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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NSAF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00727

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245493**
2.STATE VENDOR OR MEDICAID NO.
(L2) **470843100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/21/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Supervsior 01/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/23/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/08/2015
(L33)

DETERMINATION APPROVAL

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,

Anne Kleppe

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

Anne Kleppe

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245493	A. Building B. Wing	1/21/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **01/13/2015**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **01/13/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **01/13/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/13/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **01/13/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **01/13/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **01/13/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **01/13/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **01/13/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/13/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/13/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	01/23/2015	18623	01/21/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/4/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NSAF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00727

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245493**
2.STATE VENDOR OR MEDICAID NO.
(L2) **470843100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/04/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HFE NE II 12/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/06/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

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;

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

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

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

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

DEPARTMENT CONTACT

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

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

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

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/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,

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

Received 12-30-14

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

PRINTED: 12/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	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) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation was conducted for #H5493035 and found unsubstantiated.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assure bathroom mirrors were accessible for 1 of 1 resident (R64) who used a wheelchair and required a bathroom mirror to carry out activities of daily living (ADLs). Findings include: R64's annual Minimum Data Set (MDS) dated	F 246	F246 All resident rooms have standard height mirrors. Resident R64 received wheelchair- height temporary mirror on 12/4/14. Permanent mirror ordered 12/5/14, received and installed on 12/9/14. Two additional adaptive mirrors were received for future residents. Audit was completed to identify any other residents requiring special height mirror installation. Social services and/or nursing staff will continue to initiate work orders to maintenance when residents require adaptive mirrors. Maintenance Engineer will be responsible for monitoring and assuring timely completion of work orders.	1-13-15

Accepted 12-30-14 Plan Dth

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

Carla J. Dorh — Administrator — 12/29/14

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	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) COMPLETION DATE
F 246	Continued From page 1 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 (DHL). 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 missing BE stated "I don't recall seeing a 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 indicated "the second one on the top in the maintenance department knows." R64 mentioned (maintenance (M)-A) by name and then stated "he was there when the mirror fell with me and he	F 246		

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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 11/11/14, 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 246		
F 278 SS=D	483.20(g) - (j) 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. Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278		

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F 278	Continued From page 3 that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) for 1 of 3 residents (R226) who had an unstageable pressure ulcer. Findings include: 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. 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 was "unstageable" (Pressure ulcer is known but not stageable due to non-removable dressing/device or due to the coverage of the wound bed by slough or eschar),	F 278	F278 R226 had a pressure ulcer on spine at the time of admission. The ulcer was measured but a wound flow sheet was not initiated. Wound cares were being done as ordered by the physician. A wound flow sheet is in place and wound cares continue to be done as ordered and ulcer is healing. MDS was coded based upon information available from MD, NP, and RN's. An amended MDS was submitted to ensure correct coding. This was an isolated incident due to missing data. To prevent recurrence, MDS coding has been reviewed with RAI team. All MDS that include wound assessment will be audited for 3 months to ensure ongoing accuracy and compliance. Outcomes reported to facility QAPI team monthly. RAI Team and DON responsible.	1-13-15

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F 278	Continued From page 4 and there was 100 % "slough" in the wound bed. Record review indicated the following information: - The undated Resident Admission Record indicated R226 was admitted to the facility on 11/18/14, with diagnoses including Alzheimer's disease and congestive heart failure. - The Admit/Weekly skin check tool dated 11/18/14, indicated circled area on mid back of a body diagram indicating "pressure ulcer", however the stage of the wound or measurements were not documented. - The physician's progress notes dated 11/19/14 (one day after admission), noted presence of "Thoracic pressure ulcer- 2 small ulcerations surrounded by non blanchable redness-proximal ulcer 100% slough in base, distal shallow with clean base." There was no detailed description of the wounds. - The physician order dated 11/24/14, indicated "Wound care: back-clean wound with normal saline (salt water) 4x4. Cover with 4x4 Mepilex (an absorbant dressing) border or other composite dressing. Once a day Every other day." The order to "Apply Medihoney (antibacterial honey) gel to wound bed" was discontinued on 11/24/14. - 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. Even though R226's admission 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	F 278		

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F 278	Continued From page 5 white/yellow tissue]) pressure ulcer, R226 had an unstageable pressure ulcer that was not coded on the MDS which was located on the spine and midback. The registered nurse (RN)-H (also medicare nurse who completed R226's admission MDS) was interviewed on 12/3/14, at 9:57 a.m., and stated she got the information from the nurse manager via phone conversation. The RN-H acknowledged she did not review R226's medical record, and did not examine R226 to assess the back pressure ulcers to ensure coding accuracy. RN-H was interviewed again on 12/4/14, at 12:13 p.m., and after reviewing R226's record including the physician progress notes dated 11/19/14, acknowledged R226's admission MDS was inaccurate, and stated the pressure ulcer should have been coded as unstageable. According to the Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual version 3.0 dated October 2013, when coding unhealed pressure ulcer(s) "Steps for Assessment" were: "1. Review the medical record, including flow sheets or other skin tracking forms. 2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review. 3. Examine the resident and determine whether any skin ulcers are present." The RAI manual also noted in order to "Identify Unstageable Pressure Ulcers 1. Visualization of the wound bed is necessary for accurate staging. 2. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic	F 278		

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F 278	Continued From page 6 depth of tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable."	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure a careplan was comprehensively developed for respiratory problem for 1 of 5 residents (R35) reviewed for unnecessary medications. Findings include: –	F 279	F279 R35 has a diagnosis of COPD and this is addressed on his care plan. Parameters for use for PRN inhalers and nebulizers were received from the Physician and added to the orders. Review of other residents with PRN inhalers and nebulizers will be done to ensure parameters for use were included in orders. Education provided to all Licensed Nursing Staff and Health Unit Coordinators regarding this. 2 chart audits will be done per week to ensure ongoing compliance for 3 months. Audit outcomes will be reviewed monthly by facility QAPI committee. Clinical Manager and DON responsible.	1-13-15

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F 279	Continued From page 7 On 12/03/14, at 9:25 a.m. R35 was observed sitting in his wheelchair (w/c) near nurse's station coughing with his face color getting reddened, and R35 could not speak due to coughing. Licensed practical nurse (LPN)-C stated to R35, "I will get you a nebulizer treatment" and proceeded to assist R35. LPN-C also stated, "I check his [R35's] lungs every shift." R35's 14 day Minimum Data Set (MDS) dated 11/13/14, indicated R35 was cognitively intact and modified independence with some difficulty in new situations only regarding making decisions regarding tasks of daily life. R35's undated Admission Record indicated R35's diagnoses (Dx) included: adult failure to thrive, pneumonitis, chronic airway obstruction, shortness of breath. Physician Order Report dated 12/4/14, indicated R35 also had a diagnosis of reactive airways. R35's Care Area Assessment (CAA) dated 11/14/14, for R35 triggered for activities of daily living (ADLs) Functional Status/Rehabilitation Potential. Analysis of Finding included: "Patient [R35] recently admitted following recently placed peg tube due to severe dysphagia, Aspiration Pneumonia. Currently receives extensive assistance with all ADLs and mobility. Non-ambulatory at this time. Total incontinence of bowel and bladder. At risk for decline due to above listed risk factors and the following: new environment, episodes of SOB [shortness of breath], occasional pain. Uses Bi-pap at NOC [night]." The CAA dated 11/14/14, for R35 triggered for Dehydration/Fluid Maintenance indicated "Infection is indicated: Pneumonia." R35's care plan "Interdisciplinary Care Plan [paper careplan, pages not numbered]" dated	F 279		

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F 279	Continued From page 8 11/21/14, lacked evidence of any Pulmonary/Respiratory diagnoses and interventions which would have included treatments as needed (PRN) inhaler, PRN nebulizers, assessing lung sounds as physician ordered and checking O2 sats (oxygen saturation levels) which nursing routinely did for R35. R35's care plan "Care Plan [computerized careplan, pages numbered]" dated 11/17/14, indicated under "Nutritional Status, Assess bowel sounds and lung sounds q. [every] shift. Nursing" During an interview on 12/4/14, at 2:11 p.m. RN-E stated, "I would give R35 his PRN inhaler or PRN nebulizer treatment when R35 was wheezing, SOB or if his oxygen sats gets low, 89-90%." RN-D also stated, "Since R35 has a diagnosis of COPD [chronic obstructive pulmonary disease] we can give the PRN inhaler or PRN nebulizer treatment." RN-E verified R35's physician orders did not indicate whether to give the PRN inhaler or PRN nebulizer treatment when R35 was having SOB or other respiratory concerns. --At 3:21 p.m. RN-I when asked stated, "I would give R35 a PRN nebulizer treatment when R35 has shortness of breath or if R35 requested one." RN-I also stated, "I have never given R35 a PRN inhaler, only a PRN nebulizer." --At 3:27 p.m. RN-R stated, "I float all over and I am on call. I would look when R35 last had his PRN inhaler or nebulizer treatment and if it was time I would start with the inhaler and give R35 his PRN inhaler. And if that was not effective and it was time I would give R35 his PRN nebulizer treatment. And if the PRN nebulizer treatment was not effective I would call the physician." Physician Orders for R35 included physician order dated 11/01/14, Ventolin HFA (albuterol	F 279		

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F 279	Continued From page 9 sulfate) HFA aerosol inhaler; 90 mcg (micrograms)/actuation; amt: 2 puffs; inhalation Special Instructions: Non pharmacological Interventions: 1) Encourage deep breathing to relax; 2) Encourage incentive spirometer (if applicable) 3) Offer emotional support Every 3 Hours - PRN; and physician order dated 11/19/14, Ipratropium-albuterol solution for nebulization; 0.5 mg - 3 milligrams (mg) (2.5 mg base)/3 milliliters (ml); amt: 3 mls; inhalation Special Instructions: Dx: reactive airways Once A Day PRN. R35's physician order dated 11/19/14, Acetylcysteine solution; 100 mg/ml (10%) Amount to administer: 10 ml; inhalation, miscellaneous Once A Day - PRN. The Medication Administration History dated 11/1/14 through 11/30/14, indicated on 11/18/14, at 2:42 a.m. R35 was given a PRN Ventolin HFA (albuterol sulfate) HFA aerosol inhaler; 90 mcg/actuation 2 puffs inhalation for wheezing and the inhaler was effective. The November 2014 Medication Administration History also indicated R35 received a PRN Acetylcysteine sol 10 ml on 11/25/14, at 3:14 p.m. for congestion and wheeze and was effective. The November Medication Administration History also indicated R35 received a PRN Acetylcysteine sol 10 ml on 11/26/14, at 13:56 for congestion and was effective. The Medication Administration History dated 12/1/14 through 14/04/14, indicated R35 was 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	F 279		

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F 279	Continued From page 10 nebulizer treatments were effective. The parameters for usage for R35's PRNs could not be determined. The Treatment Administration History for R35 dated 11/01/14 through 11/30/14, indicated R35's lung sounds were assessed by nursing every shift. Progress notes by physician dated 12/01/14, indicated "He [R35] has had recurrent episodes of aspiration pneumonia and was requiring more care. He [R35] has a productive cough with yellow sputum and occasionally coughs with eating. Denies any fever, chills or increased shortness of breath. Pt [R35] with dry nose and epistaxis noted every few days." Augustana Chapel View Health Care Center Policy Subject Care Plan dated 1/14, directed "Provide a written guide for intervention, assisting the resident to meet their needs for ADLs, health care, and psychosocial needs."	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document interview, the facility did not ensure care plans were followed for 2 of 4 residents (R11, R14) reviewed for activities of daily living (ADLs).	F 282	F282 Residents R11 and R14 are being shaved daily as needed. Nursing Assistants involved have been educated on grooming needs and requirements. To prevent recurrence, Shaving policy has been reviewed with Nursing Department staff. 5 audits will be done weekly for 3 months to ensure ongoing compliance. Audit outcomes will be reviewed by facility QAPI committee. Nurse Managers and DON responsible.	1-13-15

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F 282	Continued From page 11 Findings Include: R11 was observed on 12/1/14, at 6:24 p.m. with seven, white 1/2 inch length facial hairs on her chin. R11 stated, "My chin hairs are not all right." R11 also stated, "Which ever staff notices them just plucks them." R11 further stated, "I just received my shower this morning." R11's quarterly MDS dated 9/3/14, indicated R11 was cognitively intact and needed extensive staff assist with activity of daily living (ADLs) including personal hygiene. R11's diagnoses indicated on the undated resident admission record included: malaise, fatigue, weakness and dementia. On 12/3/14, at 8:00 a.m. R11 was observed lying in bed with seven, white 1/2 inch length facial hairs on her chin. R11 requested of nursing assistant (NA)-B to get her up from bed. NA-B asked R11 what she wanted to wear and R11 answered. NA-B pulled privacy curtain, put his gloves on and gave R11 wet wash cloth and R11 proceeded to wash her face and then dried her face with the towel NA-B provided. NA-B put R11's socks and slacks on and assisted R11 to sit up on side of bed. NA-B washed and dried R11's upper half and R11 stated, "That feels good." NA-B finished assisting R11 with dressing, applied transfer belt to R11 and assisted R11 to stand, turn and sit in R11's wheelchair (w/c). NA-B then wheeled R11 to the bathroom. NA-B then took off the soiled gloves. NA-B stated, "I stand nearby, R11 prefers it." After R11 finished toileting NA-B with new gloves on assisted R11 with washing and drying R11's backside and pulling up R11's pants up and assisted R11 to the w/c with the transfer belt applied to R11.	F 282		

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F 282	Continued From page 12 -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 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 residents' care plans.	F 282		

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F 282	Continued From page 13 R14 was observed on 12/1/14, at 3:30 p.m. and on 12/3/14, at 2:38 p.m. to have multiple white facial hairs approximately one-half (1/2") inch observed on upper lip and jaw below mouth and was never offered assistance to remove them. R14's activities of daily living (ADL) function care plan dated 11/14/14, identified R14 had alteration for self performance of bathing, dressing, grooming related to diagnoses of arthritis, impaired functional mobility, short term memory loss, and weakness. The care plan directed R14 required assistance of one, staff to wash lower and upper body, dress lower and upper body but did not address R14's grooming needs which included facial hair removal. On 12/3/14, at 8:07 a.m. occupational therapist (OT)-E stated the aides help R14 to get out of bed, to the toilet and cued her to do as much as she could as she was improving. When asked what grooming needs R14 required OT-E stated R14 brushed her own teeth, did get help with pericares and brushed hair herself. When asked what she had assisted R14 with during morning cares, OT-E indicated she had assisted her with pericares. On 12/3/14, at 2:09 p.m. NA-C stated OT-E had gotten R14 dressed that morning and NA-C had gone back to the room to makes sure R14 had brushed teeth and NA-C would assisted her with toileting. When asked what she reports to the nurse NA-C stated abnormal vitals, if the resident was in pain, whatever is unusual, breathing problems, if she saw something happen that should not would report, skin check/changes and redness among others.	F 282		

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F 282	Continued From page 14 On 12/3/14, at 2:38 p.m. licensed practical nurse (LPN)-B verified R14 had multiple facial hair. When asked who was responsible to ensure residents were properly groomed LPN-B stated "the nursing assistants are." On 12/3/14, at 3:02 p.m. when asked about facial hairs RN-C indicated "the nursing assistant and the nurse should be looking out for residents' grooming to make sure they were properly groomed." On 12/4/14, at 2:24 p.m. the DON stated "Women should be asked to be shaved, same as men" when asked her expectation of staff with assisting female residents with facial hair removal. Augustana Chapel View Health Care Center Policy Subject Care Plans dated 1/14, directed "Provide a written guide for intervention, assisting the resident to meet their needs for ADLs, health care, and psychosocial needs, to provide for individualization (choice/preferences) of the resident's plan of care."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309		

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F 309	Continued From page 15 by: Based on observation, interview and document review, the facility failed to ensure pain medication and oxygen was provided in timely manner to 1 of 1 resident (R59) reviewed for hospice care. In addition, the facility failed to identify a non-pressure skin condition (bruise), assess for root cause and provide preventative measures to prevent bruising for 1 of 3 residents (R14) reviewed for non-pressure skin condition. Findings include: Hospice care: On 12/4/14, at 7:50 a.m. R59 was observed lying in bed and was calling out "will somebody call [did not understand name] to come!?" R59 called out twice, no staff responded to the call. -At 7:54 a.m. R59 called out for the third time, nursing assistant (NA)-D came out from the room across R59's room, entered R59's room and was overheard talking to R59. -At 7:55 a.m. NA-D came out from R59's room and went back to the room across R59's room. -At 7:58 a.m. R59 responded to surveyor's knock on the door, and when surveyor moved closer to R59's bed, R59 stated "do not leave me." R59's oxygen tank was running but not hooked to R59's nostrils. Oxygen cannula and tubing were observed on top of R59's chest area. R59's right hand was also holding a telephone set placed on top of her abdominal area. R59 coughed at times with moist but non-productive cough while talking. R59 was observed to have facial grimaces after coughing and with slight body movements. R59 also showed signs of discomfort while shifting body as she adjusted pillow with her left hand. R59 stated to have "hollered all night long" asking for staff to give "nitro" (used for treatment of	F 309	F309 R59 did receive her pain medication as requested and oxygen cannula properly placed. Nurse and Nursing Assistant involved were educated on importance of timely medication administration and ensuring proper administration of oxygen. R14 bruise of unknown origin on right hand was assessed. Resident unsure how this bruise occurred but was able to participate in interview. Nurses involved were educated on importance of completing incident reports and follow up investigations timely for skin alterations. Timely medication administration, placement of oxygen tubing and appropriate follow up for skin alterations was included in all staff education. Clinical Managers and DON responsible.	1-13-15

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F 309	Continued From page 16 angina and heart failure) for pain. R59 added having wanted to drink since "last night " but nobody could help her. There was neither fluid nor any fluid container on R59's bedside table. -At 7:59 a.m. NA-D entered R59's room and told R59 she was going to get her something to drink. NA-D verified there was no fluid available at R59's bedside and confirmed R59 asked NA-D for a drink when NA-D first entered R59's room at 7:54 a.m. -At 8:01 a.m. NA-D returned to R59's room with a small pitcher of water and fluids contained in two while cartons, however, NA-D did not bring straws so R59 was still unable to drink. -At 8:03 a.m. registered nurse (RN)-B entered R59's room, washed his hands and went ahead to hook R59's oxygen through R59's nostrils, RN-B increased the oxygen to be delivered at three liters per minute. R59 told RN-B that she needed medication for pain, wanted to have a drink and wanted to call family member (F)-B. RN-B told R59 he would find the nurse to give the pain medication. RN-B also stated he would bring straws for R59's drinks and would get the telephone number of R59's F-B. It could not be determined how long R59 laid in bed without the oxygen prior to the observation. -At 8:07 a.m. the oxygen saturation per pulse oximeter read at 77% then gradually increased to 90% at 8:10 a.m. -At 8:11 a.m. RN-B brought straws and opened one carton of the drinks provided, put straw and handed it to R59. RN-B also dialed the number written on a piece of paper he was holding and gave the telephone to R59. R59 was unable to talk to F-B, put telephone down and stated no one was answering. R59 was observed to show signs of discomfort by trying to shift positions while lying in bed. R59 had audible breath sounds	F 309		

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F 309	Continued From page 17 and facial grimaces were still noted when R59 would attempt body shifting. -At 8:31 a.m. R59 told RN-B who re-entered R59's room that nobody had given R59's pain medication as of the time. RN-B told R59 that he would go look for the nurse, and then RN-B stepped out of R59's room. -At 8:33 a.m. RN-B returned to R59's room with a gown, asked for NA-D's help to boost R59 in bed, then went on to change R59's gown which became wet from spilled drink. R59 reacted with some moaning sounds when RN-B and NA-D moved her in bed. -At 8:35 a.m. RN-D entered room, apologized to R59 for being late in coming to room to give R59's pain medication. RN-D explained R59 that she was then giving R59's pain medication. After taking pain medications from RN-D, R59 looked at RN-B who was also at the bedside, repeated fear of dying, and told RN-B about not wishing to be on Hospice anymore. RN-B informed R59 that they would talk about R59's wish. RN-B again dialed F-B's number and stated no body answered. R59's quarterly Minimum Data Set (MDS) dated 11/19/14, indicated R59 had moderately impaired decision making. The MDS listed R59's diagnoses included respiratory failure, chronic airway obstruction, morbid obesity, pain, hypertension, and anxiety. The MDS identified R59 to have moderate pain frequently; and shortness of breath with activity, at rest and when lying flat. The Analysis of Findings section of the Care Area Assessments (CAA) dated 8/14/14, indicated R59 had alteration in comfort due to multiple mental and physical risk factors. R59 was also identified	F 309		

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F 309	Continued From page 18 to complain of mild to severe degree of pain daily. It was further noted R59 was on scheduled and as needed (PRN) pain medications. The care plan dated 8/13/14, indicated R59 had alteration in comfort with mild to severe complaints of pain daily. Pain was characterized as generalized. R59 was also identified to have chest pain. The care plan directed staff to implement interventions which included anticipating resident's pain, observing for non-verbal indications of pain; giving PRN pain medications as ordered by the nurse practitioner (NP) or the physician (MD; applying topical medicated creams for pain; giving Nitrostat as ordered by NP or MD; and applying warm packs to legs for 20 minutes four times a day. A review of the medication administration records (MAR) dated 11/4/14 to 12/4/14, revealed R59 never had PRN BenGay greaseless cream (topical medicated cream for pain); and the PRN doses of Dilaudid (an analgesic) 3 milligrams (mg) and PRN Nitrostat were last given eight days ago on 11/26/14. It was noted in the MAR that R59 requested the Dilaudid and also complained of chest pain on 11/26/14. R59's oxygen saturation was noted as 60% with the complaint of chest pain. The Physician Order Report dated 11/28/14, directed staff to assess pain every three hours while awake and offer Dilaudid for pain; to give Nitrostat 0.4 mg tablet under the tongue for chest pain; Lyrica 75 mg by mouth for neuropathic pain; Dilaudid liquid 3 mg by mouth for generalized pain every 4 hours and Dilaudid 3 to 5 mg by mouth every hour as needed for pain; Methadone 10 mg by mouth twice a day; and oxygen via	F 309		

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F 309	Continued From page 19 nasal cannula every shift for comfort. On 12/4/14, at 8:49 a.m. RN-D verified R59 last received PRN Dilaudid pain medication and Nitrostat medication on 11/26/14. -At 1:15 p.m. the director of nursing (DON) stated she expected staff to assess any resident's complaints of pain and implement interventions according to care plan. The facility's policy on Pain Management/Assessment last reviewed on 8/14, provided for staff to administer ordered PRN medications for breakthrough pain. R59 did not receive the hospice related services in a timely manner to maintain and /or control the pain and to ensure the oxygen was being delivered to maintain the oxygen levels. Bruise: R14's diagnoses included muscle weakness (generalized), rheumatoid arthritis, pressure ulcer, and chronic pain obtained from the admission MDS dated 11/3/14. R14's activities of daily living (ADLs) functional status/rehabilitation potential CAA dated 11/4/14, identified R14 had severe impairment with cognition and required physical assist with ADLs which included dressing, grooming and toileting. R14's skin care plan dated 11/10/14, identified R14 was at risk for skin irritation/breakdown. Goal "will remain intact during stay at facility..." The care plan directed staff to use care when assisting resident with cares or positioning-lift, do not slide and to complete wound flow sheets per protocol. R14's care plan did not address R14 was on aspirin daily which would make R14 prone to bruising.	F 309		

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F 309	Continued From page 20 On 12/1/14, at 4:09 p.m. observed R14 seated on wheelchair in her room with husband visiting. RN-G in room observed moving resident wheelchair slightly, then briefly, never discussed anything about the dark purple bruise to right thumb that was visible. On 12/2/14, at 8:28 a.m. observed bruise on right hand between thumb and second finger. When asked how the bruise may have occurred R14 stated "I bruise easily." On 12/3/14, at 7:18 a.m. observed door shut to R14's room. Upon entering room observed occupational therapist (OT)-E making the bed and R14 was observed seated on the toilet. -At 7:32 a.m. observed OT-E come out of room with bag of soiled contents, R14 was seated on wheelchair, door was slightly open. -At 7:34 a.m. OT-E went back to room. Observed R14 seated on the wheelchair by sink, door was slightly open, then OT-E shut the door. -At 7:38 a.m. observed R14 leaving her room with OT-E. Bruise visible as OT-E wheeled R14 through the dining room and got on elevator to lower level where the therapy room was located. -At 7:40 a.m. observed R14 in therapy room doing upper arm exercises on table bruise visible. R14 stayed in therapy room until 8:09 a.m. On 12/3/14, at 9:08 a.m. NA-E was observed wheeling R14 from the DR to her room. -At 9:09 a.m. NA-E left room briefly after assisting R14 with turning television on. R14 still seated in her wheelchair overheard NA-E saying she will be back never asked R14 about the bruise. -At 9:12 a.m. R14 observed seated in wheelchair watching television and door to room was wide open.	F 309		

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F 309	Continued From page 21 -At 9:12 a.m. NA-E came back to room observed holding blanket and overheard telling R14 she had brought a warm towel. NA-E assisted R14 to get wrapped with blanket and left room briefly. -At 9:17 a.m. observed NA-C and physical therapist (PT)-G enter room. NA-C left and shut the door. -At 9:19 a.m. PT-G left room stated she was getting an oximeter (a machine used to measure oxygen level) and would be back. PT-G came back and said she would test the oxygen level, then stated it was spell this out ninety four (94) percent (%) PT-G got R14 to push up from chair and push seat up. R14 was resting arms on walker and was observed walking in room. R14's dark purple bruise between thumb and first finger was visible to PT-G but nothing was said about it. On 12/3/14, at 12:10 p.m. when asked what she would report to the nurse PT-G indicated she would report abuse and bruising. On 12/3/14, at 2:09 p.m. NA-C stated occupational therapy got R14 dressed. When asked what she would report to the nurse stated abnormal vitals, reports of pain, whatever is unusual, breathing or attitude, skin checks and redness. On 12/3/14, at 2:38 p.m. licensed practical nurse (LPN)-B verified the bruise and stated it was a purple bruise. LPN-B then asked R14 how she had gotten the bruise and R14 stated she did not know how it happened. LPN-B stated R14 was on aspirin and methaltrexate (medication used to treat rheumatoid arthritis) and both caused easy bruising. LPN-B further stated the nursing assistants usually let the nurse know about bruises.	F 309		

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F 309	Continued From page 22 On 12/3/14, at 3:02 p.m. RN-C was asked if he was aware of R14's bruise to right hand between thumb and first finger. RN-C stated he had just been informed by LPN-B about the bruise. RN-C further stated he would have expected staff who had cared for residents to have reported bruises to nurses and to assess it. RN-C also indicated usually the nurse would fill out an incident report and he would review it. On 12/04/14, at 2:24 p.m. the director of nursing when asked about bruises stated "the nurse that discover it should make sure to document it and anybody who sees it should follow up on it." During review of Interdisciplinary Team (IDT) Notes dated 10/28/14, through 12/3/14, it was revealed the dark purple bruise to right hand between the thumb and first finger had not been identified nor documented. During further IDT Notes it was revealed LPN-C had entered a nursing note dated 12/3/14, after concern had been brought to the facility attention. Skin Care Program policy date 9/14, directed staff "Residents at risk without skin alterations: Residents at risk for impaired skin integrity will have interventions to protect skin noted on Care Plan, computer Care Path and NAR [nursing assistant registered] care sheet." In addition the policy directed nursing assistants to observe skin condition during cares and report any skin changes or alterations to the licensed staff person immediately.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	Continued From page 23 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide perineal care for 1 of 3 residents (R226) reviewed for bowel incontinence care. In addition, the facility failed to provide assistance with facial grooming cares for 2 of 4 residents (R11, R14) who were dependent on staff. Findings include: R226 did not receive genital area cares during cares for bowel incontinence. The undated Resident Admission Record indicated was admitted to the facility on 11/18/14, with diagnoses including dementia, Alzheimer's disease, Congestive heart failure. The care plan dated 11/18/14, indicated resident was on hospice care. The Admission Minimum Data Set (MDS) dated 12/1/14, indicated R226 was frequently incontinent with urine and was always incontinent with bowel movements. The MDS also indicated R226 needed two staff assistance with personal hygiene and toilet use. The Nursing Admission and Temporary care plan dated 11/18/14, indicated the following:	F 312	F312 Peri-care protocol was reviewed with Nursing Assistants involved in care of R226. Residents R11 and R14 are being shaved daily as needed. Nursing Assistants involved have been educated on grooming needs and requirements. To prevent recurrence, Shaving and Peri-Care policies have been reviewed with Nursing Department staff. 5 audits of resident shaving and 2 audits of peri care practices will be done weekly for 3 months to ensure ongoing compliance. Audit outcomes will be shared with facility QAPI committee ongoing. Nurse Managers and DON responsible.	1-13-15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 24 - 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. The undated TCU (transitional care care) Care card also indicated R226 needed assist of one staff with grooming. R226 was observed on 12/3/14, from 7:30 a.m. to 8:15 a.m. while nursing assistants (NA)-B and NA-F provided morning cares to help R226 get ready for breakfast. NA-B opened R226's incontinence pad, pushed it down between R226's legs. R226 was turned to the right side. R226 was observed to have a large amount of green colored stool in the incontinence pad which visibly covered the perineal area. NA-B used wet washcloths and soap to wipe R226's bottom, however did not attempt to lift R226's leg to provide genital area care. The two NA's proceeded to turn R226 on her left side, when NA-F wiped R226's bottom using wet wash cloths, however R226's genital area and inner thighs were not cleaned. Staff applied a clean incontinence pad, turned R226 on her back, fastened the incontinence pad and stated they had completed the pericare. At that point licensed practical nurse (LPN)-C entered the room, and surveyor requested LPN-C to verify R226's perineal cleanliness. LPN-C requested more wet washcloths, separated R226's legs, and provided genital area care. The washcloths were soiled with dark green bowel movement. LPN-A used five additional washcloths to successfully clean R226's genital area and inner thighs.	F 312		

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	245493	A. BUILDING _____ B. WING _____	12/04/2014

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F 312	Continued From page 25 LPN-C was interviewed on 12/3/14, at 8:28 a.m. and stated that when she checked R226's genital area cleanliness R226 was dirty with stool on her genital area and thighs. LPN-C also stated the nursing assistants were expected to clean resident's genital area while on back and with legs separated. During interview on 12/3/14, at 9:18 a.m. NA-B stated NA-F "was supposed to clean resident when she was turned to the left side", and that she thought NA-F completed the genital area cleaning. During interview on 12/3/14, at 10:13 a.m. NA-F stated she "thought" NA-C "cleaned resident". The infection control nurse (ICN) who was also responsible for staff development was interviewed on 12/3/14, at 2:46 p.m. The ICN stated staff received extensive training upon hire; they had a mentor, and also watched videos on proper pericare. The ICN also stated staff did not use wipes, but only wet washcloths, towels and special soap to perform pericare, and staff was expected to clean until washcloths came off the skin clean. The facilities Perineal Care policy and procedure dated revised on 10/14, indicated "Place a waterproof pad under the resident's hips. Spread legs and lift the knees up so the feet are flat in bed." The policy also described in details cleaning of the "Female Genitals", with instructions to "spread the labia" and "wipe each side of the perineum from the urethral opening towards the anus in one motion." The policy also indicated staff needed to "repeat until the area is clean."	F 312		

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F 312	Continued From page 26 R11 and R14 were not provided services to be free from unwanted facial hair. R11 was observed with seven, white 1/2 inch length facial hairs on her chin on 12/1/14, at 6:24 p.m. R11 stated, "My chin hairs are not all right." R11 also stated, "Which ever staff notices them just plucks them." R11 further stated, "I just received my shower this morning." R11's quarterly MDS dated 9/3/14, indicated R11 was cognitively intact and needed extensive staff assist with activity of daily living (ADLs) including personal hygiene. R11's diagnoses indicated on the undated resident admission record included: malaise, fatigue, weakness and dementia. On 12/3/14, at 8:00 a.m. R11 was observed lying in bed with seven, white 1/2 inch length facial hairs on her chin. R11 requested of NA-B to get her up from bed. NA-B asked R11 what she wanted to wear and R11 answered. NA-B pulled privacy curtain, put his gloves on and gave R11 wet wash cloth and R11 proceeded to wash her face and then dried her face with the towel NA-B provided. NA-B put R11's socks and slacks on and assisted R11 to sit up on side of bed. NA-B washed and dried R11's upper half and R11 stated, "That feels good." NA-B finished assisting R11 with dressing, applied transfer belt to R11 and assisted R11 to stand, turn and sit in R11's wheelchair (w/c). NA-B then wheeled R11 to the bathroom. NA-B then took off the soiled gloves. NA-B stated, "I stand nearby, R11 prefers it." After R11 finished toileting NA-B with new gloves on assisted R11 with washing and drying R11's backside and pulling up R11's pants up and assisted R11 to the w/c with the transfer belt applied to R11.	F 312		

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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 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 residents' care plans. 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		

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F 312	Continued From page 28 member (F)-A was seated in chair in corner of the room. Multiple white facial hairs approximately one-half (1/2") inch observed on upper lip and jaw below mouth. On 12/2/14, at 4:09 p.m. observed R14 seated on wheelchair in her room with F-A visiting. RN-G was observed in the room moving resident wheelchair slightly, then briefly, never offered to remove the facial hairs. On 12/3/14, at 7:18 a.m. observed occupational therapist (OT)-E making bed, R14 was seated on the toilet. -At 7:32 a.m. observed OT-E coming out of room with bag of soiled contents, R14 was seated on wheelchair, door was slightly open. -At 7:34 a.m. OT-E went back to room. Observed R14 sitting on wheelchair by sink, door was slightly open; OT-E shut the door. -At 7:38 a.m. observed R14 leaving her room with Occupational Therapist (OT)-E wheeling her went through the dining room and took elevator to lower level where the therapy room was located facial hair still visible. -At 7:40 a.m. to 8:09 a.m. observed R14 in therapy room doing upper arm exercises on table. R14 stayed in therapy room, facial hairs were visible then came back to dining room. -At 8:12 a.m. observed R14 in dining room at table with three other ladies eating breakfast. -At 8:51 a.m. R14 still in dining room had completed eating. Facial hair was visible and no staff in the dining room offered to remove it. -At 9:08:08 a.m. NA-E was observed wheeling R14 from breakfast table to her room. -At 9:09 a.m. NA-E left room briefly after assisting R14, and put television (TV) on. R14 still seated in her wheelchair overheard NA-E saying she will be back never offered to remove the facial hairs.	F 312		

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F 312	Continued From page 29 -At 9:12 a.m. R14 was observed seated in wheelchair watching TV with door to room wide open. -At 9:12 a.m. NA-E came back to room observed holding blanket and overheard telling R14 she had brought a warm towel. NA-E assisted R14 to get wrapped with blanket around R14 upper body and left room briefly never offered to remove the facial hairs. -At 9:17 a.m. both NA-C and physical therapist (PT)-G entered room. NA-C left and shut the door. -At 9:19 a.m. PT-G left room stated she was getting an oximeter and would be back. PT-G came back and said she would test the oxygen level, and then stated it was ninety four (94) percent (%). PT-G got R14 to push up from chair and push seat up. R14 was resting her arms on walker and was walking in room. PT-G was standby assist as R14 walked in room to sit in chair by window. R14 was able to sit in chair without assistance. R14 was still observed with multiple white facial hairs above lip and on chin were not acknowledged, and no assistance was offered to remove it. R14's diagnoses included muscle weakness (generalized), rheumatoid arthritis, pressure ulcer, and chronic pain obtained from the admission MDS dated 11/3/14. In addition, the MDS indicated R14 did not reject cares and required extensive assist of one to two staff with dressing, toilet use and personal hygiene. R14's ADLs functional status/rehabilitation potential Care Area Assessment (CAA) dated 11/4/14, identified that R14 had severe impairment with cognition and required physical assist with ADLs which included dressing,	F 312		

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F 312	Continued From page 30 grooming and toileting. ADL function care plan dated 11/14/14, identified R14 had alteration for self-performance of bathing, dressing, grooming related to diagnoses of arthritis, impaired functional mobility, short term memory loss, and weakness. The care plan directed R14 required assistance of one, staff to wash lower and upper body, dress lower and upper body but did not address R14's grooming needs which included facial hair removal. On 12/3/14, at 8:07 a.m. OT-E stated the aides help R14 to get out of bed, to the toilet and cued her to do as much as she could as she was improving. When asked what grooming needs R14 required OT-E stated R14 brushed her own teeth, did get help with pericare and brushed hair herself. When asked what she had assisted R14 during morning cares as observed OT-E indicated she had assisted her with pericare. On 12/3/14, at 2:09 p.m. NA-C stated OT-E had gotten R14 dressed that morning and NA-C had gone back to the room to makes sure R14 had brushed teeth and NA-C would assisted her with toileting. When asked what she reported to nurse NA-C stated abnormal vitals, reported if resident was in pain, whatever was unusual, breathing problems, if she saw something happen that should not would report, skin check/changes and redness among others. On 12/3/14, at 2:38 p.m. LPN-B verified R14 had multiple facial hairs. When asked who was responsible to ensure residents were properly groomed LPN-B stated "the nursing assistants are." On 12/3/14, at 3:02 p.m. when asked about facial	F 312		

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F 312	Continued From page 31 hairs RN-C indicated "the nursing assistant and the nurse should be looking out for residents' grooming to make sure they were properly groomed." On 12/4/14, at 2:24 p.m. the DON stated "Women should be asked to be shaved, same as men" when asked her expectation of staff with assisting female residents with facial hair removal. Augustana Chapel View Health Care Center Policy Subject Care Plans dated 1/14, directed "Provide a written guide for intervention, assisting the resident to meet their needs for ADLs, health care, and psychosocial needs, to provide for individualization (choice/preferences) of the resident's plan of care."	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess a pressure ulcer upon admission, failed to provide treatment as physician ordered and failed	F 314	F314 As stated above, R226 had a pressure ulcer on spine at the time of admission. The ulcer was measured but a wound flow sheet was not initiated. Wound cares were being done as ordered by the physician with the exception noted. The exception noted was reviewed with the nurse involved and a return demonstration was performed. A wound flow sheet is in place and wound cares continue to be done as ordered and ulcer is healing.	1-13-15

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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 12/3/14. 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 using 4x4 gauze and Dermal wound cleanser spray. The LPN removed the gloves, put clean gloves on and applied Medihoney gel into the wound bed using 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 was "unstageable (Pressure ulcer is known but not stageable due to non-removable dressing/device or due to the coverage of 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 further	F 314	To prevent recurrence, an audit was done of all other existing wounds to ensure a wound flow sheet is in place. To further ensure ongoing compliance, the facility has contracted with Accelercare Wound Professionals (AWP) to facilitate regular wound rounds inclusive of assessment and management. AWP will be available for consultation between scheduled visits and provide education and training to facility staff. Weekly audits of wound documentation will be done for 3 months and then randomly to ensure ongoing compliance. Audit outcomes will be reviewed by facility QAPI committee. Clinical Managers and DON responsible.	cont'd 1-13-15

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F 314	Continued From page 33 explained she remembered using the Medihoney the previous week when she worked, and admitted did not verify physician order prior dressing change. The undated Resident Admission Record indicated was admitted to the facility on 11/18/14, with diagnoses including Alzheimer's disease, and congestive heart failure. The care plan dated 11/18/14, indicated resident was on hospice care. The physician order dated 11/24/14, indicated, "Wound care: back-clean wound with normal saline (salt water) 4x4. Cover with 4x4 Mepilex (an absorbent dressing) border or other composite dressing. Once a day Every other day." The order to "Apply Medihoney gel (a wound dressing used to speed up healing) to wound bed" was discontinued on 11/24/14. Record review indicated the following incomplete and contradicting information: - The Admit/Weekly skin check tool dated 11/18/14, indicated circled area on mid back of a body diagram indicating "pressure ulcer", however the stage of the wound or measurements were not documented. - The progress notes dated from 11/18/14, also lacked evidence the pressure ulcers were assessed upon admission or any time after admission to ensure monitoring. - The physician's progress notes dated 11/19/14, noted presence of "Thoracic pressure ulcer- 2 small ulcerations surrounded by non blanchable redness- proximal ulcer 100% slough in base, distal shallow with clean base." - The Tissue Tolerance Assessment Laying dated 11/19/14, noted "Came into facility with pressure ulcers", however the pressure ulcers were not	F 314		

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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 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 the wounds being at stage two, but he did not	F 314		

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F 314	Continued From page 35 document them. Five minutes later during interview RN-C stated that actually he did not see 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."	F 314		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329 SS=D	Continued From page 36 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a sleep medication had adequate monitoring for 1 of 5 residents (R118). Findings include: R118 received trazodone for insomnia since admit 8/20/14, however the record lacked monitoring of sleep after it was identified the	F 329	F329 Sleep monitoring was initiated for R118. Audits were conducted on all other residents receiving medication for sleep to ensure sleep monitoring was in place. To prevent recurrence, sleep monitoring has been added to Order Reminder list. Education was provided to Licensed Nursing Staff and Social Services. Audits of all residents with medication for sleep will be monitored for 3 months to ensure ongoing compliance. Audit outcomes will be reviewed by facility QAPI committee. Clinical Managers, Social Worker and DON responsible.	1-13-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 37 resident had difficulty sleeping. Review of the electronic medication administration record (EMAR) from admit on 8/20/14 through 12/3/14, indicated R118 had received Trazodone 50 mg every night since admit and had not received as needed (PRN) Trazodone. Review of the Physician Orders dated 10/25/14, indicated R118 was to receive Trazodone (an antidepressant used for insomnia) 50 milligrams (mg) at bedtime, and 50 mg at bedtime - PRN for insomnia. Review of R118's care plan, dated 9/19/14, indicated "Resident expresses feeling tired and having little energy R/T [due to] insomnia." Approaches included to document mood/behavior alterations every shift, administer medications for insomnia and to provide comfortable environment to promote sleep. 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. R118 had diagnoses including insomnia and dementia obtained from the resident admission record dated 8/20/14. Review of the quarterly Minimum Data Set (MDS) dated 12/4/14, identified that 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	F 329		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	12/04/2014

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F 329	Continued From page 38 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." - At 12:30 p.m. the licensed social worker (LSW) stated that 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 12/5/14, 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. Review of the facility policy and procedure titled Psychotropic Medication Monitoring for Appropriateness and for Side Effects with review date of 8/14, indicated that each resident's drug regimen must be free of unnecessary drugs, that an unnecessary drug is any drug used "without adequate monitoring" and that for hypnotic medications "a sleep log worksheet will be initiated and patterns of sleep will be monitored for a minimum of three days and up to week for a baseline and will be summarized by the licensed staff in the progress note and Care Plan developed accordingly."	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be	F 428		

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F 428	Continued From page 39 reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not ensure the consulting pharmacist identified that sleep monitoring was not being completed for 1 of 5 residents (R118). Findings include: R118 had diagnoses including insomnia and dementia obtained from the Resident Admission Record dated 8/20/14. R118 received Trazodone for insomnia since admit 8/20/14, however the record lacked monitoring of sleep after it was identified the resident had difficulty sleeping. Review of the electronic medication administration record (EMAR) from admit on 8/20/14 through 12/3/14, indicated R118 had received Trazodone 50 mg every night since admit and had not received PRN trazodone. Review of the consulting pharmacist (CP) reports dated 9/12/14 and 10/17/14, identified no irregularities. The pharmacist Report dated 11/20/14, noted "per the care plan and target behavior sheets the only thing being tracked is insomnia", and recommended updating care plan	F 428	F428 As stated above, sleep monitoring was initiated for R118. Audits were conducted on all other residents receiving medication for sleep to ensure sleep monitoring was in place. To prevent recurrence, sleep monitoring has been added to Order Reminder list. Education was provided to Licensed Nursing Staff and Social Services. Audits of all residents with medication for sleep will be monitored for 3 months to ensure ongoing compliance. Audit outcomes will be reviewed by facility QAPI committee. Clinical Managers, Social Worker and DON responsible.	1-13-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 40 and target behaviors for the medication Zyprexa. Although the CP noted on 11/20/14, that "per the care plan and target behavior sheets the only thing being tracked is insomnia", the CP did not identify that the monitoring was not being completed by nursing personnel. Review of R118's care plan, dated 9/19/14, indicated, "Resident expresses feeling tired and having little energy R/T [related to] insomnia." Approaches included to document mood/ behavior alterations every shift, administer medications for insomnia and to provide comfortable environment to promote sleep. 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."	F 428		

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F 428	Continued From page 41 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 have expected the night shift would document hours of sleep so that effectiveness and need could be evaluated. On 12/4/14, at 3:00 p.m. the facility's CP was called with a message left to contact the facility. A returned call was not received. Review of the facility policy and procedure titled Psychotropic Medication Monitoring for Appropriateness and for Side Effects with review date of 8/14, indicated that each resident's drug regimen must be free of unnecessary drugs, that an unnecessary drug is any drug used "without adequate monitoring" and that for hypnotic medications "a sleep log worksheet will be initiated and patterns of sleep will be monitored for a minimum of three days and up to week for a baseline and will be summarized by the licensed staff in the progress note and Care Plan developed accordingly."	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		

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F 431	Continued From page 42 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 7 medication carts were free of expired medications, wound dressings and oral	F 431	F431 Expired medications and dressings were removed from med carts. Cleaning of medication carts has been done. To prevent recurrence, routine cleaning schedule has been implemented. All medication carts were audited for expired meds. Education was provided to Licensed Nursing Staff. 5 weekly audits of locked and clean med carts and expired medications will be done for 3 months and then randomly to prevent recurrence. Audit outcomes will be reviewed by facility QAPI committee. Clinical Manager and DON responsible.	1-13-15

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F 431	Continued From page 43 medications for R86 and R75. In addition, the facility failed to ensure 1 of 7 medication carts was kept clean. This had the potential to affect 50 of 177 residents. Findings include Lower Level Unit On 12/3/14, at 1:30 p.m. medication cart was reviewed with licensed practical nurse (LPN)-D and the following medications were noted to be stored in the cart: · R86's tube of Bengay (pain relieving cream) with an expiration date 9/2014 · R75's Clotrimazole Cream 1% antifungal medication commonly used in the treatment of fungal infections) with expiration date 11/14/14 · House supply Mineral oil opened 8/1/13, and expiration date 9/14. At 1:37 p.m. LPN-D acknowledged expired medications were not supposed to be stored in medication cart. LPN-D further stated medications were used as needed and had been overlooked. On 12/3/14, at 1:42 p.m. the medication cart was reviewed with registered nurse (RN)-D. During the tour the bottom and back of the second drawer was observed to have a thick white colored powder, debris of paper, foil pieces built-up in the corners of the drawer and approximately nine loose pills some of which were divided/split. In addition, an open one hundred quantity house supply bottle of Aspirin 325 milligrams (mg) opened date 9/15/14, with expiration date 11/14, was observed stored on the same drawer. At 1:50 p.m. RN-D acknowledged the medication cart was not kept clean; when asked who was responsible of cleaning the	F 431		

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F 431	Continued From page 44 medication carts RN-D stated all the nurses were responsible and RN-D verified the Aspirin was expired and indicated she would remove it from the cart. TCU (Transitional Care Unit) On 12/4/14, at 10:08 a.m. the medication cart reviewed was completed with LPN-C. During the review a box Silver antimicrobial alginate dressing, Algicell Ag (antimicrobial wound dressing) with expiration date 4/2014, was observed stored on the bottom drawer of the cart. When asked who was responsible of cleaning and ensuring expired medications and supplies were not stored in the cart LPN-C stated the night shift was responsible. On 12/4/14, at 12:37 p.m. RN-C unit manager when asked about date for silver antimicrobial alginate dressing, stated it should not be in the medication cart and should have been tossed out. On 12/4/14, at 2:20 p.m. the director of nursing stated expired medications and dressings should not have been stored in medication carts. When asked about medication cart cleanliness DON stated "they should be clean and everyone is responsible to keep medication carts clean."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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 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. Findings include:	F 441	F441 Dressing change for R226 was reviewed with the nurse involved. Policy was reviewed inclusive of checking orders and infection control principles. Return demonstration has been performed. Dressing Change Policy reviewed with all Licensed Nursing Staff. Weekly audits of 2 dressing changes will be done for 3 months to ensure ongoing compliance. Infection Control/Staff Development Director, Clinical Managers and DON responsible. MN Rule 4568.0810 Tuberculin testing had been completed for R16. Results were reviewed with nurse involved and she states results were negative. Importance of documenting millimeters of induration was also reviewed with same nurse. Facility Tuberculin testing policy will be reviewed by all licensed nurses. Weekly audits will be done for 3 months to ensure compliance. Audit outcomes will be reviewed by facility QAPI committee Infection Control Nurse and DON responsible.	1-13-15

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F 441	Continued From page 46 The undated Resident Admission Record indicated R226 was admitted to the facility on 11/18/14, with diagnoses including dementia, Alzheimer's disease, congestive heart failure. The care plan dated 11/18/14, indicated resident was on hospice care. The physician order dated 11/24/14, indicated, "Wound care: back-clean wound with normal saline 4x4. Cover with 4x4 Mepilex border or other composite dressing. Once a day Every other day." The order to "Apply Medihoney gel to wound bed" was discontinued on 11/24/14. 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 without changing gloves or washing hands LPN-C proceeded and washed the wound using 4x4 gauze and Dermal wound cleanser spray. LPN removed the gloves at this time, without washing hands, put clean gloves on and applied Medihoney gel into the wound bed using 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 they needed to change gloves and wash hands between the clean and dirty parts of R226's pressure ulcer dressing change, and verified she "forgot" to remove the dirty gloves and wash hands after she removed the old dressing before she washed the wound.	F 441		

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F 441	Continued From page 47 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."	F 441		

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	245493	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/03/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on December 03, 2014. At the time of this survey, Augustana Chapel View Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 2-story split level building was determined to be of Type II(000) construction. It has a partial basement and is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 115 beds and had a census of 99 beds at the time of the survey.	K 000		

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

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

MINNESOTA MDH DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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.

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: gloria.derfus@state.mn.us
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,

Anne Kleppe

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00727	A. BUILDING: _____ B. WING _____	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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On December 1 through December 4, 2014, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's	2 000	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.	

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2 000	Continued From page 1 signature." Make a copy of these orders for your records and return the original to the address below: Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program; P.O. Box 64900, St. Paul, Minnesota 55164-0900. A complaint investigation was conducted for #H5493035 and found unsubstantiated. No correction orders are issued.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 430	MN Rule 4658.0210 Subp. 1 Room Assignments Subpart 1. Room assignments and furnishings. A nursing home must attempt to accommodate a resident's preferences on room assignments, roommates, and furnishings whenever possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assure bathroom mirrors were accessible for 1 of 1 resident (R64) who used a wheelchair and required a bathroom	2 430		

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2 430	Continued From page 2 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 missing BE stated "I don't recall seeing a 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	2 430		

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2 430	Continued From page 3 indicated "the second one on the top in the maintenance department knows" as R64 mentioned (maintenance (M)-A) name then stated "he was there when the mirror fell with me and he 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 11/11/14, 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. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review, revise policies and procedures to ensure room furnishings to accomodate resident needs and preferences are provided. Facility staff could be educated on these policies and procedures. The administrator or designee could develop a monitoring system to ensure ongoing compliance. Time Period for Correction: Forty (40) days.	2 430		

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2 560	Continued From page 4	2 560		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure a careplan was comprehensively developed for respiratory problem for 1 of 5 residents (R35) reviewed for unnecessary medications. Findings include: On 12/03/14, at 9:25 a.m. R35 was observed sitting in his wheelchair (w/c) near nurse's station coughing with his face color getting reddened, and R35 could not speak due to coughing. Licensed practical nurse (LPN)-C stated to R35, "I will get you a nebulizer treatment" and proceeded to assist R35. LPN-C also stated, "I check his [R35's] lungs every shift." R35's 14 day Minimum Data Set (MDS) dated 11/13/14, indicated R35 was cognitively intact and modified independence with some difficulty in new situations only regarding making decisions regarding tasks of daily life. R35's undated Admission Record indicated R35's diagnoses (Dx) included: adult failure to thrive, pneumonitis,	2 560		

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2 560	Continued From page 5 chronic airway obstruction, shortness of breath. Physician Order Report dated 12/4/14, indicated R35 also had a diagnosis of reactive airways. R35's Care Area Assessment (CAA) dated 11/14/14, for R35 triggered for activities of daily living (ADLs) Functional Status/Rehabilitation Potential. Analysis of Finding included: "Patient [R35] recently admitted following recently placed peg tube due to severe dysphagia, Aspiration Pneumonia. Currently receives extensive assistance with all ADLs and mobility. Non-ambulatory at this time. Total incontinence of bowel and bladder. At risk for decline due to above listed risk factors and the following: new environment, episodes of SOB [shortness of breath], occasional pain. Uses Bi-pap at NOC [night]." The CAA dated 11/14/14, for R35 triggered for Dehydration/Fluid Maintenance indicated "Infection is indicated: Pneumonia." R35's care plan "Interdisciplinary Care Plan [paper careplan, pages not numbered]" dated 11/21/14, lacked evidence of any Pulmonary/Respiratory diagnoses and interventions which would have included treatments as needed (PRN) inhaler, PRN nebulizers, assessing lung sounds as physician ordered and checking O2 sats (oxygen saturation levels) which nursing routinely did for R35. R35's care plan "Care Plan [computerized careplan, pages numbered]" dated 11/17/14, indicated under "Nutritional Status, Assess bowel sounds and lung sounds q. [every] shift. Nursing" During an interview on 12/4/14, at 2:11 p.m. RN-E stated, "I would give R35 his PRN inhaler or PRN nebulizer treatment when R35 was wheezing, SOB or if his oxygen sats gets low, 89-90%." RN-D also stated, "Since R35 has a diagnosis of	2 560		

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2 560	Continued From page 6 COPD [chronic obstructive pulmonary disease] we can give the PRN inhaler or PRN nebulizer treatment." RN-E verified R35's physician orders did not indicate whether to give the PRN inhaler or PRN nebulizer treatment when R35 was having SOB or other respiratory concerns. --At 3:21 p.m. RN-I when asked stated, "I would give R35 a PRN nebulizer treatment when R35 has shortness of breath or if R35 requested one." RN-I also stated, "I have never given R35 a PRN inhaler, only a PRN nebulizer." --At 3:27 p.m. RN-R stated, "I float all over and I am on call. I would look when R35 last had his PRN inhaler or nebulizer treatment and if it was time I would start with the inhaler and give R35 his PRN inhaler. And if that was not effective and it was time I would give R35 his PRN nebulizer treatment. And if the PRN nebulizer treatment was not effective I would call the physician." Physician Orders for R35 included physician order dated 11/01/14, Ventolin HFA (albuterol sulfate) HFA aerosol inhaler; 90 mcg (micrograms)/actuation; amt: 2 puffs; inhalation Special Instructions: Non pharmacological Interventions: 1) Encourage deep breathing to relax; 2) Encourage incentive spirometer (if applicable) 3) Offer emotional support Every 3 Hours - PRN; and physician order dated 11/19/14, Ipratropium-albuterol solution for nebulization; 0.5 mg - 3 milligrams (mg) (2.5 mg base)/3 milliliters (ml); amt: 3 mls; inhalation Special Instructions: Dx: reactive airways Once A Day PRN. R35's physician order dated 11/19/14, Acetylcysteine solution; 100 mg/ml (10%) Amount to administer: 10 ml; inhalation, miscellaneous Once A Day - PRN. The Medication Administration History dated 11/1/14 through 11/30/14, indicated on 11/18/14,	2 560		

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2 560	Continued From page 7 at 2:42 a.m. R35 was given a PRN Ventolin HFA (albuterol sulfate) HFA aerosol inhaler; 90 mcg/actuation 2 puffs inhalation for wheezing and the inhaler was effective. The November 2014 Medication Administration History also indicated R35 received a PRN Acetylcysteine sol 10 ml on 11/25/14, at 3:14 p.m. for congestion and wheeze and was effective. The November Medication Administration History also indicated R35 received a PRN Acetylcysteine sol 10 ml on 11/26/14, at 13:56 for congestion and was effective. The Medication Administration History dated 12/1/14 through 14/04/14, indicated R35 was 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. The Treatment Administration History for R35 dated 11/01/14 through 11/30/14, indicated R35's lung sounds were assessed by nursing every shift. Progress notes by physician dated 12/01/14, indicated "He [R35] has had recurrent episodes of aspiration pneumonia and was requiring more care. He [R35] has a productive cough with yellow sputum and occasionally coughs with eating. Denies any fever, chills or increased shortness of breath. Pt [R35] with dry nose and epistaxis noted every few days." Augustana Chapel View Health Care Center	2 560		

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2 560	Continued From page 8 Policy Subject Care Plan dated 1/14, directed "Provide a written guide for intervention, assisting the resident to meet their needs for ADLs, health care, and psychosocial needs." SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service licensed staff to develop a care plan to include appropriate interventions for all identified care needs. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document interview, the facility did not ensure care plans were followed for 2 of 4 residents (R11, R14) reviewed for activities of daily living (ADLs). Findings Included: R11 was observed on 12/1/14, at 6:24 p.m. with seven, white 1/2 inch length facial hairs on her chin. R11 stated, "My chin hairs are not all right." R11 also stated, "Which ever staff notices them just plucks them." R11 further stated, "I just	2 565		

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2 565	Continued From page 9 received my shower this morning." R11's quarterly MDS dated 9/3/14, indicated R11 was cognitively intact and needed extensive staff assist with activity of daily living (ADLs) including personal hygiene. R11's diagnoses indicated on the undated resident admission record included: malaise, fatigue, weakness and dementia. On 12/3/14, at 8:00 a.m. R11 was observed lying in bed with seven, white 1/2 inch length facial hairs on her chin. R11 requested of nursing assistant (NA)-B to get her up from bed. NA-B asked R11 what she wanted to wear and R11 answered. NA-B pulled privacy curtain, put his gloves on and gave R11 wet wash cloth and R11 proceeded to wash her face and then dried her face with the towel NA-B provided. NA-B put R11's socks and slacks on and assisted R11 to sit up on side of bed. NA-B washed and dried R11's upper half and R11 stated, "That feels good." NA-B finished assisting R11 with dressing, applied transfer belt to R11 and assisted R11 to stand, turn and sit in R11's wheelchair (w/c). NA-B then wheeled R11 to the bathroom. NA-B then took off the soiled gloves. NA-B stated, "I stand nearby, R11 prefers it." After R11 finished toileting NA-B with new gloves on assisted R11 with washing and drying R11's backside and pulling up R11's pants up and assisted R11 to the w/c with the transfer belt applied to R11. -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 her chin hairs shaved nor did assist R11. NA-B then asked R11 if she wanted to go to	2 565		

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2 565	Continued From page 10 breakfast. R11's care plan dated 9/17/14, indicated: Potential Alteration in ADL Self Performance of Grooming, R11 will groom self with Mod-Max staff assist daily. R11 requires extensive assist with grooming assist of 1 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 residents' care plans. R14 was observed on 12/1/14, at 3:30 p.m. to 12/3/14, at 2:38 p.m. R14 was observed to have multiple white facial hairs approximately one-half (1/2") inch observed on upper lip and jaw below mouth and was never offered assistance to remove them. R14's ADL function care plan dated 11/14/14, identified R14 had alteration for self performance of bathing, dressing, grooming related to	2 565		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 11 diagnoses of arthritis, impaired functional mobility, short term memory loss, and weakness. The care plan directed R14 required assistance of one, staff to wash lower and upper body, dress lower and upper body but did not address R14's grooming needs which included facial hair removal. On 12/3/14, at 8:07 a.m. occupational therapy (OT)-E stated the aides help R14 to get out of bed, to the toilet and cued her to do as much as she could as she was improving. When asked what grooming needs R14 required OT-E stated R14 brushed her own teeth, did get help with pericares and brushed hair herself. When asked what she had assisted R14 during morning cares as observed OT-E indicated she had assisted her with pericares. On 12/3/14, at 2:09 p.m. NA-C stated OT-E had gotten R14 dressed that morning and NA-C had gone back to the room to makes sure R14 had brushed teeth and NA-C would assisted her with toileting. When asked what she reports to nurse NA-C stated abnormal vitals, reported if resident was in pain, whatever is unusual, breathing problems, if she saw something happen that should not would report, skin check/changes and redness among others. On 12/3/14, at 2:38 p.m. licensed practical nurse (LPN)-B verified R14 had multiple facial hair. When asked who was responsible to ensure residents were properly groomed LPN-B stated "the nursing assistants are." On 12/3/14, at 3:02 p.m. when asked about facial hairs RN-C indicated "the nursing assistant and the nurse should be looking out for residents' grooming to make	2 565		

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2 565	Continued From page 12 sure they were properly groomed." On 12/4/14, at 2:24 p.m. the DON stated "Women should be asked to be shaved, same as men" when asked her expectation of staff with assisting female residents with facial hair removal. Augustana Chapel View Health Care Center Policy Subject Care Plans dated 1/14, directed "Provide a written guide for intervention, assisting the resident to meet their needs for ADLs, health care, and psychosocial needs, to provide for individualization (choice/preferences) of the resident's plan of care." Suggested Method of Correction: (1) Develop a system which ensures that resident care plans are current and that all staff are delivering care according to the care plan; educate all care givers. (2) Ensure all Nurse Managers are observing resident care for accurate delivery of interventions. (3) Document all corrective action taken. Time Period for Correction: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out	2 830		

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2 830	Continued From page 13 of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pain medication and oxygen was provided in timely manner to 1 of 1 resident (R59) reviewed for hospice care. In addition, the facility failed to identify a non-pressure skin condition (bruise), assess for root cause and provide preventative measures to prevent bruising for 1 of 3 residents (R14) reviewed for non-pressure skin condition. Findings include: Hospice care: On 12/4/14, at 7:50 a.m. R59 was observed lying in bed and was calling out "will somebody call [did not understand name] to come!?" R59 called out twice, no staff responded to the call. -At 7:54 a.m. R59 called out for the third time, nursing assistant (NA)-D came out from the room across R59's room, entered R59's room and was overheard talking to R59. -At 7:55 a.m. NA-D came out from R59's room and went back to the room across R59's room. -At 7:58 a.m. R59 responded to surveyor's knock on the door, and when surveyor moved closer to R59's bed, R59 stated "do not leave me." R59's oxygen tank was running but not hooked to R59's nostrils. Oxygen cannula and tubing were observed on top of R59's chest area. R59's right hand was also holding a telephone set placed on	2 830		

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2 830	Continued From page 14 top of her abdominal area. R59 coughed at times with moist but non-productive cough while talking. R59 was observed to have facial grimaces after coughing and with slight body movements. R59 also showed signs of discomfort while shifting body as she adjusted pillow with her left hand. R59 stated to have "hollered all night long" asking for staff to give "nitro" (used for treatment of angina and heart failure) for pain. R59 added having wanted to drink since "last night " but nobody could help her. There was neither fluid nor any fluid container on R59's bedside table. -At 7:59 a.m. NA-D entered R59's room and told R59 she was going to get her something to drink. NA-D verified there was no fluid available at R59's bedside and confirmed R59 asked NA-D for a drink when NA-D first entered R59's room at 7:54 a.m. -At 8:01 a.m. NA-D returned to R59's room with a small pitcher of water and fluids contained in two while cartons, however, NA-D did not bring straws so R59 was still unable to drink. -At 8:03 a.m. registered nurse (RN)-B entered R59's room, washed his hands and went ahead to hook R59's oxygen through R59's nostrils, RN-B increased the oxygen to be delivered at three liters per minute. R59 told RN-B that she needed medication for pain, wanted to have a drink and wanted to call family member (F)-B. RN-B told R59 he would find the nurse to give the pain medication. RN-B also stated he would bring straws for R59's drinks and would get the telephone number of R59's F-B. It could not be determined how long R59 laid in bed without the oxygen prior to the observation. -At 8:07 a.m. the oxygen saturation per pulse oximeter read at 77% then gradually increased to 90% at 8:10 a.m. -At 8:11 a.m. RN-B brought straws and opened one carton of the drinks provided, put straw and	2 830		

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2 830	Continued From page 15 handed it to R59. RN-B also dialed the number written on a piece of paper he was holding and gave the telephone to R59. R59 was unable to talk to F-B, put telephone down and stated no one was answering. R59 was observed to show signs of discomfort by trying to shift positions while lying in bed. R59 had audible breath sounds and facial grimaces were still noted when R59 would attempt body shifting. -At 8:31 a.m. R59 told RN-B who re-entered R59's room that nobody had given R59's pain medication as of the time. RN-B told R59 that he would go look for the nurse, and then RN-B stepped out of R59's room. -At 8:33 a.m. RN-B returned to R59's room with a gown, asked for NA-D's help to boost R59 in bed, then went on to change R59's gown which became wet from spilled drink. R59 reacted with some moaning sounds when RN-B and NA-D moved her in bed. -At 8:35 a.m. RN-D entered room, apologized to R59 for being late in coming to room to give R59's pain medication. RN-D explained R59 that she was then giving R59's pain medication. After taking pain medications from RN-D, R59 looked at RN-B who was also at the bedside, repeated fear of dying, and told RN-B about not wishing to be on Hospice anymore. RN-B informed R59 that they would talk about R59's wish. RN-B again dialed F-B's number and stated no body answered. R59's quarterly Minimum Data Set (MDS) dated 11/19/14, indicated R59 had moderately impaired decision making. The MDS listed R59's diagnoses included respiratory failure, chronic airway obstruction, morbid obesity, pain, hypertension, and anxiety. The MDS identified R59 to have moderate pain frequently; and shortness of breath with activity, at rest and when	2 830		

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2 830	Continued From page 16 lying flat. The Analysis of Findings section of the Care Area Assessments (CAA) dated 8/14/14, indicated R59 had alteration in comfort due to multiple mental and physical risk factors. R59 was also identified to complain of mild to severe degree of pain daily. It was further noted R59 was on scheduled and as needed (PRN) pain medications. The care plan dated 8/13/14, indicated R59 had alteration in comfort with mild to severe complaints of pain daily. Pain was characterized as generalized. R59 was also identified to have chest pain. The care plan directed staff to implement interventions which included anticipating resident's pain, observing for non-verbal indications of pain; giving PRN pain medications as ordered by the nurse practitioner (NP) or the physician (MD; applying topical medicated creams for pain; giving Nitrostat as ordered by NP or MD; and applying warm packs to legs for 20 minutes four times a day. A review of the medication administration records (MAR) dated 11/4/14 to 12/4/14, revealed R59 never had PRN BenGay greaseless cream (topical medicated cream for pain); and the PRN doses of Dilaudid (an analgesic) 3 milligrams (mg) and PRN Nitrostat were last given eight days ago on 11/26/14. It was noted in the MAR that R59 requested the Dilaudid and also complained of chest pain on 11/26/14. R59's oxygen saturation was noted as 60% with the complaint of chest pain. The Physician Order Report dated 11/28/14, directed staff to assess pain every three hours while awake and offer Dilaudid for pain; to give Nitrostat 0.4 mg tablet under the tongue for chest	2 830		

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2 830	Continued From page 17 pain; Lyrica 75 mg by mouth for neuropathic pain; Dilaudid liquid 3 mg by mouth for generalized pain every 4 hours and Dilaudid 3 to 5 mg by mouth every hour as needed for pain; Methadone 10 mg by mouth twice a day; and oxygen via nasal cannula every shift for comfort. On 12/4/14, at 8:49 a.m. RN-D verified R59 last received PRN Dilaudid pain medication and Nitrostat medication on 11/26/14. -At 1:15 p.m. the director of nursing (DON) stated she expected staff to assess any resident's complaints of pain and implement interventions according to care plan. The facility's policy on Pain Management/Assessment last reviewed on 8/14, provided for staff to administer ordered PRN medications for breakthrough pain. R59 did not receive the hospice related services in a timely manner to maintain and /or control the pain and to ensure the oxygen was being delivered to maintain the oxygen levels. Bruise: R14's diagnoses included muscle weakness (generalized), rheumatoid arthritis, pressure ulcer, and chronic pain obtained from the admission MDS dated 11/3/14. R14's activities of daily living (ADLs) functional status/rehabilitation potential CAA dated 11/4/14, identified R14 had severe impairment with cognition and required physical assist with ADLs which included dressing, grooming and toileting. R14's skin care plan dated 11/10/14, identified R14 was at risk for skin irritation/breakdown. Goal "will remain intact during stay at facility..." The	2 830		

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2 830	Continued From page 18	2 830		

care plan directed staff to use care when assisting resident with cares or positioning-lift, do not slide and to complete wound flow sheets per protocol. R14's care plan did not address R14 was on aspirin daily which would make R14 prone to bruising.

On 12/1/14, at 4:09 p.m. observed R14 seated on wheelchair in her room with husband visiting. RN-G in room observed moving resident wheelchair slightly, then briefly, never discussed anything about the dark purple bruise to right thumb that was visible.

On 12/2/14, at 8:28 a.m. observed bruise on right hand between thumb and second finger. When asked how the bruise may have occurred R14 stated "I bruise easily."

On 12/3/14, at 7:18 a.m. observed door shut to R14's room. Upon entering room observed occupational therapist (OT)-E making the bed and R14 was observed seated on the toilet.
-At 7:32 a.m. observed OT-E come out of room with bag of soiled contents, R14 was seated on wheelchair, door was slightly open.
-At 7:34 a.m. OT-E went back to room. Observed R14 seated on the wheelchair by sink, door was slightly open, then OT-E shut the door.
-At 7:38 a.m. observed R14 leaving her room with OT-E. Bruise visible as OT-E wheeled R14 through the dining room and got on elevator to lower level where the therapy room was located.
-At 7:40 a.m. observed R14 in therapy room doing upper arm exercises on table bruise visible. R14 stayed in therapy room until 8:09 a.m.

On 12/3/14, at 9:08 a.m. NA-E was observed wheeling R14 from the DR to her room.
-At 9:09 a.m. NA-E left room briefly after assisting

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2 830	Continued From page 19 R14 with turning television on. R14 still seated in her wheelchair overheard NA-E saying she will be back never asked R14 about the bruise. -At 9:12 a.m. R14 observed seated in wheelchair watching television and door to room was wide open. -At 9:12 a.m. NA-E came back to room observed holding blanket and overheard telling R14 she had brought a warm towel. NA-E assisted R14 to get wrapped with blanket and left room briefly. -At 9:17 a.m. observed NA-C and physical therapist (PT)-G enter room. NA-C left and shut the door. -At 9:19 a.m. PT-G left room stated she was getting an oximeter (a machine used to measure oxygen level) and would be back. PT-G came back and said she would test the oxygen level, then stated it was spell this out ninety four (94) percent (%) PT-G got R14 to push up from chair and push seat up. R14 was resting arms on walker and was observed walking in room. R14's dark purple bruise between thumb and first finger was visible to PT-G but nothing was said about it. On 12/3/14, at 12:10 p.m. when asked what she would report to the nurse PT-G indicated she would report abuse and bruising. On 12/3/14, at 2:09 p.m. NA-C stated occupational therapy got R14 dressed. When asked what she would report to the nurse stated abnormal vitals, reports of pain, whatever is unusual, breathing or attitude, skin checks and redness. On 12/3/14, at 2:38 p.m. licensed practical nurse (LPN)-B verified the bruise and stated it was a purple bruise. LPN-B then asked R14 how she had gotten the bruise and R14 stated she did not know how it happened. LPN-B stated R14 was on	2 830		

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2 830	Continued From page 20 aspirin and methaltrexate (medication used to treat rheumatoid arthritis) and both caused easy bruising. LPN-B further stated the nursing assistants usually let the nurse know about bruises. On 12/3/14, at 3:02 p.m. RN-C was asked if he was aware of R14's bruise to right hand between thumb and first finger. RN-C stated he had just been informed by LPN-B about the bruise. RN-C further stated he would have expected staff who had cared for residents to have reported bruises to nurses and to assess it. RN-C also indicated usually the nurse would fill out an incident report and he would review it. On 12/04/14, at 2:24 p.m. the director of nursing when asked about bruises stated "the nurse that discover it should make sure to document it and anybody who sees it should follow up on it." During review of Interdisciplinary Team (IDT) Notes dated 10/28/14, through 12/3/14, it was revealed the dark purple bruise to right hand between the thumb and first finger had not been identified nor documented. During further IDT Notes it was revealed LPN-C had entered a nursing note dated 12/3/14, after concern had been brought to the facility attention. Skin Care Program policy date 9/14, directed staff "Residents at risk without skin alterations: Residents at risk for impaired skin integrity will have interventions to protect skin noted on Care Plan, computer Care Path and NAR [nursing assistant registered] care sheet." In addition the policy directed nursing assistants to observe skin condition during cares and report any skin changes or alterations to the licensed staff person immediately.	2 830		

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2 830	Continued From page 21 SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and re-educate staff on policies to ensure that all residents are assessed and provided necessary care and services for pain management and to prevent bruising. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers 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: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess a pressure ulcer upon admission, failed to	2 900		

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2 900	Continued From page 22 provide treatment as physician ordered and failed 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 12/3/14. 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 using 4x4 gauze and Dermal wound cleanser spray. The LPN removed the gloves, put clean gloves on and applied Medihoney gel into the wound bed using 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 was "unstageable (Pressure ulcer is known but not stageable due to non-removable dressing/device or due to the coverage of 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 further	2 900		

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2 900	Continued From page 23 explained she remembered using the Medihoney the previous week when she worked, and admitted did not verify physician order prior dressing change. The undated Resident Admission Record indicated was admitted to the facility on 11/18/14, with diagnoses including Alzheimer's disease, and congestive heart failure. The care plan dated 11/18/14, indicated resident was on hospice care. The physician order dated 11/24/14, indicated, "Wound care: back-clean wound with normal saline (salt water) 4x4. Cover with 4x4 Mepilex (an absorbent dressing) border or other composite dressing. Once a day Every other day." The order to "Apply Medihoney gel (a wound dressing used to speed up healing) to wound bed" was discontinued on 11/24/14. Record review indicated the following incomplete and contradicting information: - The Admit/Weekly skin check tool dated 11/18/14, indicated circled area on mid back of a body diagram indicating "pressure ulcer", however the stage of the wound or measurements were not documented. - The progress notes dated from 11/18/14, also lacked evidence the pressure ulcers were assessed upon admission or any time after admission to ensure monitoring. - The physician's progress notes dated 11/19/14, noted presence of "Thoracic pressure ulcer- 2 small ulcerations surrounded by non blanchable redness- proximal ulcer 100% slough in base, distal shallow with clean base." - The Tissue Tolerance Assessment Laying dated 11/19/14, noted "Came into facility with pressure ulcers", however the pressure ulcers were not described as being assessed. The Assessment	2 900		

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	00727	A. BUILDING: _____ B. WING _____	12/04/2014

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2 900	Continued From page 24 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 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 the wounds being at stage two, but he did not document them. Five minutes later during interview RN-C stated that actually he did not see	2 900		

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2 900	Continued From page 25 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	2 900		

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2 900	Continued From page 26 necessary treatment/services to prevent pressure sores from developing and to promote healing. The Director of Nursing could assign the Quality Assurance Committee to provide on-going monitoring of the delivery of care to residents to ensure that pressure sores do not develop unless the resident's clinical condition demonstrates that they were unavoidable TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide perineal care for 1 of 3 residents (R226) reviewed for bowel incontinence care. In addition, the facility failed to provide assistance with facial grooming cares for 2 of 4 residents (R11, R14) who were dependent on staff. Findings include: R226 did not receive genital area cares during cares for bowel incontinence. The undated Resident Admission Record	2 920		

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2 920	Continued From page 27 indicated was admitted to the facility on 11/18/14, with diagnoses including dementia, Alzheimer's disease, Congestive heart failure. The care plan dated 11/18/14, indicated resident was on hospice care. The Admission Minimum Data Set (MDS) dated 12/1/14, indicated R226 was frequently incontinent with urine and was always incontinent with bowel movements. The MDS also indicated R226 needed two staff assistance with personal 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. The undated TCU (transitional care care) Care card also indicated R226 needed assist of one staff with grooming. R226 was observed on 12/3/14, from 7:30 a.m. to 8:15 a.m. while nursing assistants (NA)-B and NA-F provided morning cares to help R226 get ready for breakfast. NA-B opened R226's incontinence pad, pushed it down between R226's legs. R226 was turned to the right side. R226 was observed to have a large amount of green colored stool in the incontinence pad which visibly covered the perineal area. NA-B used wet washcloths and soap to wipe R226's bottom, however did not attempt to lift R226's leg to provide genital area care. The two NA's proceeded to turn R226 on her left side, when	2 920		

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2 920	Continued From page 28 NA-F wiped R226's bottom using wet wash cloths, however R226's genital area and inner thighs were not cleaned. Staff applied a clean incontinence pad, turned R226 on her back, fastened the incontinence pad and stated they had completed the pericare. At that point licensed practical nurse (LPN)-C entered the room, and surveyor requested LPN-C to verify R226's perineal cleanliness. LPN-C requested more wet washcloths, separated R226's legs, and provided genital area care. The washcloths were soiled with dark green bowel movement. LPN-A used five additional washcloths to successfully clean R226's genital area and inner thighs. LPN-C was interviewed on 12/3/14, at 8:28 a.m. and stated that when she checked R226's genital area cleanliness R226 was dirty with stool on her genital area and thighs. LPN-C also stated the nursing assistants were expected to clean resident ' s genital area while on back and with legs separated. During interview on 12/3/14, at 9:18 a.m. NA-B stated NA-F "was supposed to clean resident when she was turned to the left side", and that she thought NA-F completed the genital area cleaning. During interview on 12/3/14, at 10:13 a.m. NA-F stated she "thought" NA-C "cleaned resident". The infection control nurse (ICN) who was also responsible for staff development was interviewed on 12/3/14, at 2:46 p.m. The ICN stated staff received extensive training upon hire; they had a mentor, and also watched videos on proper pericare. The ICN also stated staff did not use wipes, but only wet washcloths, towels and special soap to perform pericare, and staff was	2 920		

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2 920	Continued From page 29 expected to clean until washcloths came off the skin clean. The facilities Perineal Care policy and procedure dated revised on 10/14, indicated "Place a waterproof pad under the resident's hips. Spread legs and lift the knees up so the feet are flat in bed." The policy also described in details cleaning of the "Female Genitals", with instructions to "spread the labia" and "wipe each side of the perineum from the urethral opening towards the anus in one motion." The policy also indicated staff needed to "repeat until the area is clean." Tatro, Sandra R11 and R14 were not provided services to be free from facial unwanted facial hair. R11 was observed with seven and 1/2 inch length white facial hair on her chin on 12/1/14, at 6:24 p.m. R11 stated, "My chin hairs are not all right." R11 also stated, "Which ever staff notices them just plucks them." R11 further stated, "I just received my shower this morning." On 12/3/14, at 8:00 a.m. R11 was observed lying in bed with seven and 1/2 inch length facial white hair on her chin. R11 requested of NA-B to get her up from bed. NA-B asked R11 what she wanted to wear and R11 answered. NA-B pulled privacy curtain, put his gloves on and gave R11 wet wash cloth and R11 proceeded to wash her face and then dried her face with the towel NA-B provided. NA-B put R11's socks and slacks on and assisted R11 to sit up on side of bed. NA-B washed and dried R11's upper half and R11 stated, "That feels good." NA-B finished assisting R11 with dressing, applied transfer belt to R11	2 920		

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2 920	Continued From page 30 and assisted R11 to stand, turn and sit in R11's wheelchair (w/c). NA-B then wheeled R11 to the bathroom. NA-B then took off the soiled gloves. NA-B stated, "I stand nearby, R11 prefers it." After R11 finished toileting NA-B with new gloves on assisted R11 with washing and drying R11's backside and pulling up R11's pants up and assisted R11 to the w/c with the transfer belt applied to R11. -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 and 1/2 inch length white facial hair was 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 quarterly MDS dated 9/3/14, indicated R11 was cognitively intact and needed extensive staff assist with activity of daily living (ADLs) including personal hygiene. R11's diagnoses indicated on the undated resident admission record included: malaise, fatigue, weakness and dementia. Care plan for R11 dated 9/17/14, indicated R11 Potential Alteration in ADL Self Performance of Grooming, R11 will groom self with Mod-Max staff assist daily. R11 requires extensive assist with grooming assist of 1 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	2 920		

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2 920	Continued From page 31 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. diretor of nursing (DON) stated she expected nursing staff to follow residents' care plans. R11 was provided the services to maintain her appearance of being free from facial hair. 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. DON stated she expected nursing staff to follow residents' care plans. R11 was provided the services to maintain her appearance of being free from facial hair. R14 was observed lying in bed on her back in her room on 12/1/14, at 3:30 a.m. R14's family member (F)-A was seated in chair in corner of the room. Multiple white facial hairs approximately one-half (1/2") inch observed on upper lip and jaw below mouth. On 12/2/14, at 4:09 p.m. observed R14 seated on wheelchair in her room with F-A visiting. RN-G in room observed moving resident wheelchair slightly, then briefly, never offered to remove the facial hairs.	2 920		

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2 920	Continued From page 32 On 12/3/14, at 7:18 a.m. observed occupational therapist (OT)-E making bed, R14 was seated on the toilet. -At 7:32 a.m. observed OT-E coming out of room with bag of soiled contents, R14 was seated on wheelchair, door was slightly open. -At 7:34 a.m. OT-E went back to room. Observed R14 sitting on wheelchair by sink, door was slightly open; OT-E shut the door. -At 7:38 a.m. observed R14 leaving her room with Occupational Therapist (OT)-E wheeling her went through the dining room and took elevator to lower level where the therapy room was located. -At 7:40 a.m. to 8:09 a.m. observed R14 in therapy room doing upper arm exercises on table. R14 stayed in therapy room, facial hairs were visible then came back to dining room. -At 8:12 a.m. observed R14 in dining room at table with three other ladies eating breakfast. -At 8:51 a.m. R14 still in dining room had completed eating. Facial hair was visible and no staff in the dining room offered to remove it. -At 9:08:08 a.m. NA-E was observed wheeling R14 from breakfast table to her room. -At 9:09 a.m. NA-E left room briefly after assisting R14, and put television (TV) on. R14 still seated in her wheelchair overheard NA-E saying she will be back never offered to remove the facial hairs. -At 9:12 a.m. R14 was observed seated in wheelchair watching TV with door to room wide open. -At 9:12 a.m. NA-E came back to room observed holding blanket and overheard telling R14 she had brought a warm towel. NA-E assisted R14 to get wrapped with blanket around R14 upper body and left room briefly never offered to remove the facial hairs. -At 9:17 a.m. both NA-C and physical therapist (PT)-G entered room. NA-C left and shut the	2 920		

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2 920	Continued From page 33 door. -At 9:19 a.m. PT-G left room stated she was getting an oximeter and would be back. PT-G came back and said she would test the oxygen level, and then stated it was ninety four (94) percent (%). PT-G got R14 to push up from chair and push seat up. R14 was resting her arms on walker and was walking in room. PT-G was standby assist as R14 walked in room to sit in chair by window. R14 was able to sit in chair without assistance. R14 was still observed with multiple white facial hairs above lip and on chin were not acknowledged, and no assistance was offered to remove it. R14's diagnoses included muscle weakness (generalized), rheumatoid arthritis, pressure ulcer, and chronic pain obtained from the admission MDS dated 11/3/14. In addition, the MDS indicated R14 did not reject cares and required extensive assist of one to two staff with dressing, toilet use and personal hygiene. R14's ADLs functional status/rehabilitation potential Care Area Assessment (CAA) dated 11/4/14, identified that R14 had severe impairment with cognition and required physical assist with ADLs which included dressing, grooming and toileting. ADL function care plan dated 11/14/14, identified R14 had alteration for self-performance of bathing, dressing, grooming related to diagnoses of arthritis, impaired functional mobility, short term memory loss, and weakness. The care plan directed R14 required assistance of one, staff to wash lower and upper body, dress lower and upper body but did not address R14's grooming needs which included facial hair removal. On 12/3/14, at 8:07 a.m. OT-E stated the aides	2 920		

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2 920	Continued From page 34 help R14 to get out of bed, to the toilet and cued her to do as much as she could as she was improving. When asked what grooming needs R14 required OT-E stated R14 brushed her own teeth, did get help with pericare and brushed hair herself. When asked what she had assisted R14 during morning cares as observed OT-E indicated she had assisted her with pericare. On 12/3/14, at 2:09 p.m. NA-C stated OT-E had gotten R14 dressed that morning and NA-C had gone back to the room to makes sure R14 had brushed teeth and NA-C would assisted her with toileting. When asked what she reports to nurse NA-C stated abnormal vitals, reported if resident was in pain, whatever is unusual, breathing problems, if she saw something happen that should not would report, skin check/changes and redness among others. On 12/3/14, at 2:38 p.m. LPN-B verified R14 had multiple facial hairs. When asked who was responsible to ensure residents were properly groomed LPN-B stated "the nursing assistants are." On 12/3/14, at 3:02 p.m. when asked about facial hairs RN-C indicated "the nursing assistant and the nurse should be looking out for residents' grooming to make sure they were properly groomed." On 12/4/14, at 2:24 p.m. the DON stated "Women should be asked to be shaved, same as men" when asked her expectation of staff with assisting female residents with facial hair removal. Augustana Chapel View Health Care Center Policy Subject Care Plans dated 1/14, directed	2 920		

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2 920	Continued From page 35 "Provide a written guide for intervention, assisting the resident to meet their needs for ADLs, health care, and psychosocial needs, to provide for individualization (choice/preferences) of the resident's plan of care." SUGGESTED METHOD FOR CORRECTION: The DON could insure that staff are re-inserviced as to their responsibility to provide dependent residents with assistance with facial and peri area grooming according to facility policy. The DON could conduct audits to ensure the care is being provided as indicated and take action as needed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN 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. Findings include: The undated Resident Admission Record indicated R226 was admitted to the facility on 11/18/14, with diagnoses including dementia,	21375		

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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
21375	Continued From page 36 Alzheimer's disease, and congestive heart failure. The care plan dated 11/18/14, indicated resident was on hospice care. The physician order dated 11/24/14, indicated "Wound care: back-clean wound with normal saline 4x4. Cover with 4x4 Mepilex border or other composite dressing. Once a day Every other day. " The order to "Apply Medihoney gel to wound bed" was discontinued on 11/24/14. 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 without changing gloves or washing hands LPN-C proceeded and washed the wound using 4x4 gauze and Dermal wound cleanser spray. LPN removed the gloves at this time, without washing hands, put clean gloves on and applied Medihoney gel into the wound bed using 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 they needed to change gloves and wash hands between the clean and dirty parts of R226's pressure ulcer dressing change, and verified she "forgot" to remove the dirty gloves and wash hands after she removed the old dressing before she washed the wound. 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	21375		

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21375	Continued From page 37 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." Suggested Method of Correction: The DON or her designee could review policy and procedures regarding infection control program and pressure ulcer dressing changes. The DON or her designee could educate staff on policy and procedures regarding pressure ulcer and/or wound dressing changes. Time Period for Correction: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.	21426		

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21426	Continued From page 38 (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	21426		

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21426	Continued From page 39 been read after 72 hours is not valid- repeat test." The policy also included guidelines for "TST Documentation Requirements", which included "At time of reading: name and signature of the person reading the test date and time test read Exact number of mm of induration (if no induration, document '0' mm) Interpretation of reading" SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review policies regarding TB screening, educate staff and perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review 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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21530	Continued From page 40 upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: On 12/03/14, at 9:25 a.m. R35 was observed sitting in his wheelchair (w/c) near nurse's station coughing with his face color getting reddened, and R35 could not speak due to coughing. Licensed practical nurse (LPN)-C stated to R35, "I will get you a nebulizer treatment" and proceeded to assist R35. LPN-C also stated, "I check his [R35's] lungs every shift." R35's 14 day Minimum Data Set (MDS) dated 11/13/14, indicated R35 was cognitively intact and modified independence with some difficulty in new situations only regarding making decisions regarding tasks of daily life. R35's undated Admission Record indicated R35's diagnoses	21530		

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21530	Continued From page 41 included: adult failure to thrive, pneumonitis, chronic airway obstruction, shortness of breath. Physician order report dated 12/4/14, indicated R35 also had a diagnosis of reactive airways. R35's care area assessment (CAA) dated 11/14/14, for R35 triggered for activities of daily living (ADLs) Functional Status/Rehabilitation Potential. Analysis of Finding included: "Patient [R35] recently admitted following recently placed peg tube due to severe dysphagia, Aspiration Pneumonia. Currently receives extensive assistance with all ADLs and mobility. Non-ambulatory at this time. Total incontinence of bowel and bladder. At risk for decline due to above listed risk factors and the following: new environment, episodes of SOB, occasional pain. Uses Bi-pap at NOC." The CAA dated 11/14/14, for R35 triggered for Dehydration/Fluid Maintenance indicated "Infection is indicated: Pneumonia." During an interview on 12/04/14, at 2:11 p.m. RN-E stated, "I would give R35 his PRN (as needed) inhaler or PRN nebulizer treatment when R35 was wheezing, short of breath (SOB) or if his oxygen sat [saturation] gets low, 89-90%." RN-D also stated, "Since R35 has a diagnosis of COPD (chronic obstructive pulmonary disease) we can give the PRN inhaler or PRN nebulizer treatment." RN-E verified R35's physician orders did not indicate whether to give the PRN inhaler or PRN nebulizer treatment when R35 was having SOB or other respiratory concerns. --At 3:21 p.m. RN-I when asked stated, "I would give R35 a PRN nebulizer treatment when R35 has shortness of breath or if R35 requested one." RN-I also stated, "I have never given R35 a PRN inhaler, only a PRN nebulizer." --At 3:27 p.m. RN-R stated, "I float all over and I	21530		

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am on call. I would look when R35 last had his PRN inhaler or nebulizer treatment and if it was time I would start with the inhaler and give R35 his PRN inhaler. And if that was not effective and it was time I would give R35 his PRN nebulizer treatment. And if the PRN nebulizer treatment was not effective I would call the physician."

Physician orders for R35 included physician order dated 11/01/14, Ventolin HFA (albuterol sulfate) HFA aerosol inhaler; 90 mcg/actuation; amt: 2 puffs; inhalation Special Instructions: Non pharmacological Interventions: 1) Encourage deep breathing to relax; 2) Encourage incentive spirometer (if applicable) 3) Offer emotional support Every 3 Hours - PRN; and physician order dated 11/19/14, Ipratropium-albuterol solution for nebulization; 0.5 mg - 3 mg (2.5 mg base)/3 ml; amt: 3 mls; inhalation Special Instructions: Dx: reactive airways Once A Day PRN. R35's physician order dated 11/19/14, Acetylcysteine solution; 100 mg/ml (10%) Amount to administer: 10 ml; inhalation, miscellaneous Once A Day - PRN.

The Medication Administration History dated 11/01/14-11/30/14, indicated on 11/18/14, at 2:42 R35 was given a PRN Ventolin HFA (albuterol sulfate) HFA aerosol inhaler; 90 mcg/actuation 2 puffs inhalation for wheezing and the inhaler was effective. The November Medication Administration History also indicated R35 received a PRN Acetylcysteine sol 10 ml on 11/25/14, at 15:14 for congestion and wheeze and was effective. The November Medication Administration History also indicated R35 received a PRN Acetylcysteine sol 10 ml on 11/26/14, at 13:56 for congestion and was effective. The Medication Administration History dated 12/01/14-14/04/14, indicated R35 was

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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.

Progress notes by physician dated 12/01/14,

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21530	Continued From page 44 indicated "He [R35] has had recurrent episodes of aspiration pneumonia and was requiring more care. He [R35] has a productive cough with yellow sputum and occasionally coughs with eating. Denies any fever, chills or increased shortness of breath. Pt [R35] with dry nose and epistaxis noted every few days." Pharmacy progress note for R35 dated 11/6/14, by consulting pharmacist (CP) indicated "Medication regimen review completed. No irregularities noted." On 12/4/14, at 3:00 p.m. the facility's consulting pharmacist was called with a message left to contact the facility. A returned call was not received. The Pharmaceutical Administration Policy dated 8/14 indicated under "Administration Six Rights of Medication Administration--4. Right route and 5. Right time." Under "Administration of Medications, All medications will be given per physician's order." The facility's "Drug Regimen Review" review date 08/14, indicated 'Policy: All drug regimens will be reviewed per Survey and Certification Guidelines. Rationale: To ensure safe, accurate medication administration. Responsibility: Pharmacist, Nursing Staff." SUGGESTED METHOD OF CORRECTION: The administrator, DON and Consulting Pharmacist could review and revise policies and procedures for assuring medications had indications for use, parameters and proper monitoring of medication usage. Staff could be educated as necessary. The DON or designee could monitor medications on a regular basis to	21530		

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21530	Continued From page 45 ensure compliance with state and federal regulations. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, 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 and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a sleep medication had adequate monitoring for 1 of 5 residents (R118).	21535		

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21535	Continued From page 46 Findings include: R118 received trazodone for insomnia since admit 8/20/14, however the record lacked monitoring of sleep after it was identified the resident had difficulty sleeping. Review of the electronic medication administration record (EMAR) from admit on 8/20/14 through 12/3/14, indicated R118 had received Trazodone 50 mg every night since admit and had not received as needed (PRN) Trazodone. Review of the Physician Orders dated 10/25/14, indicated R118 was to receive Trazodone (an antidepressant used for insomnia) 50 milligrams (mg) at bedtime, and 50 mg at bedtime - PRN for insomnia. Review of R118's care plan, dated 9/19/14, indicated "Resident expresses feeling tired and having little energy R/T [due to] insomnia." Approaches included to document mood/behavior alterations every shift, administer medications for insomnia and to provide comfortable environment to promote sleep. 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. R118 had diagnoses including insomnia and dementia obtained from the resident admission record dated 8/20/14. Review of the quarterly Minimum Data Set (MDS) dated 12/4/14, identified that the resident was cognitively intact	21535		

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21535	Continued From page 47 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." - At 12:30 p.m. the licensed social worker (LSW) stated that 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 was in the MDS. 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. Review of the facility policy and procedure titled Psychotropic Medication Monitoring for Appropriateness and for Side Effects with review date of 8/14, indicated that each resident's drug regimen must be free of unnecessary drugs, that an unnecessary drug is any drug used "without adequate monitoring" and that for hypnotic medications "a sleep log worksheet will be initiated and patterns of sleep will be monitored for a minimum of three days and up to week for a baseline and will be summarized by the licensed staff in the progress note and Care Plan developed accordingly."	21535		

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21535	Continued From page 48 Suggested Method of Correction: The DON or desigee could work with the medical director and consultant pharmacist to ensure medications were reviewed for unnecessary medications and that all medications have parameters and indications for use. The DON or designee could also perform audits of resident records to determine if all medications had parameters and indications for use. Time Period for Correction: Thirty (30) days.	21535		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.	21540		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 49 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility did not ensure the consulting pharmacist identified that sleep monitoring was not being completed for 1 of 5 residents (R118). Findings include: R118 had diagnoses including insomnia and dementia obtained from the Resident Admission Record dated 8/20/14. R118 received Trazodone for insomnia since admit 8/20/14, however the record lacked monitoring of sleep after it was identified the resident had difficulty sleeping. Review of the electronic medication administration record (EMAR) from admit on 8/20/14 through 12/3/14, indicated R118 had received Trazodone 50 mg every night since admit and had not received PRN trazodone. Review of the consulting pharmacist (CP) reports dated 9/12/14 and 10/17/14, identified no irregularities. The pharmacist Report dated 11/20/14, noted "per the care plan and target behavior sheets the only thing being tracked is insomnia", and recommended updating care plan and target behaviors for the medication Zyprexa. Although the CP noted on 11/20/14, that "per the care plan and target behavior sheets the only thing being tracked is insomnia", the CP did not identify that the monitoring was not being completed by nursing personnel. Review of R118's care plan, dated 9/19/14, indicated, "Resident expresses feeling tired and having little energy R/T [related to] insomnia." Approaches included to document mood/ behavior alterations every shift, administer	21540		

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	00727	A. BUILDING: _____ B. WING _____	12/04/2014

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21540	Continued From page 50 medications for insomnia and to provide comfortable environment to promote sleep. 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	21540		

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21540	Continued From page 51 have expected the night shift would document hours of sleep so that effectiveness and need could be evaluated. On 12/4/14, at 3:00 p.m. the facility's CP was called with a message left to contact the facility. A returned call was not received. Review of the facility policy and procedure titled Psychotropic Medication Monitoring for Appropriateness and for Side Effects with review date of 8/14, indicated that each resident's drug regimen must be free of unnecessary drugs, that an unnecessary drug is any drug used "without adequate monitoring" and that for hypnotic medications "a sleep log worksheet will be initiated and patterns of sleep will be monitored for a minimum of three days and up to week for a baseline and will be summarized by the licensed staff in the progress note and Care Plan developed accordingly." Suggested Method of Correction: The DON or desigee could work with the medical director and consultant pharmacist to ensure medications were reviewed for unnecessary medications, appropriate interventions and monitoring was in place, and then could educate staff on appropriate documentation of sleep monitoring, behaviors and interventions. The DON or designee could also perform audits of resident records to determine if adequate monitoring and documentation was in place. Time Period for Correction: Thirty (30) days.	21540		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage	21610		

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21610	Continued From page 52 Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 7 medication carts were free of expired medications, wound dressings and oral medications for R86 and R75. In addition, the facility failed to ensure 1 of 7 medication carts was kept clean. This had the potential to affect 50 of 177 residents. Findings include Lower Level Unit On 12/3/14, at 1:30 p.m. medication cart was reviewed with licensed practical nurse (LPN)-D and the following medications were noted to be stored in the cart: · R86's tube of Bengay (pain relieving cream) with an expiration date 9/2014 · R75's Clotrimazole Cream 1% antifungal medication commonly used in the treatment of fungal infections) with expiration date 11/14/14 · House supply Mineral oil opened 8/1/13, and expiration date 9/14. At 1:37 p.m. LPN-D acknowledged expired medications were not supposed to be stored in medication cart. LPN-D further stated medications were used as needed and had been overlooked. On 12/3/14, at 1:42 p.m. the medication cart was reviewed with registered nurse (RN)-D. During the tour the bottom and back of the second	21610		

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21610	Continued From page 53 drawer was observed to have a thick white colored powder, debris of paper, foil pieces built-up in the corners of the drawer and approximately nine loose pills some of which were divided/split. In addition, an open one hundred quantity house supply bottle of Aspirin 325 milligrams (mg) opened date 9/15/14, with expiration date 11/14, was observed stored on the same drawer. At 1:50 p.m. RN-D acknowledged the medication cart was not kept clean; when asked who was responsible of cleaning the medication carts RN-D stated all the nurses were responsible and RN-D verified the Aspirin was expired and indicated she would remove it from the cart. TCU (Transitional Care Unit) On 12/4/14, at 10:08 a.m. the medication cart reviewed was completed with LPN-C. During the review a box Silver antimicrobial alginate dressing, Algicell Ag (antimicrobial wound dressing) with expiration date 4/2014, was observed stored on the bottom drawer of the cart. When asked who was responsible of cleaning and ensuring expired medications and supplies were not stored in the cart LPN-C stated the night shift was responsible. On 12/4/14, at 12:37 p.m. RN-C unit manager when asked about date for silver antimicrobial alginate dressing, stated it should not be in the medication cart and should have been tossed out. On 12/4/14, at 2:20 p.m. the director of nursing stated expired medications and dressings should not have been stored in medication carts. When asked about medication cart cleanliness DON stated "they should be clean and everyone is responsible to keep medication carts clean."	21610		

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21610	Continued From page 54 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.	21610		