcers had a score of 13 (moderate risk), interventions included pressure reducing devices for chair and bed, pressure ulcer care and turning and repositioning program. However, there was no documentation the	
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-The Skin Risk assessment w[with]/ Braden scale dated 11/27/14, (tool used to determine risk for developing pressure ulcers had a score of 13 (moderate risk), interventions included pressure reducing devices for chair and bed, pressure ulcer care and turning and repositioning program. However, there was no documentation the	
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(moderate risk), interventions included pressure reducing devices for chair and bed, pressure ulcer care and turning and repositioning program. However, there was no documentation the	
reducing devices for chair and bed, pressure ulcer care and turning and repositioning program. However, there was no documentation the	
ulcer care and turning and repositioning program. However, there was no documentation the	
However, there was no documentation the	
pressure ulcers were measured or assessed for	
stage The Admission Minimum Data Set (MDS) dated	
12/1/14, indicated R226 had two stage 2 (Partial	
thickness loss of dermis presenting as a shallow	
open ulcer with a red-pink wound bed without	
slough [non viable white/yellow tissue]) pressure	
ulcers, R226 was on hospice care and R226 needed two staff assist with mobility, dressing	
and personal hygiene.	
- There was no Weekly wound documentation	
form flowsheet completed in the facility's wound	
book.	
The registered nurse (RN)-C, also clinical	
manager on the transitional care unit was	
interviewed on 12/3/14, at 10:11 a.m. and stated	
R226 currently had two stage 2 pressure ulcers	
on the mid spine. RN-C looked through the wound book and stated there was no wound flow	
sheet initiated upon admission to complete	
weekly measurements, verified the Admit/ Weekly	
skin check tool, and verified although staff	
identified pressure ulcers on the body diagram, staff did not indicate assessment or	
measurement. During interview RN-C stated he	
saw R226's pressure ulcers on 11/25/14, and	
remembered the two wounds measurements, and	i
the wounds being at stage two, but he did not	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		245493	B. WING		12/0	4/2014
	ROVIDER OR SUPPLIE ANA CHAPEL VIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 314	interview RN-C stathe wounds on 11 11/19/14. After reconfirmed the recevidence R226's comprehensively include measurer of the wound. The director of not 12/4/14, at 1:55 pexpected to do a upon admission, nurse was expectassessment inclustage, and located document on the form, and start the DON further explassessment week completed to mode After reviewing Fiverified R226's beassessed upon at 15 The Skin Care Pog/14, indicated ulcers noted on the Information Quewound Flow Shebe completed in The policy also completed in The Policy als	page 35 Five minutes later during tated that actually he did not see /25/14, but he saw them on viewing R226's record RN-C cord did not contain any pressure ulcer on the back was assessed since admission to ments, staging, and monitoring dursing (DON) was interviewed on the ments, staging, and monitoring dursing (DON) was interviewed on the ments, staging, and monitoring dursing (DON) was interviewed on the ments, and stated staff were head to toe skin assessment if a resident came with a wound, ading wound measurements, on of the wound. Staff needed to admission Skin Assessment he weekly wound flow sheet. The lained after the initial admission kly wound measurements were nitor wound healing progression. R226's medical record the DON ack pressure ulcer was not admission, or thereafter weekly. Trogram policy last reviewed on "Any pressure and/or vascular the Nursing Admission stionnaire are to have a Weekly set completed and scheduled to the care path on a weekly basis." If the care path on a weekly basis. Sument on pressure and/or on a weekly basis utilizing the Flow Sheet scheduled every				
1	1					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, .	TIPLE CONSTRUCTION	COME	PLETED
		245493	B. WING			04/2014
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COD 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343		
(X4) ID PREFIX TAG	YEARH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL. R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD BE	(X5) COMPLETION DATE
F 329 SS=D	Each resident's cunnecessary drudrug when used duplicate therapy without adequate indications for its adverse consequence should be reduced combinations of the saddent, the fact who have not us given these drugs receive graph behavioral interventraindicated, drugs. This REQUIRES by: Based on intervent facility failed to adequate monit findings included admit 8/20/14.	drug regimen must be free from gs. An unnecessary drug is any in excessive dose (including y); or for excessive duration; or emonitoring; or without adequate a use; or in the presence of uences which indicate the dose ed or discontinued; or any the reasons above. prehensive assessment of a sility must ensure that residents and antipsychotic drugs are not gs unless antipsychotic drug sary to treat a specific condition and documented in the clinical dents who use antipsychotic adual dose reductions, and ventions, unless clinically in an effort to discontinue these when the desired and documented in the clinical dents who use antipsychotic adual dose reductions, and ventions, unless clinically in an effort to discontinue these when the desired as leep medication had toring for 1 of 5 residents (R118).		Sleep monitoring was in R118. Audits were conducted oresidents receiving medisleep to ensure sleep mowas in place. To prevent recurrence, semonitoring has been addorder Reminder list. Edwas provided to License Staff and Social Service Audits of all residents were medication for sleep with monitored for 3 months ongoing compliance. A outcomes will be review facility QAPI committee Clinical Managers, Sociand DON responsible.	on all other cation for onitoring sleep ded to ducation ed Nursing es. with all be to ensure udit wed by ee.	1-13-15

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		re survey MPLETED
		245493	B. WING		12	/04/2014
	PROVIDER OR SUPPLIES			STREET ADDRESS, CITY, STATE, ZIP 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
F 329	resident had diffice Review of the ele administration rec 8/20/14 through 1 received Trazodo admit and had no Trazodone. Review of the Phy indicated R118 w. antidepressant us (mg) at bedtime, insomnia. Review of R118's indicated "Reside having little energ Approaches inclu- alterations every insomnia and to p to promote sleep. Review of the soc quarterly mood/b 11/10/14, indicate difficulty falling/st started 9/19/14. R118 had diagno dementia obtainer record dated 8/20 Minimum Data Solidentified that the	culty sleeping. ctronic medication cord (EMAR) from admit on 2/3/14, indicated R118 had ne 50 mg every night since t received as needed (PRN) ysician Orders dated 10/25/14, as to receive Trazodone (an sed for insomnia) 50 milligrams and 50 mg at bedtime - PRN for care plan, dated 9/19/14, ant expresses feeling tired and by R/T [due to] insomnia." ded to document mood/behavior shift, administer medications for provide comfortable environment		329		
		ew on 12/4/14, at 12:01 p.m. (RN-B) stated he could find only				

STATEMENT (AND PLAN OF	OF DEFICIENCIES: CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMF	PLETED
		245493	B. WING			12/0	4/2014
	ROVIDER OR SUPPLIEF			615	EET ADDRESS, CITY, STATE, ZIP CODE MINNETONKA MILLS ROAD PKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 428	was in the transiti to this floor. RN-E was completed or social worker, but - At 12:30 p.m. th stated that she we the behavior/mod setting up the mod tracking, but that responsible to trawas no sleep asset the MDS. During an interviolating and interviolating and interviolating and need could be have expected the document hours and need could be an unnecessary adequate monitor medications "a sinitiated and pat for a minimum of baseline and will staff in the progression of the progres	monitoring for R118 when she onal care unit before she came of verified no sleep monitoring documented as outlined by the "have started it now." e licensed social worker (LSW) as responsible for developing of section of the care plan and and behavioral record for the nursing department was ack the sleep. LSW stated there seesment except for what is in ew on 12/5/14, 5:00 p.m. the g (DON) stated nursing should progress note and she would not the night shift would of sleep so that effectiveness be evaluated. Cility policy and procedure titled adication Monitoring for and for Side Effects with review icated that each resident's drug are free of unnecessary drugs, that drug is any drug used "without oring" and that for hypnotic sleep log worksheet will be terns of sleep will be monitored of three days and up to week for a loe summarized by the licensed ress note and Care Plan redingly." CREGIMEN REVIEW, REPORT		329			
	I no arag regime	-					

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245493	B. WING	i,		12/0	4/2014
	PROVIDER OR SUPPLIER	CARE CENTER		61	REET ADDRESS, CITY, STATE, ZIP CODE 5 MINNETONKA MILLS ROAD OPKINS, MN 55343 PROVIDER'S PLAN OF CORRECTI	ON	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
F 428	reviewed at least pharmacist. The pharmacist in the attending physical phy	page 39 conce a month by a licensed nust report any irregularities to sician, and the director of the reports must be acted upon.	F	428	F428 As stated above, sleep monwas initiated for R118. Audits were conducted on a residents receiving medicat sleep to ensure sleep monit was in place. To prevent recurrence, sleep monitoring has been added	all other ion for oring	l-13-15
	by: Based on observereview the facility pharmacist idention not being completed. Findings include: R118 had diagnodementia obtained Record dated 8/3 for insomnia sincrecord lacked midentified the residential page 15 for insomnia sincrecord lacked midentified the residential pharmacist identified in the residential page 15 for insomnia sincrecord lacked midentified the residential pharmacist identified in the residential pharmacist identified identified in the residential pharmacist identified identified in the residential pharmacist identified identifi	oses including insomnia and ed from the Resident Admission 20/14. R118 received Trazodone ce admit 8/20/14, however the onitoring of sleep after it was ident had difficulty sleeping.			Order Reminder list. Educe was provided to Licensed I Staff and Social Services. Audits of all residents with medication for sleep will be monitored for 3 months to ongoing compliance. Audioutcomes will be reviewed facility QAPI committee. Clinical Managers, Social and DON responsible.	eation Nursing n be ensure t l by	
	administration re 8/20/14 through received Trazod admit and had n Review of the co dated 9/12/14 a irregularities. Th 11/20/14, noted behavior sheets	ectronic medication ecord (EMAR) from admit on 12/3/14, indicated R118 had one 50 mg every night since ot received PRN trazodone. onsulting pharmacist (CP) reports nd 10/17/14, identified no te pharmacist Report dated "per the care plan and target the only thing being tracked is recommended updating care pla					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
		245493	B. WING		12	/04/2014
	PROVIDER OR SUPPLIER ANA CHAPEL VIEW			STREET ADDRESS, CITY, STATE, ZIP C 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		I SHOULD BE	(X5) COMPLETION DATE
F 428	Although the CP r care plan and targ thing being tracke identify that the m completed by nurs indicated, "Reside having little energ Approaches inclubed behavior alteration medications for in comfortable environmedicated R118 was antidepressant us bedtime, 20:00 ar needed (PRN) for Review of the soc quarterly mood/be 11/10/14 indicated difficulty falling/stastarted 9/19/14. Review of the quadated 12/4/14, idea cognitively intact staying asleep, or	ors for the medication Zyprexa. The core on 11/20/14, that "per the set behavior sheets the only dis insomnia", the CP did not onitoring was not being sing personnel. Care plan, dated 9/19/14, ent expresses feeling tired and y R/T [related to] insomnia." ded to document mood/ as every shift, administer somnia and to provide comment to promote sleep. Vician Orders dated 10/25/14, as to receive Trazodone (an end for insomnia) 50 mg at and 50 mg at bedtime - as a insomnia. Itial services progress note for chavior tracking review dated did R118 was on tracking for aying asleep and that tracking arterly Minimum Data Set (MDS) centified the resident was and had no trouble falling or sleeping too much.	F 4			
	registered nurse one day of sleep was in the transiti to this floor. RN-E was completed of	ew on 12/4/14, at 12:01 p.m. (RN)-B stated he could find only monitoring for R118 when she onal care unit before she came 3 verified no sleep monitoring a documented as outlined by the transfer that the started it now."			. •	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l · · ·	TIPLE CONSTRUCTION		E SURVEY IPLETED
		245493	B. WING		12/	04/2014
	ROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, 615 MINNETONKA MILLS ROA HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 428	licensed social wor responsible for dev section of the care and behavioral rec nursing departmen sleep. LSW stated assessment excep During an interview director of nursing do a weekly sleep have expected the hours of sleep so could be evaluated On 12/4/14, at 3:0	on 12/4/14, at 12:30 p.m. the rker (LSW) stated she was veloping the behavior/mood plan and setting up the mood ord for tracking, but that the it was responsible to track the there was no sleep of for what is in the MDS. on 12/4/14, 5:00 p.m. the (DON) stated nursing should progress note and she would enight shift would document that effectiveness and need it.		428		
F 431 SS=E	Review of the faci Psychotropic Med Appropriateness a date of 8/14, indic regimen must be than unnecessary of adequate monitori medications "a sle initiated and patte for a minimum of baseline and will be staff in the progred developed accorded 483.60(b), (d), (e) LABEL/STORE D	lity policy and procedure titled ication Monitoring for and for Side Effects with review ated that each resident's drug free of unnecessary drugs, that rug is any drug used "without ing" and that for hypnotic pep log worksheet will be rns of sleep will be monitored three days and up to week for a pe summarized by the licensed as note and Care Plan	F	431		

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S GOMPL	SURV E Y .ETED
AND FEAT	0011112011011	045402	B. WING	,		12/04	4/2014
	PROVIDER OR SUPPLIER			ST 61:	REET ADDRESS, CITY, STATE, ZIP CODE 5 MINNETONKA MILLS ROAD DPKINS, MN 55343		
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F 431	a licensed pharm of records of records of records of recontrolled drugs accurate reconcil records are in ord controlled drugs reconciled. Drugs and biolog labeled in accord professional prinappropriate accessional prinappropriate accessionative instructions, and applicable. In accordance with facility must store locked compartice controls, and permanently afficentrolled drugs Comprehensive Control Act of 1 abuse, except with package drug of quantity stored be readily detection. This REQUIRE by: Based on observeiew, the facting carried according carried according carried according to the control according to th	acist who establishes a system eipt and disposition of all in sufficient detail to enable an iation; and determines that drug der and that an account of all is maintained and periodically gicals used in the facility must be dance with currently accepted ciples, and include the essory and cautionary the expiration date when with State and Federal laws, the e all drugs and biologicals in ments under proper temperature rmit only authorized personnel to the keys. It provide separately locked, ixed compartments for storage of listed in Schedule II of the Drug Abuse Prevention and 976 and other drugs subject to when the facility uses single unit listribution systems in which the is minimal and a missing dose care	f	431	F431 Expired medications and drawere removed from med carbeen done. To prevent recurrence, rour cleaning schedule has been implemented. All medicate were audited for expired medication was provided to Licensed Nursing Staff. 5 weekly audits of locked med carts and expired medicate will be done for 3 months randomly to prevent recurred Audit outcomes will be reby facility QAPI committee Clinical Manager and DO responsible.	ressings arts. ts has tine ion carts heds. and clean dications and then rence. viewed ee.	1-13-15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUING			E SURVEY APLETED
		245493	B. WING				/04/2014
	PROVIDER OR SUPPLIE			615 MINNET	RESS, CITY, STATE, ZIP COD TONKA MILLS ROAD MN 55343	E	
(X4) ID PREFIX TAG	(FACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EA	PROVIDER'S PLAN OF CORRE ACH CORRECTIVE ACTION SH SS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	medications for f	R86 and R75. In addition, the nsure 1 of 7 medication carts This had the potential to affect	F	431			
	Findings include						
	reviewed with lic and the following stored in the car · R86's tube with an expiratio · R75's Clotri medication com fungal infections · House supp expiration date s acknowledged e supposed to be further stated m and had been o	:30 p.m. medication cart was ensed practical nurse (LPN)-D medications were noted to be to be to Bengay (pain relieving cream) and the 9/2014 mazole Cream 1% antifungal monly used in the treatment of by with expiration date 11/14/14 may be more allowed by Mineral oil opened 8/1/13, and 19/14. At 1:37 p.m. LPN-D expired medications were not stored in medication cart. LPN-D edications were used as needed verlooked.					
	reviewed with re the tour the both drawer was obsectioned powder built-up in the capproximately rapproximately	1:42 p.m. the medication cart was egistered nurse (RN)-D. During from and back of the second served to have a thick white debris of paper, foil pieces orners of the drawer and nine loose pills some of which olit. In addition, an open one ty house supply bottle of Aspirin (mg) opened date 9/15/14, with 11/14, was observed stored on that 1:50 p.m. RN-D acknowledged cart was not kept clean; when is responsible of cleaning the	0				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245493	B. WING			12/0	04/2014
	PROVIDER OR SUPPLIER	CARE CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 15 MINNETONKA MILLS ROAD IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	responsible and RN	age 44 N-D stated all the nurses were N-D verified the Aspirin was ed she would remove it from	F 4	131			
	reviewed was compreview a box Silver dressing, Algicell A dressing) with expirobserved stored or When asked who wand ensuring expire	observations and supplies the nedication cart pleted with LPN-C. During the antimicrobial alginate g (antimicrobial wound ration date 4/2014, was a the bottom drawer of the cart. was responsible of cleaning and medications and supplies the cart LPN-C stated the night					
	when asked about alginate dressing, s	37 p.m. RN-C unit manager date for silver antimicrobial stated it should not be in the d should have been tossed out.	·				
F 441 SS=D	stated expired med not have been stor asked about medic stated "they should responsible to keep 483.65 INFECTION	p.m. the director of nursing dications and dressings should ed in medication carts. When eation cart cleanliness DON be clean and everyone is medication carts clean." N CONTROL, PREVENT	F۷	141			
	Infection Control Place safe, sanitary and control Place sanitary and control Place safe, sanitary safe, saf	stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ection.					
	(a) Infection Contro	ol Program					

THAT PROVIDER OR BUPPLIER 245493 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 515 MINNETONIA MILLS ROAD HOPKINS, MN S5343 TAG STREET ADDRESS, CITY, STATE, ZIP CODE 515 MINNETONIA MILLS ROAD HOPKINS, MN S5343 TAG STREET ADDRESS, CITY, STATE, ZIP CODE 515 MINNETONIA MILLS ROAD HOPKINS, MN S5343 TAG STREET ADDRESS, CITY, STATE, ZIP CODE 515 MINNETONIA MILLS ROAD HOPKINS, MN S5343 TAG STREET ADDRESS, CITY, STATE, ZIP CODE 515 MINNETONIA MILLS ROAD HOPKINS, MN S5343 TAG STREET ADDRESS, CITY, STATE, ZIP CODE 515 MINNETONIA MILLS ROAD HOPKINS, MN S5343 TAG STREET ADDRESS, CITY, STATE, ZIP CODE 515 MINNETONIA MILLS ROAD HOPKINS, MN S5343 TAG STREET ADDRESS, CITY, STATE, ZIP CODE 515 MINNETONIA MILLS ROAD HOPKINS, MN S5343 TAG STREET ADDRESS, CITY, STATE, ZIP CODE 515 MINNETONIA MILLS ROAD HOPKINS, MN S5343 TAG STREET ADDRESS, CITY, STATE, ZIP CODE 515 MINNETONIA MILLS ROAD HOPKINS, MN S5343 TAG STREET ADDRESS, CITY, STATE, ZIP CODE 515 MINNETONIA MILLS ROAD HOPKINS, MN S5343 TAG STREET ADDRESS, CITY, STATE, ZIP CODE 515 MINNETONIA MILLS ROAD HOPKINS, MN S5343 TAG STREET ADDRESS, CITY, STATE, ZIP CODE 515 MINNETONIA MILLS ROAD HOPKINS, MN S5343 TAG TAG TAG TAG TAG TAG THOSE PROVIDER PLAN OF CORRECTION CRACH CORRECTION (EACH CORRECTIVE ADDRESSING CRACH CORRECTION (EACH COR	This REQUIREMENT is not met as evidenced by: B. WING 245493 B. WING 245493 B. WING 245493 B. WING 245493 STREET ADDRESS, CITY, STATE, 79 CODE 616 MINNETONKA MILLE BROAD HOPKINS, MIN 5343 B. WING 2576ET ADDRESS, CITY, STATE, 79 CODE 616 MINNETONKA MILLE BROAD HOPKINS, MIN 5343 B. WING 2576ET ADDRESS, CITY, STATE, 79 CODE 616 MINNETONKA MILLE BROAD HOPKINS, MIN 5343 B. WING 2576ET ADDRESS, CITY, STATE, 79 CODE 616 MINNETONKA MILLE BROAD HOPKINS, MIN 5343 B. WING 2676ET ADDRESS, CITY, STATE, 79 CODE 616 MINNETONKA MILLE BROAD HOPKINS, MIN 5343 D. WING 2676ET ADDRESS, CITY, STATE, 79 CODE 616 MINNETONKA MILLE BROAD HOPKINS, MIN 5343 D. WING 2676ET ADDRESS, CITY, STATE, 79 CODE 616 MINNETONKA MILLE BROAD HOPKINS, MIN 5343 D. WING 2676ET ADDRESS, CITY, STATE, 79 CODE 616 MINNETONKA MILLE BROAD HOPKINS, MIN 5343 D. WING 2676ET ADDRESS, CITY, STATE, 79 CODE 616 MINNETONKA MILLE BROAD HOPKINS, MIN 5343 PROPRIEME TABLE BROAD HOPKINS, MIN 5343 D. WING 2676ET ADDRESS, CITY, STATE, 79 CODE 616 MINNETONKA MILLE BROAD HOPKINS, MIN 5343 PROPRIEME TABLE BROAD HOPKINS, MIN 5343 D. WING 2676ET ADDRESS, CITY, STATE, 79 CODE 616 MINNETONKA MILLE BROAD HOPKINS, MIN 5343 PROPRIEME TABLE BROAD HOPKINS, MIN 5343 PROPRIEME TABLE BROAD HOPKINS, MIN 5343 D. WING 2676ET ADDRESS, CITY, STATE, 79 CODE 616 MINNETONKA MILLE BROAD HOPKINS, MIN 5343 PROPRIEME TABLE BROAD HOPKINS, MIN 5343 PORTUGE TRANSPORTED TO THE APPROPRIATE DEPERTY THE APPROPRIATE D			(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE S	ETED
AME OF PROVIDER OR SUPPLER AUGUSTANA CHAPEL VIEW CARE CENTER DEADLY STATEMENT OF DEFICIENCIES SEASON MUST BE PRECEDED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 45 The facility must establish an Infection Control Program under which it - (1) investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility falled to ensure nursing staff provided wound cares to minimize the risk of Intections or pressure ulter for 1 of 3 residents The facility resident procedures, such as isolation to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility falled to ensure nursing staff provided wound cares to minimize the risk of Intections or pressure ulter for 1 of 3 residents The facility resident contact for which hand washing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility falled to ensure nursing staff provided wound cares to minimize the risk of Int	AME OF PROVIDER OR SUPPLIER UGUISTANA CHAPEL VIEW CARE CENTER STREET ADDRESS, CITY, STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. STREET ADDRESS, CITY, STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. STREET ADDRESS, CITY, STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. STREET ADDRESS, CITY, STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. STREET ADDRESS, CITY, STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. STREET ADDRESS, CITY, STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. STREET ADDRESS, CITY, STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. STREET ADDRESS, CITY, STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. STREET ADDRESS, CITY, STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. STREET ADDRESS, CITY, STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. STREET ADDRESS, CITY, STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. STREET ADDRESS, CITY, STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. STREET ADDRESS, CITY, STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. STREET ADDRESS, CITY, STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. STREET ADDRESS. CITY, STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. STREET ADDRESS. CITY, STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. STREET ADDRESS. CITY, STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. STREET ADDRESS. CITY STATE, 2PD CODE 615 MINISTONKA MILLS ADDRESS. PROPOTERS RESOLED OF CORPORATION. PROPOTERS RESOLED OF CORPORATION. PROPOTERS ADDRESS A	ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUİLD	ING _			1004.4
AUGUSTANA CHAPEL VIEW CARE CENTER 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343	### AME OF PROVIDER OR SUPPLIER **UGUISTANA CHAPEL VIEW CARE CENTER** GAM DEPOLICATION OF DESCRIPTION OF DESCRIPTION OF OF			245493	B. WING		OTATE 719 COL		1/2014
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F 441 F 441 Continued From page 45 The facility must establish an infection Control Program under which it - (1) investigates, controls, and prevents infections in the facility. (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infection. (b) Preventing Spread of Infection (1) When the infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must stablished in the disease. (c) The facility must require staff to wash their hands after each direct resident contact with residents or infected skin lesions from direct contact will transmit the disease. (a) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nursing staff provided wound cares to minimize the risk of infections of a pressure ulcer for 1 of 3 residents	F 441 Continued From page 45 The facility must establish an infection Control Program under which it - (1) investigates, controls, and prevents infections in the facility. (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infection. (b) Preventing Spread of Infection (1) When the infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must proprible employees with a communicable disease or infected skin lesions from direct contact will reasmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nursing staff provided wound cares to minimize the risk of infections of a pressure ulcer for 1 of 3 residents (R226) reviewed for pressure ulcers.	AUGUST			ID.	1	PROVIDER'S PLAN OF CORE	RECTION HOULD BE	(X5) COMPLETION
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(R226) reviewed for pressure dicers.	Findings include. Facility in: 00727 If continuation sheet Page 49		The facility must Program under w (1) Investigates, in the facility; (2) Decides what should be applied (3) Maintains a reactions related to (b) Preventing S (1) When the Infedermines that prevent the spresionate the resid (2) The facility momentum direct contact w (3) The facility mands after each and washing in professional pr	establish an Infection Control which it - controls, and prevents infections procedures, such as isolation, d to an individual resident; and ecord of incidents and corrective of infections. pread of Infection ection Control Program a resident needs isolation to ead of infection, the facility must ent. In the instruction of the infection of the	f ch	441	Policy was reviewed incorrection orders and information has been Dressing Change Policy with all Licensed Nursi Weekly audits of 2 dreschanges will be done for to ensure ongoing com Infection Control/Staff Development Director Managers and DON remains and DON remains and provided for R16. Remains the states results were she states results were she states results were she states results were she states of indurative wed with same of the reviewed with same of the reviewed by all licent weekly audits will be months to ensure con Audit outcomes will by facility QAPI con Infection Control Noresponsible.	involved. clusive of ection irn performed. y reviewed ing Staff. ssing or 3 months pliance. f. Clinical esponsible. I been tesults were nvolved and e negative. ienting tion was also nurse. Facili olicy will be used nurses. he done for 3 mpliance. be reviewed mmittee urse and DO	o ty

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
		245493	B. WING		12	/04/2014
	PROVIDER OR SUPPLIER TANA CHAPEL VIEW			STREET ADDRESS, CITY, STATE, ZI 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343		·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	Continued From particles of the undated Residindicated R226 was 11/18/14, with diagal Alzheimer's disease care plan dated 11 on hospice care. The physician order wound care: backsaline 4x4. Cover of their composite do other day." The order wound bed was defended by the language of the performed by the language of th	·	F 4	DEFICIENC		
	time, without wash and applied Medih using folded 4x4 g on the wound, date During interview of LPN-C stated they wash hands betwee R226's pressure u verified she "forgo"	ing hands, put clean gloves on oney gel into the wound bed auze. Applied Mepilex dressing	no A Mari			

245493 B. WING 12/04/2	
	/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343	
	(X5) COMPLETION DATE
During interview on 12/3/14, at 2:46 p.m. the infection control nurse (ICN) stated during wound dressing change staff were expected once they removed the old dressing to take gloves off, wash hands, and apply clean pair of gloves to continue with washing the wound. The Infection Control Policy with subject dressing change with revision date 10/14, indicated in order "to provide treatment as ordered by the physician while preventing the spread of infection", staff was directed to "Sanitize/wash hands and apply clean gloves" before and after removing soiled dressing and gloves."	

Printed: 12/08/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245493

B. WING

12/03/2014

NAME OF PROVIDER OR SUPPLIER

AUGUSTANA CHAPEL VIEW CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

615 MINNETONKA MILLS ROAD

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL R OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		
15	FIRE SAFETY A Life Safety Code Survey was conducte Minnesota Department of Public Safety, Marshal Division on December 03, 2014 time of this survey, Augustana Chapel Vi	Fire . At the		
	Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the edition of National Fire Protection Associ (NFPA) Standard 101, Life Safety Code (Chapter 19 Existing Health Care.	2000 ation		
	This 2-story split level building was deter be of Type II(000) construction. It has a pasement and is fully fire sprinkler protect facility has a fire alarm system with smok detection in the corridors and spaces oper corridor that is monitored for automatic fidepartment notification. The facility has a capacity of 115 beds and had a census of beds at the time of the survey.	partial cted. The se en to the re		ч

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.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4356

December 18, 2014

Ms. Paula Sparling, Administrator Augustana Chapel View Care Center 615 Minnetonka Mills Road Hopkins, MN 55343

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5493025 and Complaint Number H5493035

Dear Ms. Sparling:

The above facility was surveyed on December 1, 2014 through December 4, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5493035 that was found to be substantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

Augustana Chapel View Care Center December 18, 2014 Page 2

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

When all orders are corrected, the order form should be signed and returned to:

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

Email: <u>gloria.derfus@state.mn.us</u> Telephone: (651) 201-3792 Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Dre Klegge

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program

Health Regulations Division

Minnesota Department of Health

Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00727	B. WING		12/04/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
AUGUST	ANA CHAPEL VIEW (CARE CENTER	IETONKA MI S, MN 55343	LLS ROAD	
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2 000	Initial Comments		2 000		
	*****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.			
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was			
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.			
	surveyors of this De above provider and were issued. Wher please sign and dat page in the line ma	rS: ough December 4, 2014, epartment's staff visited the the following licensing orders a corrections are completed, ee on the bottom of the first rked with "Laboratory er/Supplier Representative's		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	ftware. to

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00727		B. WING		12/04	1/2014
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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2 000	Continued From pa	ge 1		2 000			
	records and return below: Minnesota Departm Compliance Monito Certification Progra Minnesota 55164-0 A complaint investig	m; P.O. Box 64900, 900. gation was conducte und unsubstantiated	on of St. Paul,		The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule out of complisted in the "Summary Statement Deficiencies" column and replaces Comply" portion of the correction of This column also includes the find which are in violation of the state safter the statement, "This Rule is as evidence by." Following the sur findings are the Suggested Metho Correction and Time period for Correction and Time period for Correction." THIS APPLIES THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT T SUBMIT A PLAN OF CORRECTIONS OF MINNESOTA STATES.	Tag." liance is of sthe "To order. ings statute not met reyors d of orrection. DING OF TO THIS ODN FOR	
2 430	MN Rule 4658.0210) Subp. 1 Room Ass	ianments	2 430	STATUTES/RULES.		
	Subpart 1. Room a A nursing home muresident's preference	assignments and furnust attempt to acconces on room assign rnishings whenever	nishings. nmodate a ments,				
	by: Based on observati review, the facility fa mirrors were acces	ent is not met as ev on, interview, and de ailed to assure bath sible for 1 of 1 resid hair and required a l	ocument oom ent (R64)				

Minnesota Department of Health

STATE FORM NSAF11 If continuation sheet 2 of 55

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
AUGUSTANA CHAPEL VIEW CARE CENTER 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343 ID PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE		00727		B. WING	12/	04/2014
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mirror reviewed for accommodation for needs. Findings include: R64's annual Minimum Data Set (MDS) dated 10/29/14, identified the R64 had intact cognition and required extensive physical assist of one staff with personal hygiene. On 12/2/14, at 10:06 a.m. during interview R64 expressed there was no mirror at wheelchair level in his bathroom. R64 stated it fell off the wall about one month ago. R64 further stated "I was outside the room with maintenance guy at the time, so he knows. I have asked for it many times. I can't shave without it. I have been shaving by feel right now." On 12/4/14, at 3:10 p.m. an environment tour was completed with building engineer (BE) and director of housekeeping/Laundry (DH). During the tour the BE and the DHL both verified the mirror was missing from the wall. The BE indicated he did not know about it and would have expected staff to let him know if there were any problems. When asked if he knew about the mirror here, we have used double sided tape to tape a mirror in other rooms for other residents." When asked if there were any work logs relating to the mirror being replaced/repaired, the BE stated "We don't keep a log of our work orders. I am more than happy to install a mirror." When asked how the staff would report to his department about resident 's equipment which needed repairs, BE indicated the bins for work orders were in the same spot in all units and would fix things with top priority being safety. On 12/4/14, at 3:37 p.m. when interviewed R64	Findings include R64's annual Min 10/29/14, identificand required ext with personal hys On 12/2/14, at 16 expressed there in his bathroom. about one month outside the room time, so he know times. I can't sha shaving by feel r On 12/4/14, at 3: completed with to director of house the tour the BE a mirror was missi indicated he did expected staff to problems. When mirror missing B mirror here, we h tape a mirror in o When asked if th to the mirror bein stated "We don't am more than ha asked how the s department abou needed repairs, orders were in th would fix things were	or accommodation for needs. Simum Data Set (MDS) dated ed the R64 had intact cognition ensive physical assist of one staffgiene. Simum Data Set (MDS) dated ed the R64 had intact cognition ensive physical assist of one staffgiene. Simum Data Set (MDS) dated ed the R64 had intact cognition ensive physical assist of one staffgiene. Simum Data Set (MDS) dated ed the wall assist as with maintening interview R64 was no mirror at wheelchair level R64 stated it fell off the wall ago. R64 further stated "I was with maintenance guy at the si. I have asked for it many ve without it. I have been ght now." 10 p.m. an environment tour was uilding engineer (BE) and keeping/Laundry (DH). During and the DHL both verified the not know about it and would have let him know if there were any asked if he knew about the E stated "I don't recall seeing a lave used double sided tape to other rooms for other residents." Here were any work logs relating any greplaced/repaired, the BE keep a log of our work orders. I appy to install a mirror." When had with eport to his at resident 's equipment which BE indicated the bins for work esame spot in all units and with top priority being safety.	D R R I I I I I I I I I I I I I I I I I	ntaff vel s vas ave ' a b ." g g		

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

AND DIANIOE CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED	
		00727	B. WING		12/	04/2014
	PROVIDER OR SUPPLIER	CARE CENTER 615	EET ADDRESS, CITY, MINNETONKA MI PKINS, MN 55343	ILLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 430	indicated "the secondinate and he knew about -At 3:39 p.m. M-As mirror but did not have and the term and the knew about -At 3:39 p.m. M-As mirror but did not have a secondinate and the fell. He furth of it and there was mirror had been order further indicated he -At 3:42 p.m. surve informed him M-Ak BE indicated "There don't go through all he would provide the would provide the On 12/4/14, at 4:01 dated 11/11/14, and work order, as he did stated "This will be measurements from corrected." When a maintenance/repair nothing on paper be department and consumption of the secondinistrator or depolicies and proceed furnishings to accompreferences are proceducated on these administrator or demonitoring system in the system of the system and the system and the secondinistrator or demonitoring system in the system and the system	and one on the top in the the thent knows" as R64 hance (M)-A) name then he when the mirror fell with it." Itated he knew about the ave a good re-collection of ppened and he was there her stated the BE was aw a work order for it, and the dered but not delivered. We would provide the work of yor approached BE and knew about the mirror mister is so much I don't know the work orders." BE stated in the work orders are invoice and work orders. p.m. BE brought a work of stated he had not seen the invoice and will get it sked if the facility had a policy BE stated "There is the work together in the interest as the policy BE stated "There is the policy BE stated "There is the work together in the interest as the policy BE stated "There is t	of are e 1-A order. sing.; I ted s. order that orther the se e e e e e e e e e e e e e e e e e			

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NSAF11 If continuation sheet 4 of 55

Minnesota Department of Health

AND DI AN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00727	B. WING		12/	04/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA CHAPEL VIEW	CARE CENTER	NETONKA MI IS, MN 55343	LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 4	2 560			
2 560	MN Rule 4658.0408 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			
	comprehensive plate objectives and time long- and short-term and mental and psylidentified in the contassessment. The compassessment include the increquired by Minness subdivision 14, para This MN Requirements. Based on observation review, the facility comprehensively designed.	ent is not met as evidenced on, interview and document lid not ensure a careplan was eveloped for respiratory esidents (R35) reviewed for				
	Findings include:					
	sitting in his wheeld coughing with his fa and R35 could not s Licensed practical r "I will get you a neb	5 a.m. R35 was observed thair (w/c) near nurse's station ace color getting reddened, speak due to coughing. nurse (LPN)-C stated to R35, ulizer treatment" and t R35. LPN-C also stated, "I ings every shift."				
	11/13/14, indicated modified independence situations only regarding tasks of a Admission Record	num Data Set (MDS) dated R35 was cognitively intact an ence with some difficulty in regarding making decisions daily life. R35's undated indicated R35's diagnoses failure to thrive, pneumonitis				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		00727	B. WING		12/	04/2014
	PROVIDER OR SUPPLIER	CARE CENTER 615 MIN	ADDRESS, CITY, S INETONKA MIL NS, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 560	chronic airway obsist Physician Order Res R35 also had a diagram of the R35 also had been also had bee	cruction, shortness of breath. Export dated 12/4/14, indicated gnosis of reactive airways. Seessment (CAA) dated riggered for activities of daily ional Status/Rehabilitation of Finding included: "Patient itted following recently placed vere dysphagia, Aspiration of the process of the proce	n s			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7.1. 20.25.1.10.			
		00727	B. WING		12/0	4/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AUGUST	TANA CHAPEL VIEW	CARE CENTER	IETONKA MII 6, MN 55343	LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	COPD [chronic obswe can give the PF treatment." RN-E v did not indicate whor PRN nebulizer to having SOB or other-At 3:21 p.m. RN-I give R35 a PRN new has shortness of both RN-I also stated, "I inhaler, only a PRN-At 3:27 p.m. RN-I am on call. I would PRN inhaler or new time I would start whis PRN inhaler. And if the was time I would treatment. And if the was not effective I have been been been been been been been be	structive pulmonary disease] RN inhaler or PRN nebulizer erified R35's physician orders ether to give the PRN inhaler reatment when R35 was er respiratory concerns. when asked stated, "I would ebulizer treatment when R35 requested one." have never given R35 a PRN I nebulizer." R stated, "I float all over and I look when R35 last had his eulizer treatment and if it was with the inhaler and give R35 and if that was not effective and give R35 his PRN nebulizer treatment would call the physician." or R35 included physician 14, Ventolin HFA (albuterol				

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AND DI AN OF CORRECTION IN INDENTIFICATION NUMBERS		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00727	B. WING		12/0	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	TANA CHAPEL VIEW (CARE CENTER	IETONKA MI 6, MN 55343	LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	at 2:42 a.m. R35 wa (albuterol sulfate) H mcg/actuation 2 put the inhaler was effe Medication Adminis R35 received a PRI 11/25/14, at 3:14 p. and was effective. The Administration Historeceived a PRN Act 11/26/14, at 13:56 f effective. The Medicated 12/1/14 throus was given an Ipratronebulization 3 mls of saturation was 90% PRN was not address On the November M History, 11/18/14, 1 nurse indicated R33 nebulizer treatment parameters for usage be determined. The Treatment Admidated 11/01/14 throus lung sounds were as shift. Progress notes by pindicated "He [R35] of aspiration pneumicare. He [R35] has yellow sputum and eating. Denies any shortness of breath epistaxis noted ever	as given a PRN Ventolin HFA IFA aerosol inhaler; 90 ffs inhalation for wheezing and active. The November 2014 stration History also indicated N Acetylcysteine sol 10 ml on m. for congestion and wheeze The November Medication by also indicated R35 etylcysteine sol 10 ml on or congestion and was cation Administration History 14/04/14, indicated R35 epium-albuterol solution for 12/4/14, at 9:09 O2 and the effectiveness of the essed. Medication Administration 1/25/14, and 11/26/14, the 5's PRN inhaler and PRN is were effective. The ge for R35's PRNs could not ininistration History for R35 age for R35's PRNs could not hinistration dated 12/01/14, has had recurrent episodes in and was requiring more a productive cough with occasionally coughs with fever, chills or increased. Pt [R35] with dry nose and	2 560			

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AND DIAN OF CORRECTION . IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			3) DATE SURVEY COMPLETED	
		00727	B. WING		12/	04/2014
	PROVIDER OR SUPPLIER	CARE CENTER 615 MINN	DRESS, CITY, S ETONKA MII 5, MN 55343	STATE, ZIP CODE L LS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 560	"Provide a written g the resident to mee care, and psychoso SUGGESTED MET The director of nurs staff to develop a conterventions for all director of nursing of compliance.	e Plan dated 1/14, directed uide for intervention, assisting t their needs for ADLs, health ocial needs." THOD OF CORRECTION: sing could in-service licensed are plan to include appropriate identified care needs. The	2 560			
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care personnel involved in the	2 565			
	by: Based on observati interview, the facilit were followed for 2 reviewed for activiti Findings Included: R11 was observed seven, white 1/2 inc chin. R11 stated, "N R11 also stated, "V	on, interview and document y did not ensure care plans of 4 residents (R11, R14) es of daily living (ADLs). on 12/1/14, at 6:24 p.m. with the length facial hairs on her My chin hairs are not all right." //hich ever staff notices them R11 further stated, "I just				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
			71. BOILDING.	7. BOILDING.			
		00727	B. WING		12/0	4/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
AUGUST	ANA CHAPEL VIEW (CARE CENTER	ETONKA MII	LLS ROAD			
	OLIMANA DV. OTA		, MN 55343	PROVIDENIA PLANTOS ACRESTI		(1.5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
2 565	Continued From pa	ge 9	2 565				
	received my showe	r this morning."					
	R11's quarterly MDi was cognitively inta assist with activity opersonal hygiene. Fee the undated resider malaise, fatigue, we on 12/3/14, at 8:00 in bed with seven, whairs on her chin. Reassistant (NA)-B to asked R11 what she answered. NA-B pugloves on and gave proceeded to wash face with the towel R11's socks and slaup on side of bed. Nupper half and R11 NA-B finished assistand, turn and sit in NA-B then wheeled then took off the so stand nearby, R11 ptoileting NA-B with the solution of t	S dated 9/3/14, indicated R11 ct and needed extensive staff of daily living (ADLs) including R11's diagnoses indicated on a tadmission record included: eakness and dementia. a.m. R11 was observed lying white 1/2 inch length facial requested of nursing get her up from bed. NA-B e wanted to wear and R11 relied privacy curtain, put his R11 wet wash cloth and R11 her face and then dried her NA-B provided. NA-B put acks on and assisted R11 to sit NA-B washed and dried R11's stated, "That feels good." sting R11 with dressing, to R11 and assisted R11 to n R11's wheelchair (w/c). R11 to the bathroom. NA-B illed gloves. NA-B stated, "I prefers it." After R11 finished new gloves on assisted R11 rying R11's backside and					
	pulling up R11's par	nts up and assisted R11 to the r belt applied to R11.					
	-At 8:24 a.m. NA-B	wheeled R11 from bathroom					
		3 cleaned R11's eye glasses L-B asked R11 if she wanted to					
	brush her teeth nov	v and R11 stated, "No."					
		R11 and NA-B still in her room ch length facial hairs were					
	observed on R11's	chin. NA-B did not ask R11 if					
		n hairs shaved nor did assist ced R11 if she wanted to go to					

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_	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER	o.	E CONSTRUCTION		E SURVEY PLETED
		00727	B. WING		12/	04/2014
NAME OF	PROVIDER OR SUPPLIER		REET ADDRESS, CITY, S	,		
AUGUST	TANA CHAPEL VIEW	CARE CENTER	5 MINNETONKA MII PKINS, MN 55343	LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	breakfast. R11's care plan da Potential Alteration Grooming, R11 will assist daily. R11 regrooming assist of care card for R11 ir checked for facial hyreen bath book incresidents are to be On 12/2/14, at 3:21 stated, "The care care care of the care planand are to follow the care planand are to follow the care of the care of cards." On 12/3/14, at 7:24 expect the NAs to for cards." On 12/4/14, at 12:10 day we shave residently are clean and care of the care planand on 12/4/14, at 12:10 (DON) stated she can be residently care planal care p	ited 9/17/14, indicated: in ADL Self Performance groom self with Mod-Ma quires extensive assist was 1 staff to shave. NAs undicated R11 was to be nair and shaved daily. The dicated: "ATTENTION, A shaved on a daily basis." p.m. registered nurse (Fards for the residents are ns, and the NAs carry the em." a.m. RN-B stated, "We collow the residents' care of the care of the period of the period of the residents." 1 p.m. NA-F stated, "Ever the period of the perio	x staff with dated e II RN)-A e a em ery e sure g follow to have e-half elow 4,			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00727	B. WING		12/0	4/2014
NAME OF PRO	OVIDER OR SUPPLIER			STATE, ZIP CODE		
AUGUSTAN	NA CHAPEL VIEW (CARE CENTER	INETONKA MI IS, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
din Tologre C(Cbs) we post to N we post to the C(L) we to the control of the cont	nobility, short term the care plan direct one, staff to wash ower and upper bour owning needs whemoval. On 12/3/14, at 8:07 OT)-E stated the ared, to the toilet and he could as she with the grooming needs and brushed her ownericares and brush what grooming needs and brush what she had assists observed OT-E in with pericares. On 12/3/14, at 2:09 totten R14 dressed one back to the rowning needs and the politering. When asked who were adness among othe one totten R14 dressed one back to the rowning as in pain, whatever oblems, if she saw hould not would readness among othe one to the politering assistation 12/3/14, at 2:38 LPN)-B verified R1 Vhen asked who we sidents were proposition of 12/3/14, at 3:02 to the nursing assistation 12/3/14, at 3:02 to the politering assistation 12/3/14, at 3:02 to the nursing assistation 12/3/14, at 3:02 to the politering assist	is, impaired functional memory loss, and weakness sted R14 required assistance h lower and upper body, dres dy but did not address R14's nich included facial hair a.m. occupational therapy ides help R14 to get out of d cued her to do as much as as improving. When asked ds R14 required OT-E stated wn teeth, did get help with hed hair herself. When asked that hair herself. When asked indicated she had assisted he indicated she had assisted he what she reports to nurse mal vitals, reported if resident ver is unusual, breathing w something happen that eport, skin check/changes and ers. p.m. licensed practical nurse 4 had multiple facial hair. vas responsible to ensure perly groomed LPN-B stated				

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00727		B. WING		12/0	4/2014
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
AUGUST	ANA CHAPEL VIEW (CARE CENTER		TONKA MII MN 55343	LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 565	Continued From page 12			2 565			
	sure they were prop	perly groomed."					
	"Women should be men" when asked h	4 p.m. the DON stated asked to be shaved, sam ner expectation of staff wit sidents with facial hair					
	Policy Subject Care "Provide a written g the resident to mee care, and psychoso	View Health Care Center Plans dated 1/14, directed uide for intervention, assist their needs for ADLs, he ocial needs, to provide for noice/preferences) of the are."	sting				
	care plans are curre delivering care according educate all care giv (2) Ensure all Nurse resident care for accinterventions.	om which ensures that res ent and that all staff are ording to the care plan; ers. e Managers are observing					
	Time Period for Coldays.	rrection: Twenty-one (21)					
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General		2 830			
	receive nursing car- custodial care, and individual needs an the comprehensive plan of care as des	general. A resident must e and treatment, personal supervision based on d preferences as identifier resident assessment and scribed in parts 4658.0400 ing home resident must be	d in d in d and				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	
		00727	B. WING		12/0	1/2014
		00727			12/04	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
MIGHS	TANA CHAPEL VIEW (CAPE CENTER 615 MINI	NETONKA MII	LLS ROAD		
AUGUSI	IANA CHAPEL VILW C	HOPKIN	S, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 13	2 830			
	written order from the	possible unless there is a he attending physician that the in in bed or the resident bed.	,			
	by: Based on observati review, the facility for medication and oxy manner to 1 of 1 rechospice care. In addidentify a non-press assess for root caumeasures to preven	ent is not met as evidenced on, interview and document ailed to ensure pain gen was provided in timely sident (R59) reviewed for dition, the facility failed to sure skin condition (bruise), se and provide preventative at bruising for 1 of 3 residents non-pressure skin condition.				
	Findings include:					
	in bed and was call not understand nam twice, no staff responsation of the control of the contro	alled out for the third time, IA)-D came out from the room entered R59's room and was				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			E CONSTRUCTION		SURVEY PLETED
				A. BUILDING:			
		00727		B. WING		12/	04/2014
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	TANA CHAPEL VIEW	CARE CENTER		ETONKA MII , MN 55343	LLS ROAD		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIE	S	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY .SC IDENTIFYING INFORMA	-	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETE DATE
2 830	Continued From pa	age 14		2 830			
2 830	top of her abdomin with moist but non-R59 was observed coughing and with also showed signs body as she adjust R59 stated to have for staff to give "nitt angina and heart fa having wanted to d nobody could help nor any fluid contai -At 7:59 a.m. NA-D R59 she was going NA-D verified there R59's bedside and for a drink when NA 7:54 a.mAt 8:01 a.m. NA-D small pitcher of waw while cartons, howe so R59 was still un-At 8:03 a.m. regist R59's room, washed to hook R59's oxyg RN-B increased the three liters per minneeded medication drink and wanted to RN-B told R59 he was for R59's drelephone number determined how lor oxygen prior to the -At 8:07 a.m. the oximeter read at 77 oximeter	al area. R59 coughed productive cough who to have facial grimad slight body movemer of discomfort while sed pillow with her left "hollered all night lor ro" (used for treatmentallure) for pain. R59 arink since "last night her. There was neithner on R59's bedside entered R59's room to get her something was no fluid available confirmed R59 asked A-D first entered R59's roter and fluids contain ever, NA-D did not broable to drink. There was neithered R59 asked and fluids contain ever, NA-D did not broable to drink. The rough R59's note oxygen to be delived the for pain, wanted to her call family member would find the nurse to N-B also stated he winks and would get the for R59's F-B. It could no R59 laid in bed with	ille talking. ces after nts. R59 hifting hand. ng" asking nt of added " but er fluid e table. and told g to drink. le at d NA-D 's room at om with a ed in two ring straws ntered at ahead strils, ered at nat she nave a (F)-B. to give the ould bring ne d not be thout the pulse	2 830			
	telephone number determined how lor oxygen prior to the -At 8:07 a.m. the ox oximeter read at 77 90% at 8:10 a.m. -At 8:11 a.m. RN-B	of R59's F-B. It could ng R59 laid in bed wit observation. xygen saturation per	I not be thout the pulse creased to opened				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00727	B. WING		12/	04/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	·	
ALIGUST	TANA CHAPEL VIEW (CARE CENTER 615 MIN	NETONKA MIL	LS ROAD		
A00001	ANA OHAI EE VIEW	HOPKIN	IS, MN 55343			T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	handed it to R59. R written on a piece of gave the telephone talk to F-B, put telepone was answering signs of discomfort while lying in bed. F and facial grimaces would attempt body -At 8:31 a.m. R59 to R59's room that no medication as of the would go look for the stepped out of R59 -At 8:33 a.m. RN-B gown, asked for NA then went on to chabecame wet from some moaning sou moved her in bedAt 8:35 a.m. RN-D R59 for being late in R59's pain medicat she was then giving taking pain medicat at RN-B who was a fear of dying, and to be on Hospice anyr they would talk abo dialed F-B's number answered. R59's quarterly Min 11/19/14, indicated decision making. Tidiagnoses included	N-B also dialed the number of paper he was holding and to R59. R59 was unable to phone down and stated no . R59 was observed to show by trying to shift positions R59 had audible breath sound a were still noted when R59 of shifting. Old RN-B who re-entered body had given R59's pain the time. RN-B told R59 that he are nurse, and then RN-B	t	DEFICIENCY)		
	hypertension, and a R59 to have moder	anxiety. The MDS identified ate pain frequently; and with activity, at rest and when	n			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00707	B. WING		40/0	4/004.4
		00727	D. WING		12/0	4/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AUGUS1	ANA CHAPEL VIEW	CARE CENTER	ETONKA MII , MN 55343	LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 16	2 830			
	lying flat.					
	Assessments (CAA had alteration in co and physical risk fat to complain of mild It was further noted as needed (PRN) p. The care plan date alteration in comfor complaints of pain as generalized. R5c chest pain. The car implement interven anticipating resider non-verbal indication medications as ord (NP) or the physicia medicated creams ordered by NP or N	dings section of the Care Area A) dated 8/14/14, indicated R59 mfort due to multiple mental actors. R59 was also identified to severe degree of pain daily. R59 was on scheduled and pain medications. d 8/13/14, indicated R59 had the with mild to severe daily. Pain was characterized 9 was also identified to have been plan directed staff to the tions which included at a pain, observing for ons of pain; giving PRN pain ered by the nurse practitioner an (MD; applying topical for pain; giving Nitrostat as MD; and applying warm packs tes four times a day.				
	(MAR) dated 11/4/1 never had PRN Ber (topical medicated doses of Dilaudid (a (mg) and PRN Nitro days ago on 11/26/1 that R59 requested complained of ches	dication administration records 14 to 12/4/14, revealed R59 nGay greaseless cream cream for pain); and the PRN an analgesic) 3 milligrams ostat were last given eight 14. It was noted in the MAR I the Dilaudid and also st pain on 11/26/14. R59's was noted as 60% with the pain.				
	directed staff to ass while awake and of	er Report dated 11/28/14, sess pain every three hours fer Dilaudid for pain; to give plet under the tongue for chest				

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AND PLAN OF CO	RRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI			E CONSTRUCTION		E SURVEY PLETED
		00727		B. WING		12/	04/2014
	ER OR SUPPLIER	CARE CENTER	615 MINN	DRESS, CITY, S ETONKA MII , MN 55343	ETATE, ZIP CODE	-	
	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
pain Dilau pain mou 10 m nasa On 1 rece Nitro -At 1 she com accordance Man provemed rece man to er	udid liquid 3 mg every 4 hours th every 4 hours the every hour and by mouth two all cannula ever 2/4/14, at 8:49 ived PRN Dilates the medication of paints o	by mouth for neuropage by mouth for general and Dilaudid 3 to 5 mas needed for pain; Maice a day; and oxygeny shift for comfort. If a.m. RN-D verified Fudid pain medication in on 11/26/14. rector of nursing (DO to assess any resider and implement intervalan. If an on Pain sament last reviewed administer ordered Fuckthrough pain. R59 is related services in an and /or control the pen was being delivered.	alized ag by ethadone on via R59 last and last entions on 8/14, PRN did not timely ain and	2 830			
(gen ulce adm daily pote seve phys dres	s diagnoses in eralized), rheu r, and chronic pission MDS da living (ADLs) fintial CAA dated re impairment sical assist with sing, grooming s skin care pla	cluded muscle weakr matoid arthritis, press pain obtained from the ted 11/3/14. R14's act functional status/rehated 11/4/14, identified R with cognition and re ADLs which included and toileting.	sure e tivities of bilitation 14 had quired				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
	00727	B. WING		12/0	04/2014
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUSTANA CHAPEL VIEW (CARE CENTER	ETONKA MII , MN 55343	LLS ROAD		
PRÉFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
assisting resident wont slide and to comprotocol. R14's care was on aspirin daily to bruising. On 12/1/14, at 4:09 wheelchair in her rough the length of th	staff to use care when with cares or positioning-lift, do inplete wound flow sheets per explan did not address R14 which would make R14 prone on pom with husband visiting. Except discussed dark purple bruise to right ble. If a.m. observed bruise on right in and second finger. When see may have occurred R14 illy." If a.m. observed door shut to entering room observed into the bed oved seated on the toilet. In a content, R14 was seated on ontents, R14 was seated on ontents, R14 was seated on the toilet.				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00727	B. WING		12/0	4/2014
	PROVIDER OR SUPPLIER	CARE CENTER 615 MINN	DRESS, CITY, S ETONKA MII , MN 55343	STATE, ZIP CODE L LS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	R14 with turning tell her wheelchair over back never asked F-At 9:12 a.m. R14 cwatching television openAt 9:12 a.m. NA-E holding blanket and had brought a warn get wrapped with black and said sher therapist (PT)-G enthe doorAt 9:19 a.m. PT-G getting an oximeter oxygen level) and wback and said sher then stated it was spercent (%) PT-G gand push seat up. Fwalker and was obsider and was obsider and was obsider and was obsidered by the would report to the would report abuse. On 12/3/14, at 12:1 would report abuse. On 12/3/14, at 2:09 occupational therapasked what she wo abnormal vitals, regunusual, breathing redness. On 12/3/14, at 2:38 (LPN)-B verified the purple bruise. LPN-had gotten the bruise.	evision on. R14 still seated in rheard NA-E saying she will be R14 about the bruise. Observed seated in wheelchair and door to room was wide came back to room observed to overheard telling R14 she in towel. NA-E assisted R14 to anket and left room briefly. Over NA-C and physical ter room. NA-C left and shut the left room stated she was (a machine used to measure would be back. PT-G came would test the oxygen level, pell this out ninety four (94) not R14 to push up from chair R14 was resting arms on served walking in room. R14's between thumb and first finger but nothing was said about it.	2 830			

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STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00727	B. WING		12/0	4/2014
NAME OF	PROVIDER OR SUPPLIER	•	DRESS, CITY, S	STATE, ZIP CODE	1	
AUGUS	TANA CHAPEL VIEW	CARE CENTER	ETONKA MII , MN 55343	LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	aspirin and methalit treat rheumatoid ar bruising. LPN-B fur assistants usually I bruises. On 12/3/14, at 3:02 was aware of R14 thumb and first find been informed by I further stated he whad cared for resid to nurses and to as usually the nurse wand he would reviee. On 12/04/14, at 2:2 when asked about discover it should ranybody who sees. During review of In Notes dated 10/28/revealed the dark potentified nor docur. Notes it was reveal nursing note dated been brought to the Skin Care Program staff "Residents at Residents at risk for have interventions Plan, computer Ca assistant registered policy directed nurs condition during care.	trexate (medication used to othritis) and both caused easy other stated the nursing et the nurse know about 2 p.m. RN-C was asked if he is bruise to right hand between ger. RN-C stated he had just in in in in in it is bruises in it. RN-C ould have expected staff who gents to have reported bruises in it. RN-C also indicated would fill out an incident report whit. 24 p.m. the director of nursing bruises stated "the nurse that make sure to document it and it should follow up on it." Iterdisciplinary Team (IDT) 2 830				

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-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00727		B. WING		12/0)4/2014
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA CHAPEL VIEW (CARE CENTER		ETONKA MII , MN 55343	LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	Continued From page 21		2 830				
	director of nursing of and re-educate staff residents are assest care and services for prevent bruising. T	THOD OF CORRECT or her designee could fon policies to ensur used and provided new properties or pain management the director of nursing elop monitoring systempliance.	review e that all cessary and to or her				
	TIME PERIOD FOF (21) days.	R CORRECTION: Tw	enty-one				
2 900	MN Rule 4658.0525 Ulcers	5 Subp. 3 Rehab - Pro	essure	2 900			
	Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:						
	without pressure so pressure sores unle condition demonstra	o enters the nursing hores does not developes the individual's clates, and a physician they were unavoidable	o inical				
	receives necessary	ho has pressure sore treatment and service event infection, and veloping.	ces to				
	by: Based on observati review, the facility fa	ent is not met as evid on, interview, and do- ailed to comprehension ulcer upon admission	cument vely				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
		00727	B. WING		12/04	/2014
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, S	STATE, ZIP CODE		
AUGUS	TANA CHAPEL VIEW (CARE CENTER	NNETONKA MI NS, MN 55343	LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	provide treatment at to monitor effective promote wound head (R226) reviewed for Findings include: R226's pressure ula admission (11/18/14 until surveyor observatiff did not provide the physician. R226's pressure ula dressing change or performed by the lid (LPN)-C. The press mid back, and was with 100 percent (% LPN-C washed hand change supply, app the old dressing, ar 4x4 gauze and Der The LPN removed on and applied Mediusing a folded 4x4 garesing on the word During interview on LPN-C stated the pand stated the wound (Pressure ulcer is knon-removable drescoverage of the word and there was 100 After verifying the pstated she was supclean the wound inscleanser, and was in the control of	is physician ordered and faile ness of the treatments to aling for 1 of 3 residents	ed I, to			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED		
		00727	B. WING		12/	04/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ALIGUET	TANA CHAPEL VIEW (CARE CENTER 615 MIN	NETONKA MIL	LS ROAD		
AUGUSI	IANA CHAPEL VIEW (HOPKIN	S, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 23	2 900			
	the previous week admitted did not ve dressing change. The undated Resid indicated was admit with diagnoses included and congestive heat 11/18/14, indicated The physician orde "Wound care: back saline (salt water) 4 (an absorbent dressing composite dressing admitted to the saline	embered using the Medihoney when she worked, and rify physician order prior ent Admission Record tted to the facility on 11/18/14, uding Alzheimer's disease, art failure. The care plan dated resident was on hospice care of dated 11/24/14, indicated, clean wound with normal ex4. Cover with 4x4 Mepilex sing) border or other 1. Once a day Every other				
	wound dressing use wound bed" was dis Record review indic and contradicting in	Apply Medihoney gel (a sed to speed up healing) to scontinued on 11/24/14. Cated the following incomplete formation:				
	11/18/14, indicated body diagram indicated however the stage measurements wer - The progress not lacked evidence the assessed upon adriadmission to ensure	circled area on mid back of a ating "pressure ulcer", of the wound or re not documented. es dated from 11/18/14, also e pressure ulcers were nission or any time after e monitoring.				
	noted presence of 'small ulcerations suredness- proximal udistal shallow with control of the Tissue Tolera 11/19/14, noted "Caulcers", however the	rogress notes dated 11/19/14, Thoracic pressure ulcer- 2 urrounded by non blanchable ulcer 100% slough in base, clean base." nce Assessment Laying dated ame into facility with pressure e pressure ulcers were not assessed. The Assessment				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00727		B. WING		12/	04/2014
NAME OF	PROVIDER OR SUPPLIER	•	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
4110110		0405 051150		ETONKA MII			
AUGUS	TANA CHAPEL VIEW	CARE CENTER	HOPKINS	, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 900	indicated intervention repositioning scheoto- The Skin Risk assigned atted 11/27/14, (too developing pressure (moderate risk), intreducing devices for ulcer care and turn However, there was pressure ulcers we stage. The Admission Min 12/1/14, indicated for thickness loss of doopen ulcer with a restrict slough [non viable of ulcers, R226 was coneeded two staff as and personal hygie. There was no We form flowsheet combook. The registered nurs manager on the trainterviewed on 12/3 R226 currently had on the mid spine. Rewound book and stander initiated upon weekly measurements skin check tool, and identified pressure staff did not indicate measurement. Duri saw R226's pressurembered the two the wounds being a document them. Fire the staff did not indicate measurement them. Fire the wounds being a document them.	on plan for one hour dule essment w[with]/ Bracol used to determine the ulcers had a score erventions included por chair and bed, presing and repositioning is no documentation the measured or assertinimum Data Set (MDR 226 had two stage 2 termis presenting as a red-pink wound bed with white/yellow tissue]) purchased in the facility's election of the facility is election of	risk for of 13 pressure sure program. The ssed for 2S) dated 2 (Partial shallow thout pressure 226 programs wound at stated e ulcers the pund flow ete it/ Weekly aff agram, ated he pand nents, and id not ag				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:	COMPLETED
00727 B. WING	12/04/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
AUGUSTANA CHAPEL VIEW CARE CENTER 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COL	ER'S PLAN OF CORRECTION (X5) RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DATE DEFICIENCY)
the wounds on 11/25/14, but he saw them on 11/19/14. After reviewing R226's record RN-C confirmed the record did not contain any evidence R226's pressure ulcer on the back was comprehensively assessed since admission to include measurements, staging, and monitoring of the wound. The director of nursing (DON) was interviewed on 12/4/14, at 1:55 p.m. and stated staff were expected to do a head to toe skin assessment upon admission, if a resident came with a wound, nurse was expected to do a complete wound assessment including wound measurements, stage, and location of the wound. Staff needed to document on the Admission Skin Assessment form, and start the weekly wound flow sheet. The DON further explained after the initial admission assessment weekly wound measurements were completed to monitor wound healing progression. After reviewing R226's medical record the DON verified R226's back pressure ulcer was not assessed upon admission, or thereafter weekly. The Skin Care Program policy last reviewed on 09/14, indicated "Any pressure and/or vascular ulcers noted on the Nursing Admission Information Questionnaire are to have a Weekly Wound Flow Sheet completed and scheduled to be completed in the care path on a weekly basis." The policy also directed staff to "Assess, measure, and document on pressure and/or vascular ulcers on a weekly basis utilizing the Weekly Wound Flow Sheet scheduled every Wednesday." SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could assign the interdisciplinary team to review all residents with pressure sores to assure they are receiving the	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY	
		00727	B. WING		12/0	04/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA CHAPEL VIEW (CARE CENTER	ETONKA MII , MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 900	necessary treatmer sores from develop The Director of Nur Assurance Commit monitoring of the de ensure that pressu unless the resident	nt/services to prevent pressure ing and to promote healing. sing could assign the Quality tee to provide on-going elivery of care to residents to re sores do not develop s clinical condition hey were unavoidable	2 900			
2 920	Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,	2 920			
	by: Based on observati review, the facility for 1 of 3 residents incontinence care. I provide assistance 2 of 4 residents (R1 on staff. Findings include:	ent is not met as evidenced on, interview and document ailed to provide perineal care (R226) reviewed for bowel in addition, the facility failed to with facial grooming cares for 1, R14) who were dependent				
	cares for bowel inco	e genital area cares during ontinence. ent Admission Record				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		00727	B. WING		12/	04/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ΓANA CHAPEL VIEW (CARE CENTER	IETONKA MIL	LS ROAD		
	OLIMANA DV. OTA		6, MN 55343	DDOV/IDEDIO DI ANI OF CODD	FOTION	44-1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 27	2 920			
		tted to the facility on 11/18/14, uding dementia, Alzheimer's e heart failure.				
	The care plan dated was on hospice car	d 11/18/14, indicated resident e.				
	12/1/14, indicated F incontinent with urin with bowel movemen R226 needed two s	imum Data Set (MDS) dated R226 was frequently ne and was always incontinent ents. The MDS also indicated staff assistance with personal ise.				
	hygiene and toilet use. The Nursing Admission and Temporary care plan dated 11/18/14, indicated the following: - R226 was alert and oriented to person, place and time R226 was incontinent bowel and bladder - R226 needed assist of one staff with toileting, bathing and hygiene, and assist of one/two staff with bed mobility.					
		transitional care care) Care R226 needed assist of one				
	8:15 a.m. while nur NA-F provided mor ready for breakfast, incontinence pad, p R226's legs. R226's R226 was observed green colored stool visibly covered the washcloths and soo however did not att provide genital area	d on 12/3/14, from 7:30 a.m. to sing assistants (NA)-B and ning cares to help R226 get. NA-B opened R226's bushed it down between was turned to the right side. It to have a large amount of in the incontinence pad which perineal area. NA-B used wet ap to wipe R226's bottom, empt to lift R226's leg to a care. The two NA's R226 on her left side, when				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	20727	B. WING		40/0	4/004.4
	00727	B. WING		12/0	4/2014
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AUGUSTANA CHAPEL VIEW C	CARE CENTER	ETONKA MII , MN 55343	LLS ROAD		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
cloths, however R22 thighs were not clear incontinence pad, to fastened the practical nurse (LPN surveyor requested perineal cleanliness washcloths, separar genital area care. Twith dark green bow five additional wash R226's genital area LPN-C was interview and stated that whe area cleanliness R2 genital area and this nursing assistants were sident's genital area legs separated. During interview on stated NA-F "was so when she was turned she thought NA-F coleaning. During interview on stated she "thought" The infection control responsible for staff interviewed on 12/3 stated staff received they had a mentor, proper pericare. The use wipes, but only	bottom using wet wash 26's genital area and inner aned. Staff applied a clean urned R226 on her back, inence pad and stated they pericare. At that point licensed N)-C entered the room, and LPN-C to verify R226's s. LPN-C requested more wet ted R226's legs, and provided the washcloths were soiled wel movement. LPN-A used acloths to successfully clean and inner thighs. Wed on 12/3/14, at 8:28 a.m. on she checked R226's genital 226 was dirty with stool on her ghs. LPN-C also stated the were expected to clean area while on back and with 12/3/14, at 9:18 a.m. NA-B upposed to clean resident of the left side", and that completed the genital area 12/3/14, at 10:13 a.m. NA-F "NA-C "cleaned resident".	2 920			

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-	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING:		
		00727	B. WING		12/04/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
AUGUST	TANA CHAPEL VIEW (CARE CENTER	INNETONKA MI INS, MN 55343	LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLET	
2 920	expected to clean uskin clean. The facilities Perine dated revised on 10 waterproof pad und legs and lift the knebed." The policy alsof the "Female Gen" spread the labia" a perineum from the anus in one motion	ge 29 Intil washcloths came off the pal Care policy and procedur 0/14, indicated "Place a ler the resident's hips. Spreades up so the feet are flat in so described in details cleanifials", with instructions to land "wipe each side of the lurethral opening towards the little policy also indicated locat until the area is clean."	re ad ing			
	R11 was observed white facial hair on p.m. R11 stated, "M R11 also stated, "W just plucks them." Freceived my showe On 12/3/14, at 8:00 in bed with seven a hair on her chin. R1 her up from bed. Now wanted to wear and privacy curtain, put wet wash cloth and face and then dried provided. NA-B put and assisted R11 to washed and dried Fstated, "That feels get a stated," That feels get and the provided in the stated in the	with seven and 1/2 inch leng her chin on 12/1/14, at 6:24 ly chin hairs are not all right. /hich ever staff notices them R11 further stated, "I just	ng te			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00727	B. WING		12/	04/2014
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	•	
AUGUST	TANA CHAPEL VIEW (CARE CENTER	INETONKA MIL	LS ROAD		
	T	HOPKIN	NS, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 30	2 920			
	wheelchair (w/c). N bathroom. NA-B the NA-B stated, "I star After R11 finished t on assisted R11 wit backside and pullin assisted R11 to the applied to R11. -At 8:24 a.m. NA-B into her room. NA-E and put on R11. NA brush her teeth nov -At 8:44 a.m. while seven and 1/2 inch observed on R11's she wanted her chir	o stand, turn and sit in R11's A-B then wheeled R11 to the en took off the soiled gloves. In the soiled gloves and nearby, R11 prefers it." oileting NA-B with new gloves the washing and drying R11's gup R11's pants up and w/c with the transfer belt wheeled R11 from bathroom a cleaned R11's eye glasses and R11 stated, "No." R11 and NA-B still in her root length white facial hair was chin. NA-B did not ask R11 if in hairs shaved nor did her nen asked R11 if she wanted the saked R11 if she wanted R11 if she	do m			
	was cognitively inta assist with activity of personal hygiene. F the undated resider	S dated 9/3/14, indicated R11 act and needed extensive stafe of daily living (ADLs) including R11's diagnoses indicated on the admission record included: eakness and dementia.	f			
	Potential Alteration Grooming, R11 will assist daily. R11 regrooming assist of care card for R11 ir checked for facial h green bath book incresidents are to be	dated 9/17/14, indicated R11 in ADL Self Performance of groom self with Mod-Max staquires extensive assist with 1 staff to shave. NAs undated adicated R11 was to be hair and shaved daily. The dicated: "ATTENTION, All shaved on a daily basis."	i			
	stated, "The care care	p.m. registered nurse (RN)-/ ards for the residents are a ns, and the NAs carry them	A			

Minnesota Department of Health

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			COMPLETED	
		00727		B. WING		12/	04/2014	
	PROVIDER OR SUPPLIER	CARE CENTER	615 MINNE	PRESS, CITY, SETONKA MIL	TATE, ZIP CODE LS ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FI SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
2 920	and are to follow the On 12/3/14, at 7:24 expect the NAs to ficards." On 12/4/14, at 12:1 day we shave resid they are clean and On 12/4/14, at 12:0 (DON) stated she eresidents' care plan services to maintain from facial hair. On 12/4/14, at 12:1 day we shave resid they are clean and On 12/4/14, at 12:0 expected nursing stiplans. R11 was pro		e care	2 920				
	room on 12/1/14, at member (F)-A was room. Multiple white	lying in bed on her bac t 3:30 a.m. R14's famil seated in chair in corn e facial hairs approxim observed on upper lip	y er of the ately					
	wheelchair in her ro room observed mov	p.m. observed R14 so oom with F-A visiting. F ving resident wheelcha , never offered to remo	RN-G in air					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00727	B. WING		12/0	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ALIGUES	FANIA OLIABEL MEM	615 MINN	ETONKA MII	LLS ROAD		
AUGUS	TANA CHAPEL VIEW	HOPKINS	, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ige 32	2 920			
	On 12/3/14, at 7:18 therapist (OT)-E matherapist (O	a.m. observed occupational aking bed, R14 was seated on eved OT-E coming out of room contents, R14 was seated on as slightly open. went back to room. Observed elchair by sink, door was shut the door. eved R14 leaving her room with apist (OT)-E wheeling her went room and took elevator to be therapy room was located. If all the apy room, facial hairs were each to dining room. Eved R14 in dining room at the ladies eating breakfast. Estill in dining room had each approach to remove it. A-E was observed wheeling				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		00727	B. WING		12/	04/2014
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
AUGUST	TANA CHAPEL VIEW	CARE CENTER	NNETONKA MI NS, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 920	doorAt 9:19 a.m. PT-G getting an oximeter came back and said level, and then state percent (%). PT-G and push seat up. If walker and was wa standby assist as R chair by window. R without assistance. multiple white facia were not acknowled offered to remove it R14's diagnoses in (generalized), rheur ulcer, and chronic p admission MDS da MDS indicated R14 required extensive dressing, toilet use R14's ADLs functio potential Care Area 11/4/14, identified th impairment with con assist with ADLs wh grooming and toilet dated 11/14/14, ide self-performance or related to diagnose functional mobility, weakness. The can assistance of one, s body, dress lower a address R14's groof facial hair removal.	left room stated she was and would be back. PT-G d she would test the oxygen ed it was ninety four (94) got R14 to push up from character was resting her arms on lking in room. PT-G was R14 walked in room to sit in 14 was able to sit in chair R14 was still observed with I hairs above lip and on chindged, and no assistance was the compact of the comp				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00727	B. WING		12/0	4/2014
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 12/0	772017
	ANA CHAPEL VIEW	615 MINN	ETONKA MI			
AUGUSI	ANA CHAPEL VIEW	HOPKINS	, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 920	help R14 to get out her to do as much a improving. When a R14 required OT-E teeth, did get help wherself. When asked during morning carrindicated she had a On 12/3/14, at 2:09 gotten R14 dressed gone back to the robrushed teeth and toileting. When ask NA-C stated abnorwas in pain, whatever problems, if she sa should not would redeness among other on 12/3/14, at 2:38 multiple facial hairs responsible to ensugroomed LPN-B state." On 12/3/14, at 3:02 hairs RN-C indicate the nurse should be	of bed, to the toilet and cued as she could as she was sked what grooming needs stated R14 brushed her own with pericare and brushed hair ed what she had assisted R14 es as observed OT-E assisted her with pericare. Op.m. NA-C stated OT-E had do that morning and NA-C had soom to makes sure R14 had NA-C would assisted her with ted what she reports to nurse mal vitals, reported if resident ver is unusual, breathing w something happen that eport, skin check/changes and	2 920			
	On 12/4/14, at 2:24 "Women should be men" when asked I assisting female re removal.	p.m. the DON stated asked to be shaved, same as her expectation of staff with sidents with facial hair				
		View Health Care Center Plans dated 1/14, directed				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION :	COMPLETED	
		00727	B. WING		12/04/2014
NAME OF I	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY,	STATE, ZIP CODE	
AUGUST	ANA CHAPEL VIEW (CARE CENTER	MINNETONKA MI KINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE
2 920	"Provide a written g the resident to mee care, and psychoso individualization (chresident's plan of care SUGGESTED MET The DON could instant to their responsitive residents with assist grooming according could conduct audit provided as indicated."	uide for intervention, assist their needs for ADLs, he cial needs, to provide for noice/preferences) of the	N: iced iarea N ing ded.		
21375	Program Subpart 1. Infection home must establist control program destantiary environments This MN Requirements by: Based on observation review, the facility far provided wound can infections of a press (R226) reviewed for Findings include: The undated Reside	ent is not met as evidence on, interview and docume ailed to ensure nursing sta res to minimize the risk of sure ulcer for 1 of 3 reside r pressure ulcers.	sing an and ed ant aff		
	The undated Resident indicated R226 was	ent Admission Record admitted to the facility on noses including dementia,			

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	COMPLETED		
		00727	B. WING		12/0	04/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE	•	
AUGUST	TANA CHAPEL VIEW (CARE CENTER	IETONKA MII 8, MN 55343	LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Alzheimer's disease The care plan dated was on hospice car. The physician orde "Wound care: back saline 4x4. Cover wother composite dreother day." The or wound bed" was diseased by the licuity of the composite of the care	e, and congestive heart failure. d 11/18/14, indicated resident				
	on the wound, date During interview on LPN-C stated they wash hands betwee R226's pressure uld verified she "forgot" and wash hands aff	duze. Applied Mepilex dressing d and signed it. 12/3/14, at 8:28 a.m. the needed to change gloves and en the clean and dirty parts of cer dressing change, and to remove the dirty gloves ter she removed the old e washed the wound.				
	infection control numbers dressing change sta	12/3/14, at 2:46 p.m. the rse (ICN) stated during wound aff were expected once they essing to take gloves off, wash				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00727	B. WING		12/0	4/2014
	PROVIDER OR SUPPLIER	CARE CENTER 615 MINN	DRESS, CITY, S ETONKA MII , MN 55343	STATE, ZIP CODE LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	hands, and apply cl with washing the we The Infection Contr change with revisio order "to provide tre physician while pre- infection", staff was hands and apply cle removing soiled dre Suggested Method her designee could regarding infection ulcer dressing char- designee could edu procedures regardi wound dressing char-	lean pair of gloves to continue bund. ol Policy with subject dressing of date 10/14, indicated in eatment as ordered by the venting the spread of directed to "Sanitize/wash ean gloves" before and after essing and gloves." of Correction: The DON or review policy and procedures control program and pressure inges. The DON or her locate staff on policy and ing pressure ulcer and/or	21375			
21426	(a) A nursing home maintain a compreh infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volume Health shall provides	A.04 Subd. 4 Tuberculosis antrol e provider must establish and mensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease ation (CDC), Division of mation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines.	21426			

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PRINTED: 12/18/2014

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: COMPLETED

NAME OF PROVIDER OR SUPPLIER

AUGUSTANA CHAPEL VIEW CARE CENTER

FORM APPROVED

(X2) MULTIPLE CONSTRUCTION A. BUILDING: 12/04/2014

(X2) MULTIPLE CONSTRUCTION A. BUILDING: 12/04/2014

STREET ADDRESS, CITY, STATE, ZIP CODE

615 MINNETONKA MILLS ROAD
HOPKINS, MN 55343

AUGUST	ANA CHAPEL VIEW CARE CENTER	ETONKA MII , MN 55343	LLS ROAD	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 38	21426		
	(b) Written compliance with this subdivision must be maintained by the nursing home.			
	This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure resident tuberculin skin test (TST) was completed and documented appropriately for 1 of 5 residents (R16) who were recently admitted to the facility. Findings include: Review of R16's electronic undated face sheet indicated R16 was admitted to the facility on 3/7/14.			
	Record review also indicated R16 had the TB [tuberculosis] screening tool completed on 3/7/14. The Mantoux Reporting First Step document indicated R16 received the first step TST on 3/7/14, and the results were read on 3/9/14, however the result was not documented. The second TST was completed on 3/22/14, with the results documented accurately.			
	The infection control nurse (ICN) was interviewed on 12/3/14, at 2:46 p.m., and confirmed R16 lacked accurate baseline TB screening. The ICN also stated staff were expected to measure induration and document the results in millimeters (mm).			
	The Tuberculosis Screening: Tuberculin Skin Test (TST) Procedure dated revised on 10/14, indicated "The Mantoux skin test is read 48-72 hours after injection", and "Any test that has not			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00727	B. WING		12/0	4/2014
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AUGUST	ANA CHAPEL VIEW	CARE CENTER	ETONKA MII , MN 55343	LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	Continued From page 39		21426			
	The policy also incl Documentation Rec "At time of reading: name and signature test date and time test of Exact number of m induration, docume Interpretation of rea SUGGESTED MET The director of nurs policies regarding of and perform audits	e of the person reading the read m of induration (if no nt '0' mm)				
A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted		21530				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMPLETED	
00727 B. WING			12/04/2014		
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, S	STATE, ZIP CODE	12/01/2011
AUGUS	ΓΑΝΑ CHAPEL VIEW (CARE CENTER 615 MIN	INETONKA MII IS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
21530	upon" means the acreport and the signiof nursing services C. If the attend with the pharmacist not provide adequal pharmacist believes being adversely afferefer the matter to tif the medical direct physician. If the methe attending physician does not must be referred for assessment and as by part 4658.0070. the medical direct must refer the matter to the medical direct must refer the matter than the acceptance of the medical direct must refer the matter than the services of the medical direct must refer the matter than the services of t	ge 40 cceptance or rejection of the ng or initialing by the directo and the attending physician. ing physician does not concut's recommendation, or does te justification, and the sthe resident's quality of life is ected, the pharmacist must he medical director for review for is not the attending edical director determines the cian does not have adequate order and if the attending change the order, the matter or review to the quality esurance committee required. If the attending physician is or, the consulting pharmacist er directly to the quality esurance committee.	r s		
	by: On 12/03/14, at 9:2 sitting in his wheeld coughing with his fa and R35 could not s Licensed practical r "I will get you a neb proceeded to assist check his [R35's] lu R35's 14 day Minim 11/13/14, indicated modified independe new situations only regarding tasks of c	ent is not met as evidenced 5 a.m. R35 was observed thair (w/c) near nurse's stationace color getting reddened, speak due to coughing. nurse (LPN)-C stated to R35, ulizer treatment" and t R35. LPN-C also stated, "I angs every shift." num Data Set (MDS) dated R35 was cognitively intact arence with some difficulty in regarding making decisions daily life. R35's undated indicated R35's diagnoses			

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00727	B. WING		12/0	04/2014
NAME OF			DDDEEC CITY (STATE ZID CODE	1 12/0	7-7201-
NAME OF	PROVIDER OR SUPPLIER		NETONKA MI	STATE, ZIP CODE		
AUGUST	TANA CHAPEL VIEW (CARE CENTER	S, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	chronic airway obst Physician order rep R35 also had a diag R35's care area as: 11/14/14, for R35 tr living (ADLs) Functi Potential. Analysis (R35] recently admi peg tube due to sev Pneumonia. Currer assistance with all A Non-ambulatory at bowel and bladder. above listed risk facenvironment, episouses Bi-pap at NOC for R35 triggered for Maintenance indicated Pneumonia." During an interview RN-E stated, "I wouneeded) inhaler or R35 was wheezing, oxygen sat [saturatialso stated, "Since	re to thrive, pneumonitis, ruction, shortness of breath. Fort dated 12/4/14, indicated gnosis of reactive airways. Sessment (CAA) dated iggered for activities of daily ional Status/Rehabilitation of Finding included: "Patient litted following recently placed were dysphagia, Aspiration of the total incontinence of ADLs and mobility. This time. Total incontinence of AT risk for decline due to ctors and the following: new des of SOB, occasional pain. C." The CAA dated 11/14/14, for Dehydration/Fluid ted "Infection is indicated: Ton 12/04/14, at 2:11 p.m. uld give R35 his PRN (as PRN nebulizer treatment when, short of breath (SOB) or if his ion] gets low, 89-90%." RN-D R35 has a diagnosis of COPE	n s			
	give the PRN inhale treatment." RN-E ve did not indicate whe or PRN nebulizer tr having SOB or othe	e pulmonary disease) we can er or PRN nebulizer erified R35's physician orders ether to give the PRN inhaler eatment when R35 was er respiratory concerns. when asked stated, "I would				
	give R35 a PRN ne has shortness of br RN-I also stated, "I inhaler, only a PRN	bulizer treatment when R35 reath or if R35 requested one. have never given R35 a PRN				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		00727	B. WING		12/	04/2014
	PROVIDER OR SUPPLIER	CARE CENTER 615 MIN	ADDRESS, CITY, S' INETONKA MIL NS, MN 55343	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21530	am on call. I would PRN inhaler or neb time I would start whis PRN inhaler. Ar it was time I would treatment. And if the was not effective I was not effective. The Medication Administration Historeceived a PRN Act 11/25/14, at 15:14 fand was effective. Administration Historeceived a PRN Act 11/26/14, at 13:56 feffective. The Medication. The Medication Historeceived a PRN Act 11/26/14, at 13:56 feffective. The Medication.	look when R35 last had his ulizer treatment and if it was rith the inhaler and give R35 and if that was not effective and give R35 his PRN nebulizer e PRN nebulizer treatment would call the physician." r R35 included physician ordentolin HFA (albuterol sulfate) r; 90 mcg/actuation; amt: 2 ecial Instructions: Non terventions: 1) Encourage elax; 2) Encourage incentive cable) 3) Offer emotional rurs - PRN; and physician 4, Ipratropium-albuterol ation; 0.5 mg - 3 mg (2.5 mg mls; inhalation Special active airways Once A Day an order dated 11/19/14, tion; 100 mg/ml (10%) Amoul; inhalation, miscellaneous ministration History dated indicated on 11/18/14, at 2:42 RN Ventolin HFA (albuterol of inhaler; 90 mcg/actuation 2 wheezing and the inhaler was	nt 2			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE COMP	SURVEY LETED
00727 B. WING	12/0	4/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUGUSTANA CHAPEL VIEW CARE CENTER 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
given an Ipratropium-albuterol solution for nebulization 3 mls on 12/4/14, at 9:09 O2 saturation was 90% and the effectiveness of the PRN was not addressed. On the November Medication Administration History, 11/18/14, 11/25/14, and 11/26/14, the nurse indicated R35's PRN inhaler and PRN nebulizer treatments were effective. The parameters for usage for R35's PRNs could not be determined. Nursing progress note for R35 dated 11/25/14, at 15:05 indicated: "S: Missing medication from pharmacy, Mucomist. B. Pt on Mucomist q [every] 6 hours. A: Report from NOC shift that pt [R35] missed 0400 dose of Mucomist and no remaining doses. Called pharmacy at 0700 to request doses to be sent out. At 0800 pt [R35] breathing noted to be difficult and wheezing observed. Prn [PRN] duoneb given at that time, with effect noted immediately post neb treatment. Pt received scheduled 1000 dose of duoneb, with effect noted. Mucomist delivered by pharmacy at 1215, prn dose given at 1300 for congestion. Pt reported relief." Nursing progress note for R35 dated 11/26/14, at 14:50 indicated: "Clinical observations: Patient (R35] missed his 1000 mucomist dose. Prn [PRN] mucomist given at 1320 upon delivery from pharmacy. GT clogged this morning, declogged with coca cola. Patient [R35] denies pain or discomfort this shift." The Treatment Administration History for R35 dated 11/01/14-11/30/14, indicated R35's lung sounds were assessed by nursing every shift.		

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	COMPLETED		
		00727	B. WING		12/0	4/2014
	PROVIDER OR SUPPLIER	CARE CENTER 615 MIN	ADDRESS, CITY, S INETONKA MII IS, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21530	of aspiration pneum care. He [R35] has yellow sputum and eating. Denies any shortness of breath epistaxis noted every Pharmacy progress by consulting pharm "Medication regime irregularities noted. On 12/4/14, at 3:00 pharmacist was cal contact the facility. received. The Pharmaceutica 8/14 indicated under Medication Adminis Right time." Under Medications, All me physician's order." The facility's "Drug 08/14, indicated 'Poreviewed per Surve Rationale: To ensuradministration. Res Nursing Staff." SUGGESTED MET The administrator, I Pharmacist could reprocedures for assign indications for use, monitoring of medicated as necessing the survey of the surv	has had recurrent episodes nonia and was requiring more a productive cough with occasionally coughs with fever, chills or increased. Pt [R35] with dry nose and ry few days." In note for R35 dated 11/6/14, nacist (CP) indicated n review completed. No " p.m. the facility's consulting led with a message left to A returned call was not al Administration Policy dated or "Administration Six Rights of tration4. Right route and 5.	of e e			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00727	B. WING		12/0	04/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AUGUST	ANA CHAPEL VIEW (CARE CENTER	INETONKA MI IS, MN 55343	LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 45	21530			
	ensure compliance regulations.	with state and federal				
	TIME PERIOD FOR days.	R CORRECTION: Thirty (30)				
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary ral	21535			
	must be free from unnecessary drug is A. in excessive therapy; B. for excessive C. without adec D. in the prese which indicate the codiscontinued. In addition to the discontinued. In addition to the discontinued in the provisions in the Code of Federal Ref 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Health Care Finance This standard is included in the control of the c	quate indications for its use; once of adverse consequence dose should be reduced or rug regimen review required to enursing home must comply the Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for acilities, published by the lith and Human Services, sing Administration, April 1992 corporated by reference. It is the Minitex interlibrary loan te Law Library. It is not	or S			
	by: Based on interview facility failed to ensi	ent is not met as evidenced and document review, the ure a sleep medication had g for 1 of 5 residents (R118).				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00727	B. WING		12/0	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA CHAPEL VIEW	CARE CENTER	IETONKA MI 6, MN 55343	LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	Continued From pa	age 46	21535			
	admit 8/20/14, how monitoring of sleep resident had difficu Review of the elect administration reco 8/20/14 through 12 received Trazodone admit and had not a Trazodone. Review of the Physindicated R118 was antidepressant use (mg) at bedtime, ar insomnia. Review of R118's coindicated "Resident having little energy Approaches include alterations every shading sides."					
	to promote sleep.	ovide comortable environment				
	quarterly mood/beh 11/10/14, indicated	al services progress note for navior tracking review dated R118 was on tracking for ving asleep and that tracking				
	dementia obtained record dated 8/20/1 Minimum Data Set	es including insomnia and from the resident admission 14. Review of the quarterly (MDS) dated 12/4/14, esident was cognitively intact				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00727	B. WING		12/0	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA CHAPEL VIEW	CARE CENTER	ETONKA MII , MN 55343	LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	'		21535			
	sleeping too much.	falling or staying asleep, or				
	registered nurse (R one day of sleep m was in the transition to this floor. RN-B was completed or a social worker, but " - At 12:30 p.m. the stated that she was the behavior/mood setting up the mood tracking, but that the responsible to track was no sleep assess the MDS. During an interview					
	During an interview on 12/5/14, 5:00 p.m. the director of nursing (DON) stated nursing should do a weekly sleep progress note and she would have expected that the night shift would document hours of sleep so that effectiveness and need could be evaluated.					
	Psychotropic Medic Appropriateness ar date of 8/14, indica regimen must be fr an unnecessary dru adequate monitorin medications "a slee initiated and pattern for a minimum of the baseline and will be	ty policy and procedure titled cation Monitoring for and for Side Effects with review atted that each resident's drug ee of unnecessary drugs, that ug is any drug used "without ag" and that for hypnotic ep log worksheet will be ans of sleep will be monitored are days and up to week for a esummarized by the licensed is note and Care Plan angly."				

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00727	B. WING		12/0	4/2014
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
AUGUS1	ANA CHAPEL VIEW (CARE CENTER	, MN 55343	LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	Suggested Method desigee could work consultant pharmac were reviewed for use that all medications indications for use. also perform audits determine if all medindications for use. Time Period for Could be suggested to the suggested for the sugge	ge 48 of Correction: The DON or with the medical director and cist to ensure medications innecessary medications and have parameters and The DON or designee could of resident records to dications had parameters and rection: Thirty (30) days.	21535			
	Subp. 2. Monitoring monitor each reside unnecessary drug	g. A nursing home must ent's drug regimen for usage, based on the nursing of procedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the al director for review if the not the attending physician. If a determines that the attending have adequate justification for attending physician does not not me matter must be referred for y Assurance and Assessment equired by part 4658.0070. If cian is the medical director, macist shall refer the matter				

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00727	B. WING		12/(04/2014	
NAME OF	PROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY,	STATE, ZIP CODE			
AUGUS	TANA CHAPEL VIEW (CARE CENTER	MINNETONKA MI KINS, MN 55343				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21540	This MN Requirements: Based on observation review the facility of pharmacist identified not being complete. Findings include: R118 had diagnose dementia obtained Record dated 8/20/for insomnia since record lacked monified the reside. Review of the elect administration record 8/20/14 through 12/received Trazodone admit and had not in Review of the considered 9/12/14 and irregularities. The pharmacist of the pharmacist insomnia, and record and target behavior sheets the insomnia, and record and target behavior and target behavior. Although the CP not care plan and target thing being tracked identify that the mocompleted by nursing little energy. Approaches included the process of R118's condicated, "Residential residential records included the process of R118's condicated, "Residential records included the process of R118's condicated the proce	ent is not met as evidence ion, interview and documer id not ensure the consulting of that sleep monitoring was d for 1 of 5 residents (R118 es including insomnia and from the Resident Admissional Admit 8/20/14, however the storing of sleep after it was ent had difficulty sleeping. Tonic medication red (EMAR) from admit on /3/14, indicated R118 had a 50 mg every night since received PRN trazodone. Tolitally pharmacist (CP) report of the care plan and target enthe care plan	orts Solan xa. he		,		

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:

A PLIE DINC:

00727

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:

B. WING

12/04/2014

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AUGUSTANA CHAPEL VIEW CARE CENTER 615 MINNETONKA MILLS ROAD HOPKINS, MN 55343							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
21540	Continued From page 50 medications for insomnia and to provide comfortable environment to promote sleep.	21540					
	Review of the Physician Orders dated 10/25/14, indicated R118 was to receive Trazodone (an antidepressant used for insomnia) 50 mg at bedtime, 20:00 and 50 mg at bedtime - as needed (PRN) for insomnia.						
	Review of the social services progress note for quarterly mood/behavior tracking review dated 11/10/14 indicated R118 was on tracking for difficulty falling/staying asleep and that tracking started 9/19/14.						
	Review of the quarterly Minimum Data Set (MDS) dated 12/4/14, identified the resident was cognitively intact and had no trouble falling or staying asleep, or sleeping too much.						
	During an interview on 12/4/14, at 12:01 p.m. registered nurse (RN)-B stated he could find only one day of sleep monitoring for R118 when she was in the transitional care unit before she came to this floor. RN-B verified no sleep monitoring was completed or documented as outlined by the social worker, but "have started it now."						
	During an interview on 12/4/14, at 12:30 p.m. the licensed social worker (LSW) stated she was responsible for developing the behavior/mood section of the care plan and setting up the mood and behavioral record for tracking, but that the nursing department was responsible to track the sleep. LSW stated there was no sleep assessment except for what is in the MDS.						
	During an interview on 12/4/14, 5:00 p.m. the director of nursing (DON) stated nursing should do a weekly sleep progress note and she would						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00727	B. WING		12/0	4/2014
AUGUSTANA CHAPEL VIEW CARE CENTER 615 MINN			DRESS, CITY, S ETONKA MII , MN 55343	STATE, ZIP CODE L LS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	have expected the hours of sleep so the could be evaluated. On 12/4/14, at 3:00 called with a messare turned call was not returned call was not returned call was not returned call was not regime of the facility of the fac	night shift would document hat effectiveness and need p.m. the facility's CP was age left to contact the facility. A pot received. y policy and procedure titled hation Monitoring for hat do for Side Effects with review ted that each resident's drug hat each resident's drug hat each great without great and that for hypnotic hat hat for hypnotic has of sleep will be monitored hat each great will be hat each great will be hat each great will be hat for hypnotic hat	21540			
21610	MN Rule 4658.1340 and Preparation Are	Subp. 1 Medicine Cabinet ea;Storage	21610			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00727	B. WING		12/0	04/2014
	PROVIDER OR SUPPLIER	615 MIN	ADDRESS, CITY, S			
AUGUST	TANA CHAPEL VIEW (HOPKIN	IS, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21610		e of drugs. A nursing home	21610			
	under proper tempe	s in locked compartments erature controls, and permit sing personnel to have				
	by: Based on observati review, the facility for medication carts we medications, wound medications for R86 facility failed to ens	d dressings and oral 6 and R75. In addition, the ure 1 of 7 medication carts is had the potential to affect				
	Findings include					
	reviewed with license and the following mestored in the cart: R86's tube of with an expiration of R75's Clotrimate medication common fungal infections) were House supply the expiration date 9/14 acknowledged expirations and to be sto	zole Cream 1% antifungal nly used in the treatment of rith expiration date 11/14/14 Mineral oil opened 8/1/13, and 1. At 1:37 p.m. LPN-D red medications were not red in medication cart. LPN-D cations were used as needed				
	reviewed with regis	p.m. the medication cart was tered nurse (RN)-D. During and back of the second	3			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00727	B. WING		12/0	04/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
AUGUS	TANA CHAPEL VIEW (CARE CENTER	NETONKA MII S, MN 55343	LLS ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21610	colored powder, de built-up in the corne approximately nine were divided/split. I hundred quantity ho 325 milligrams (mg expiration date 11/1 same drawer. At 1:4 the medication carts asked who was res medication carts RI responsible and RN expired and indicate the cart. TCU (Transitional COn 12/4/14, at 10:0 reviewed was compreview a box Silver dressing, Algicell Addressing) with expire observed stored on When asked who wand ensuring expire were not stored in the shift was responsiben on 12/4/14, at 12:3 when asked about alginate dressing, smedication cart and on 12/4/14, at 2:20 stated expired med not have been stored asked about medicated "they should"	ed to have a thick white bris of paper, foil pieces ers of the drawer and loose pills some of which in addition, an open one puse supply bottle of Aspirin opened date 9/15/14, with 4, was observed stored on the 50 p.m. RN-D acknowledged was not kept clean; when ponsible of cleaning the N-D stated all the nurses were N-D verified the Aspirin was ed she would remove it from care Unit) 8 a.m. the medication cart bleted with LPN-C. During the antimicrobial alginate g (antimicrobial wound ration date 4/2014, was the bottom drawer of the cart. Vas responsible of cleaning ed medications and supplies he cart LPN-C stated the night				

PRINTED: 12/18/2014 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING 00727 12/04/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 615 MINNETONKA MILLS ROAD **AUGUSTANA CHAPEL VIEW CARE CENTER** HOPKINS, MN 55343 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21610 Continued From page 54 21610 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could development and implement policies and procedures to monitor expiration of medications, cleanliness and security of the medication cart. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Forty (40) days.