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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: NVE8

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) 01/03/2014
6. DATE OF SURVEY (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:
X 1. Acceptable POC
And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room
B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: 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):
See Attached Remarks

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

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

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/28/2014
CO. NVE8

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/15/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5493

The facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on 11/21/13. On 01/03/14, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on 01/03/14 the Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on 11/21/13, effective 12/31/13. Refer to the CMS-2567B for both health and life safety code.

Effective 12/31/13, the facility is certified for 118 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5493

March 18, 2014

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

Dear Ms. Roy:

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

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

Effective December 31, 2014, the above facility is certified for:

118 - Skilled Nursing Facility/Nursing Facility Beds

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

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

Sincerely,

Anne Kleppe

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 22, 2014

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

RE: Project Number S5493024

Dear Ms. Roy:

On December 4, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 21, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 3, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 3, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 21, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 31, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 21, 2013, effective December 31, 2013 and therefore remedies outlined in our letter to you dated December 4, 2013, will not be imposed.

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

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Telephone: 651-201-3792 Fax: 651-201-3790

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245493	A. Building B. Wing	1/3/2014

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 F0155 Reg. # 483.10(b)(4) LSC	Correction Completed 12/31/2013	ID Prefix F0176 Reg. # 483.10(n) LSC	Correction Completed 12/31/2013	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 12/31/2013
ID Prefix F0311 Reg. # 483.25(a)(2) LSC	Correction Completed 12/31/2013	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 12/31/2013	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 12/31/2013
ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 12/31/2013	ID Prefix F0428 Reg. # 483.60(c) LSC	Correction Completed 12/31/2013	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 12/31/2013
ID Prefix F0456 Reg. # 483.70(c)(2) LSC	Correction Completed 12/31/2013	ID Prefix F0463 Reg. # 483.70(f) LSC	Correction Completed 12/31/2013	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	16022	1-22-14	18423	1-3-14
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 11/21/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

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 01 - MAIN BUILDING 01	1/3/2014

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0067	12/31/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	IW022	1-22-14	28120	1-3-14
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
11/19/2013		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NVE8

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 **11/21/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
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:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Angela Richey, HFE NE II 12/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/14/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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

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

CCN-245493

At the time of the standard survey completed November 21, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7685

December 4, 2013

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

RE: Project Number S5493024

Dear Ms. Roy:

On November 21, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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 December 31, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 31, 2013 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 21, 2014 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	11/21/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED DEC 16 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced	F 155	12-19-13	

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

MgC. 16 — Administrator — 12/13/13

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

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	245493	A. BUILDING _____ B. WING _____	11/21/2013

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F 155	Continued From page 1 by: Based on interview and document review, the facility failed to obtain a code status/Advanced Directives (AD) from the physician and/or nurse practitioner for 1 of 3 residents (R178) who expired. Findings include: R178 was admitted to the facility on 7/18/13, and expired on 7/24/13. R178 did not have a physician's order after being admitted to the facility with code status/AD. R178 was admitted to the facility for cardiac rehabilitation following a hospital stay from 7/14/18 through 7/18/13. R178 had the following health issues addressed during her hospital stay: chronic diastolic heart failure, bronchiectasis (chronic dilatation of the bronchial tubes), accelerated essential hypertension, renal failure, and dementia. The hospitalist (physician who treated R178 while in the hospital) indicated at the time of discharge, R178's code status/AD was Do Not Resuscitate (DNR)/Do Not Intubate (DNI). R178's medical record had the Provider Orders for Life Sustaining Treatment (POLST) in the record but had not been completely filled out. The box for DNR/DO NOT ATTEMPT RESUSCITATION (Allow Natural Death) had been checked but there was no date and no signatures. The temporary care plan dated 7/18/13, did not indicate CODE STATUS but referred to the POLST. The Admission Preference Survey did not have a question about R178's advanced directives.	F 155	F155 R178 was admitted on evening of 7/18/2013. Transfers orders received at time of admission were not signed. Signature was obtained the following day inclusive of code status of DNR/DNI. This order was followed as written. Facility did initiate POLST form inclusive of code status but did not complete entire form due to short stay. To prevent recurrence, policy will be amended to designate reference to code status order received upon admission until a POLST can be fully completed. Education provided to Nursing and Social Service staff. Each admission chart will be audited for 3 months to ensure ongoing compliance. DON/Health Information responsible.	12/31/13

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F 155	Continued From page 2 The Physician Discharge Orders from the hospital dated 7/18/13, indicated the resident's code status was DNR. The Physician's Order received from the hospital on the date of discharge 7/18/13, did not have a physician's signature. The medical record lacked documentation that R178's physician and /or nurse practitioner (NP) had been contacted for follow-up of code status. The medical record lacked documentation that the physician and/or NP had visited R178 during her stay at the facility. The Face Sheet dated 7/18/13, in the medical record on admission indicated the AD was unknown. A Nursing Progress note written on 7/18/13, indicated that R178 was confused and resistive to some cares. The resident could not articulate preferences on certain issues to include code status. The family was called for a verbal consent. R178's husband informed the nurse he had documentation about R178's code status of DNR, and would bring same to the facility tomorrow. The nurse requested verbal consent for code, but they did not call back, having promised to do so. "Family will be back, to complete other admission paper work." The medical record did not have paper work to indicate code status at time of survey, 11/20/13 (four months after the resident had expired). The progress note lacked documentation that the facility attempted to follow up with the resident's family physician on R178's code status. All progress notes from admission to discharge (7/18/13 through 7/25/13) were reviewed. On 7/24/13, at 2120 (9:20 p.m.) a voice message was left for the NP that at 2045 (8:45 p.m.) the resident had no pulse. The medical record lacked	F 155		

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F 155	Continued From page 3 any documentation of any visit by the physician or the NP during R178's six day stay at the facility. The medical record lacked documentation that the facility staff verified code status with the resident's physician and /or NP after the resident had been admitted to the facility. Licensed social worker (LSW)-A and registered nurse (RN)-E were interviewed on 11/19/13, at 11:30 a.m. and confirmed that R178's spouse had taken paper work with him related to the DNR status and was going to return the papers the next day because he did not have his glasses with him. The paper work regarding DNR status was never received by the facility. R178's family hoped that the resident would be able to go home but indications were the resident would be long term care. Staff received verbal consent from R178's husband for DNR status. The NP signed the discharge summary 6/7/13 (date of death was 7/24/13) and referred cause of death back to the hospitalist. LSW-A said she had spoken to the NP and the NP indicated that she had not seen R178 and therefore did not know the cause of death. LSW-A was interviewed again on 11/20/13, at 2:00 p.m. and was working on getting additional information on R178's code status. The policy on Palliative Care Program/AD was received. R178's family member was interviewed by telephone on 11/21/13, at approximately 10:00 a.m. and confirmed that staff had asked the family on admission their mother's wishes for an AD and stated that they had wanted DNR for code status. The family member went on to say that it was odd that the staff would ask them twice about their mother's advance directives.	F 155		

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F 155	Continued From page 4 LSW-A was interviewed on 11/21/13, a 11:30 a.m. and confirmed that the POLST had not been filled out, the face sheet had the advance directives as unknown on admission, the physician and or/NP had not seen the resident during her stay in the facility, the staff did not follow-up with the physician or NP to confirm an order for the resident's AD of DNR. The Palliative Care Program/AD which was effective and reviewed on 1/13. The policy indicated that "Upon admission all residents and/or their legal representative will be asked to declare their wishes for end of life care. These wishes will be recorded on the POLST form."	F 155		
F 176 SS=E	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine whether the practice of self-administration of nebulizer medication was safe for 4 of 4 residents (R94, R116, R147, R19) observed self-administering medications. Findings include: R94 was observed on 11/20/13, at 7:35 a.m. in her room with the door closed self-administering a nebulizer (an inhalation respiratory medication).	F 176		

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F 176	Continued From page 5 Licensed practical nurse (LPN)-E was observed in the hallway by the dining room. The Resident Choices Self-Administration of Medications form dated 8/27/12, indicated R94 did not want to exercise the right to self-administer medications. The form indicated if R94 requested to self-administer medications, a Self-Administration of Med Assessment Questionnaire would be completed. The Self-Med Administration (SAM) care plan dated 12/3/12, revealed R94 required all medications to be administered by nursing staff and R94 was not appropriate to self-administer medications related to dementia, hearing/vision alterations and seizure disorder. R94's quarterly Minimum Data Set (MDS) dated 9/23/13, included diagnoses of dementia, seizure disorder and stroke. The MDS indicated R94 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The Physician Orders for R94 dated 11/20/13, did not include an order to self-administer medications. A Progress Notes dated 11/20/13, at 11:14 a.m. indicated an order was obtained that morning for a modified self-administration of medication for R 94's nebulizers. R116's nebulizer was observed on 11/20/13, at 7:28 a.m. LPN-E was observed starting a nebulizer for R116 in her room. LPN-E then left R116 alone in her room while the nebulizer was running.	F 176	F176 Self Administration of Medication assessments were complete and orders obtained for residents identified: R94, R116, R147, R19. All other residents with nebulizers who self administer after set up have been assessed and orders obtained. To prevent recurrence, an intervention has been attached to the nebulizer overlay to prompt nurses to assess for ability to self administer after set up and to obtain MD/NP order. Education provided to Nursing staff. Random audits of 5 new nebulizer orders per month will be done for 3 months to ensure ongoing compliance. DON/Clinical Managers responsible.	12-31-13

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F 176	Continued From page 6 The Resident Choices Self-Administration of Medications form dated 7/26/11, indicated R116 did not want to exercise the right to self-administer medications. The form indicated if R116 requested to self-administer medications, a Self-Administration of Med Assessment Questionnaire would be completed. The Self-Med Administration care plan dated 5/7/13, revealed R116 required all medications to be administered by nursing staff and R116 was not appropriate to self-administer medications related to dementia with memory impairment as well as impaired decision making ability. R116's quarterly MDS dated 8/16/13, included diagnoses of dementia, anxiety disorder, depression and chronic obstruction pulmonary disease (COPD). The MDS included a Staff Assessment of Mental Status, which indicated R116 had moderately impaired cognitive skills for daily decision making. The Physician Orders for R116 dated 11/20/13, did not include an order to self-administer medications. A Progress Notes dated 11/20/13, at 11:14 a.m. indicated an order was obtained that morning for a modified self-administration of medication for R116's nebulizers. When interviewed on 11/21/13, at 10:40 a.m. LPN-A stated she did not have a Self-Administration of Med Assessment Questionnaire for either R94 or R116 and they would be completed today.	F 176		

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F 176	Continued From page 7 R147's nebulizer was observed on 11/21/13, at 9:19 a.m. R147 was observed alone in her room administering a nebulizer treatment. The LPN was not observed on the wing by R147's room. The Self-Med Administration care plan dated 1/24/12, indicated R147 did not desire to self-administer medications and noted a diagnosis of senility with psychosis. The Resident Choices Self-Administration of Medications form dated 1/29/13, indicated R147 wanted to exercise the right to self-administer nebulizer treatments only. The form indicated if R147 requested to self-administer medications, a Self-Administration of Med Assessment Questionnaire would be completed. R147's quarterly MDS dated 8/14/13, included a diagnosis of COPD. The MDS included a BIMS score of nine, which indicated moderately impaired cognitive status. The Physician Orders dated 9/30/13, did not include an order for R147 to self-administer medications. On 11/21/13, at 9:25 a.m. registered nurse (RN)-E was asked for the Self-Administration of Med Assessment Questionnaire for R147. At 10:00 a.m. RN-E reported R147 did not have the questionnaire completed and he would have the nurse on duty complete one. The director of nursing (DON) was interviewed on 11/21/13, at 12:46 p.m. and stated all residents are asked upon admit if they wish to self -administer medications. If a resident says yes,	F 176		

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F 176	Continued From page 8 then a questionnaire would be completed, a physician's order would be obtained and the care plan would be updated. The DON stated she expected that process to be completed for all residents. R19's medication was observed to be setup on 11/18/13, at 7:23 p.m. by RN-D. RN-D was observed knocking on R19's door and entered room administered the oral medications, set up the nebulizer treatment and left the room. -At 7:24 p.m. R19 was observed starting the nebulizer treatment then turned it off and shortly after turned its back on again while the nurse was two rooms down the hallway. -At 7:25 p.m. R19 continued to self-administer the nebulizer treatment in her room door wide open nurse observed to be standing by the medication cart surveyor inquired from RN-D if resident had an order to self-administer medication RN-A stated R19 did have orders but after looking at the physician order there was no notation may self-administer nebulizer after set up. -At 7:34 p.m. RN-D went over to the nursing station and was looking in R19's chart with two other nurses at the desk at the time neither of the nurses were able to find an order to self-administer medication after set up for R19. RN-D verified R19 did not have an order to self-administer the nebulizer after set up. The Resident Choices Self-Administration of Medications sheet dated 9/2/11, indicated with a check mark R19 had waived to self-administer medication with notation "NO, I do not want to exercise my right to self-administer medications." The Self-Med Administration/Medication care plan	F 176		

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F 176	Continued From page 9 dated 3/25/13, directed "All medications administered by nursing staff. Not appropriate to SAM medications D/T Cognitive impairment, Hearing/Vision impairments, Rheumatoid Arthritis, Requires assist with decision making."and "Modified SAM, for as needed (Prn) Nebs Only.*V." The quarterly MDS dated 7/19/13, indicated R19's diagnoses included chronic airway obstruction, congestive heart failure (CHF), rheumatoid arthritis and edema. In addition R19's BIMS was 12 out of the possible 15. R19's Physician Orders dated 10/21/13, directed Duoneb (a respiratory medication) twice daily The Physician's Orders did not identify R19 could self-administer nebulizer medication. During further document review it was revealed R19's Medication Administration Record for 7/1/13, through 11/18/13, that R19 had notation to self-administer nebulizer after set-up by the nurse. On 11/21/13, at 1:45 p.m. DON stated each resident was assessed for ability to self-administer medications and for R19 she had a previous order to self-administer medications but was not sure why the order had not transferred over to the current order. "It is our error." The DON further stated an order had been obtained 11/19/13, for R19 to self-administer nebulizer only. The Pharmaceutical Administration policy reviewed 11/13, directed "Each resident has a right to self-administer drugs as determined by the interdisciplinary Team as safe practice. The	F 176		

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F 176	Continued From page 10 physician and the licensed nurse using an assessment of physical, visual and cognitive ability make this determination during the assessment period. Reassessment of the self-administration process will be made quarterly if resident has chosen to self-administer medications."	F 176		
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 review, the facility did not ensure care plan interventions were followed for 1 of 1 resident (R231) reviewed for accidents and 1 of 3 residents (R159) reviewed for grooming. Findings include: The Occupational Therapist (OTR) assisted R231 back to bed without putting the bed in the lowest position and without ensuring the floor mat was in place and R231 sustained a fall from bed on 11/19/13, at 9:25 a.m. The care plan was not followed. When interviewed on 11/19/13, at 10:12 a.m. the registered nurse (RN)-A was asked if R231 had a fall in the last thirty days. RN-A replied yes that R231 had fallen that morning at 9:35 a.m. RN-A said that R231 was put back to bed by the OTR	F 282		

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F 282	Continued From page 11 without implementing care plan interventions and without letting the RN know. R231 had no visible signs of injury. The nurse was assessing the resident for injury. Observation on 11/19/13, at 4:05 p.m. revealed that the physical therapist was at R231's room for a therapy session. Interview attempt revealed R231 had severe aphasia, (a communication disorder) but could respond with a nod of yes or no. When asked if she fell out of bed that morning, R231 nodded yes, when asked if she was injured she responded by nodding no. Observation on 11/20/13, at 7:15 a.m. revealed that R231 was in bed lying on her side, two pillows under head, the bed was in the lowest position (12 inches from the floor mat). A blue floor matt was on the floor. A progress note dated 11/19/13, at 3:51 p.m. specified that R231 had fallen out of bed, was found on the floor lying on left side of body, next to bed. R231 was assisted to bed five minutes prior by the OTR, the bed was not lowered all the way to the floor, and the blue mat was not placed next to the bed as well. The facility incident report dated 11/19/13, indicated that the fall may have been preventable if all fall interventions were in place at the time of the incident. Document review revealed that R231 had suffered from a previous stroke resulting in right sided hemiplegia (partial paralysis), and aphasia. R231 was in the transitional care unit of the facility and was receiving ongoing physical, speech and occupational therapies. The Physician's Orders dated 10/27/13, included	F 282	F282 Fall interventions continue for R231. OTR involved in the fall was coached on the importance of determining what interventions are required for each patient and where to find the information. To prevent recurrence, fall interventions are now included on all Therapy Progress Notes to ensure all therapy staff have access to this information. The information is updated weekly during Rehab Rounds. Fall interventions continue to be included in kardex/care plan/assignment sheet for Nursing Staff. Weekly audits of 5 residents/patients will be done for 3 months to ensure ongoing compliance. DON/Clinical Manager/Therapy Manager responsible.	12-31-13

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F 282	Continued From page 12 orders for a hi-low bed and floor mats to both sides of bed every shift continuous. The Minimum Data Set (MDS) Care Area Assessment (CAA) dated 11/8/13, listed R231 to be at a high risk for falls due to multiple risk factors. The current care plan dated 11/15/13, listed R231's high risk for falls with the goal to remain free from falls/injury during stay at the facility. The care plan listed multiple interventions including floor mat to both sides of bed and placing the hi-low bed in the lowest position. The care plan was not followed on the morning of 11/19/13. When interviewed on 11/21/13, at 10:24 a.m. the facility director of rehabilitation (DOR) explained that the OTR who placed R231 back to bed on 11/19/13, was a float therapist and that the float OTR had been immediately retrained. The DOR also explained that it was expected that an OTR check the three ring binder titled, TCU Care Card, at the nurses' station to see if there are any precautions when returning a resident from therapy. The DOR also said it was protocol for all OTR's to also check with the nurse before putting them back to bed. The DOR said that the OTR had not followed the protocol on 11/19/13. When asked for a copy of the protocol, the DOR said that there was no written protocol. When interviewed on 11/21/13, at 10:16 a.m. the assistant director of nursing (ADON) confirmed that care plan interventions had not been put into place by the OTR and that the supervisor was aware of the situation. The ADON was in the process of conducting an investigation into the accidental fall. When interviewed on 11/21/13, at 9:39 a.m. the	F 282		

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	245493	A. BUILDING _____ B. WING _____	11/21/2013

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F 282	Continued From page 13 facility director of nursing (DON) confirmed the fall and explained that the fall protocol was being implemented and an investigation of root cause analysis was being conducted to prevent future occurrences. The facility fall protocol titled, Fall and Injury Reduction Program, dated as revised on January 2013, indicated that residents who are assessed as having a risk for falls will have care plan interventions implemented to reduce those risks. R159 was not provided assistance with nail care and shaving per the plan of care. R159's nails were observed to be approximately half (1/2) inch long, soiled, uneven, and jagged edged on both hands and was unshaved on the evening of 11/18/13, and during subsequent days of the survey 11/19/13, and 11/20/13. On 11/18/13, at 2:13 p.m. during interview with R159 when asked about grooming, he verified he needed to be shaved and stated "I do them as the staff here don't help me but am not sure if am able to do it anymore." referring to nail care and shaving. R159 diagnoses included dementia without behavior disturbances, hemiplegia affecting unspecified side, congestive heart failure and chronic airway obstruction not elsewhere classified, obtained from the quarterly MDS dated 9/10/13. R159's quarterly MDS dated 9/10/13, identified R159 required limited to extensive physical assist of one staff with activities of daily living, (ADL's). The CAA for ADL Functional Status dated	F 282	R159 is being shaved daily as needed and as he tolerates and nail care is being provided weekly. NA involved received coaching and counseling on approaches to this issue. Other residents at risk have been identified and care plans and assignment sheets have been reviewed to ensure appropriate interventions in place. Education provided to Nursing Department staff. Audits of 5 residents will be done each week for 3 months to ensure ongoing compliance. DON/Clinical Manager responsible.	12-31-13

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F 282	Continued From page 14 4/17/13, identified R159 contributing/risk factors include: impaired functional mobility, incontinence, diagnosis of cerebrovascular accident with right sided hemiparesis, dementia, depression and hypertension. The CAA indicated R159 received limited assist of one with ADL's during the Assessment Reference Date (ARD). The Grooming care plan dated 8/16/13, identified R159 with an alteration in self performance of task due to right sided hemiparesis. Goal "Resident will be clean, neat and well groomed daily for the next 90 days." The undated nursing assistant Care Card directed "**Shave resident daily in AM" and additionally directed assist of one staff with ADL's. Evening Baths lower level sheet indicated R159 had a bath on Sunday and was assigned to group six nursing assistant. On 11/19/13, at 2:16 p.m. nursing assistant (NA)-A stated he was assigned to care for R159 and in the morning when he arrived he noted resident was already dressed but had the same clothes he had on the previous day. NA-A assisted R159 to change his clothes and had completed providing cares for R159 for the day but would be going back to room to check if R159 had to use the toilet and he further stated he had completed R159's charting for the shift. On 11/20/13, at 2:23 p.m. NA-A stated he had completed providing R159 with cares for the day but would go back later to check with R159. He further stated that usually when he comes in for his shift R159 is dressed for the day. In respect to the facial hair, NA-A stated R159 is resistive with cares and usually wants to do it himself. NA-A further state he had reported to the nurses in the past but had not offered R159 to remove his	F 282		

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F 282	Continued From page 15 facial hair and trim the nails during the shift and NA-A also stated that usually nail care is done on bath day but could be done as needed. On 11/20/13, at 2:25 p.m. the surveyor, NA-A and licensed practical nurse (LPN)-D approached R159 who agreed to let staff assist him with shaving and trimming his nails. LPN-C and NA-A assisted resident to put his legs to bed, shaved him and allowed the staff to trim his nails without being resistive after soaking his nails with a wet towel. On 11/20/13, at 2:27 p.m. LPN-D stated his expectation was to have all residents neat and well groomed at all times. On 11/21/13, RN-E stated because of "Resident's history of refusing cares staff are to offer to shave him daily as directed in the NA Care Card, if he refused, the NA is supposed to let the nurse know and if the nurse intervenes and was not successful then the nurse has to write a note in the nurses notes on the refusal and the attempts. For the nail care, "It is in the care plan with bath and in the NA Care Card for the NA's to follow and if a resident is diabetic the nurse would complete the nail care." On 11/21/13, at 1:45 p.m. the DON stated her expectation was to have all residents who needed assistance with facial hair be assisted daily to removed it and as needed. If a resident was refusing care then the nurse had to document on the nurses notes regarding resident refusal of care. In respect to nail care, the DON stated resident nails need to be kept clean and short and all nail care will be completed on a resident bath day and as needed during daily cares.	F 282		

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F 282	Continued From page 16 Review of Carepath Interventions- Assessment sheets for 7/1/13 through 11/17/13, indicated R159 had skin check/Bath once every week on Sunday and the licensed staff checked the skin which was marked intact in addition there was no notation regarding nail care being completed during the time period reviewed. During further document review of Progress notes dated 7/8/13 through 11/20/13, nurses documented R159 was co-operative with cares all times except once on 7/11/13. The facility policy titled, Shaving Residents: Removal of Facial Hair, review date 11/13, directed "Residents unable to shave per self will receive daily assistance to remove facial hair as needed." The facility policy titled, Nail Care, review date 11/13, directed: Fingernails will be trimmed and filed on a regular basis and whenever necessary. The nursing assistant will follow all principles of clean technique when providing care and will provide care based on the preferences of the patient. The policy further directed, Rationale: To maintain a clean, neat appearance of the nails, to support a patient's self esteem and morale; to prevent problems caused by dry skin, broken fingernails, long nails or hang nails.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.	F 311		

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F 311	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide grooming assistance for 1 of 3 residents, (R159) reviewed for activities of daily living (ADL'S). Finding include: R159 who was unable to independently complete nail care and remove facial hair was not provided assistance with nail care and shaving. R159's nails were observed to be approximately half (1/2) inch long, soiled, uneven, and jagged edged on both hands and was unshaved on evening of 11/18/13, and during subsequent days of the survey 11/19/13, and 11/20/13. On 11/18/13, at 2:13 p.m. during interview with R159 when asked about grooming, he verified he needed to be shaved and stated "I do them as the staff here don't help me but am not sure if am able to do it anymore." referring to nailcare and shaving. On 11/19/13, during random observations: At 2:08 p.m. R159 was observed lying in his bed with the door wide open, nails soiled, uneven and jagged edged and with facial hair. At 2:18 p.m. the nursing assistant (NA)-A was observed going to R159's room and then came out briefly. At 3:00 p.m. R159 was observed lying on the bed facing the door with his legs resting up on the wheelchair and still observed to have dirty, soiled, uneven nails and was unshaven. On 11/120/13, during continuous observations:	F 311	F311 As previously stated, R159 is being shaved daily as needed and as he tolerates and nail care is being provided weekly. NA involved received coaching and counseling on approaches to this issue. Other residents at risk have been identified and care plans and assignment sheets have been reviewed to ensure appropriate interventions in place. Education provided to Nursing Department staff. Audits of 5 residents will be done each week for 3 months to ensure ongoing compliance. DON/Clinical Manager responsible.	12-3-13

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F 311	Continued From page 18 At 7:12 a.m. R159 was observed sitting in his wheelchair in the dining room at the table waiting for breakfast. R159 was observed to be unshaven and still with long, uneven, soiled nails to both hands. From 7:17-7:43 a.m. no activity in the dining room and R159 and other residents were sitting in the dining room at this time waiting for breakfast. At 7:44 a.m. R159 was observed leaving the dining room and went back to his room and grabbed a newspaper and then propelled himself back to the dining room table. Observed reading the paper. From 7:45-8:30 a.m. observed NA-A set up his breakfast. NA-A never offered to remove the facial hair or trim the nails after breakfast. At 9:10 a.m. NA-B came stood at R159's table looked at R159's plate spoke with him briefly then walked away never offered to remove the facial hair and trim the nails. At 9:32 a.m. R159 observed taking his clothing protector off, wiped his mouth and then went to his room. At 9:35 a.m. observed R159 in his room, the door was wide open, lying on his back facing the door with feet resting on the wheelchair. NA-A went to room and was overheard asking R159 if he had to use the toilet. R159 stated "No". Then came out of room. On 11/20/13, during random observations: At 11:03 a.m. R159 was still in his bed lying on his left side unshaven and with dirty soiled nails. NA-A went to resident room and toileted R159 and then came out. At 12:15 p.m. NA-C was observed setting up R159's lunch, never offered to remove the facial hair or trim his nails. At 12:23-12:46 p.m. NA-A sat between R159 and	F 311		

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F 311	Continued From page 19 another resident in the dining table and was observed assisting the other resident with eating, never offered to remove the facial hair or trim the nails after the meal. R159 diagnoses included dementia without behavior disturbances, hemiplegia, congestive heart failure and chronic airway obstruction, obtained from the quarterly Minimum Data Set (MDS) dated 9/10/13. R159's quarterly MDS dated 9/10/13, identified R159 required limited to extensive physical assist of one staff with ADL's. The Care Area Assessment (CAA) for ADL Functional Status dated 4/17/13, identified R159 contributing/risk factors include: impaired functional mobility, incontinence, diagnosis of cerebrovascular accident with right sided hemiparesis, dementia, depression and hypertension. The CAA indicated R159 received limited assist of one with ADL's during the Assessment Reference Date (ARD). The Grooming care plan dated 8/16/13, identified R159 with an alteration in self performance of task due to right sided hemiparesis. Goal: Resident will be clean, neat and well groomed daily for the next 90 days. The undated nursing assistant Care Card directed **Shave resident daily in AM, additionally directed assist of one staff with ADL's. Evening Baths lower level sheet indicated R159 had a bath on Sunday and was assigned to group six nursing assistant. On 11/19/13, at 2:16 p.m. NA-A stated he was assigned to care for R159 and in the morning when he arrived he noted resident was already dressed but had the same clothes he had on the previous day. NA-A assisted R159 to change his	F 311		

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F 311	Continued From page 20 clothes and had completed providing cares for R159 for the day but would be going back to room to check if R159 had to use the toilet and he further stated he had completed R159's charting for the shift. On 11/20/13, at 2:23 p.m. NA-A stated he had completed providing R159 with cares for the day but would go back later to check with R159. Also stated that usually when he comes in for his shift R159 is dressed for the day. In respect to the facial hair NA-A stated R159 is resistive with cares and usually wants to do it himself. NA-A further state he had reported to the nurses in the past but had not offered R159 to remove his facial hair and trim the nails during the shift and NA-A also stated that usually nail care is done on bath day but could be done as needed. On 11/20/13, at 2:25 p.m. the surveyor, NA-A and licensed practical nurse (LPN)-D approached R159 who agreed to let staff assist him with shaving and trimming his nails. LPN-C and NA-A assisted resident to put his legs to bed, shaved him and allowed the staff to trim his nails without being resistive after soaking his nails with a wet towel. On 11/20/13, at 2:27 p.m. LPN-D stated his expectation was to have all residents neat and well groomed at all times. On 11/21/13, registered nurse (RN)-E stated because of the resident's history of refusing cares, staff are to offer to shave him daily as directed in the NA Care Card, if he refused the NA is supposed to let the nurse know and if the nurse intervenes and was not successful then the nurse has to write a note in the nurses notes on	F 311		

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F 311	Continued From page 21 the refusal and the attempts. For the nail care, it is in the care plan with bath and in the NA Care Card for the NA's to follow and if a resident is diabetic the nurse would complete the nail care. On 11/21/13, at 1:45 p.m. the director of nursing (DON) stated her expectation was to have all residents who needed assistance with facial hair be assisted daily to remove it and as needed. If a resident was refusing care then the nurse had to document on the nurses notes regarding resident refusal of care. In respect to nail care, the DON stated resident nails need to be kept clean and short and all nail care will be completed on a resident bath day and as needed during daily cares. Review of Carepath Interventions- Assessment sheets for 7/1/13 through 11/17/13, indicated R159 had skin check/Bath once every week on Sunday and the licensed staff checked the skin which was marked intact in addition there was no notation regarding nail care being completed during the time period reviewed. During further document review of Progress notes dated 7/8/13, through 11/20/13, nurses documented R159 was co-operative with cares all times except once on 7/11/13. The facility policy titled, Shaving Residents: Removal of Facial Hair, review date 11/13, directed, Residents unable to shave per self will receive daily assistance to remove facial hair as needed. The facility policy titled, Nail Care, review date 11/13, directed: Fingernails will be trimmed and filed on a regular basis and whenever necessary.	F 311		

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F 311	Continued From page 22 The nursing assistant will follow all principles of clean technique when providing care and will provide care based on the preferences of the patient. The policy further directed: Rationale: To maintain a clean, neat appearance of the nails, to support a patient's self esteem and morale; to prevent problems caused by dry skin, broken fingernails, long nails or hang nails.	F 311		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure implementation of interventions for prevention of accidents for one of one resident (R231) reviewed for falls. Findings include: The Occupational Therapist (OTR) assisted R231 back to bed with out putting the bed in the lowest position and without ensuring the floor mat was in place and R231 sustained a fall from bed on 11/19/13, at 9:25 a.m. When interviewed on 11/19/13, at 10:12 a.m. the registered nurse (RN)-A was asked if R231 had a fall in the last thirty days. RN-A replied yes that R231 had fallen that morning at 9:35 a.m. RN-A	F 323		

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F 323	Continued From page 23 said that R231 was put back to bed by the OTR without implementing care plan interventions and without letting the RN know. R231 had no visible signs of injury. The nurse was assessing the resident for injury. Observation on 11/19/13, at 4:05 p.m. revealed that the physical therapist was at R231's room for a therapy session. Interview attempt revealed R231 had severe aphasia (a communication disorder) but could respond with a nod of yes or no. When asked if she fell out of bed that morning, R231 nodded yes, when asked if she was injured she responded by nodding no. Observation on 11/20/13, at 7:15 a.m. revealed R231 was in bed lying on her side, two pillows under head, the bed was in the lowest position (12 inches from the floor mat). A blue floor matt was on the floor. A progress note dated 11/19/13, at 3:51 p.m. specified that R231 had fallen out of bed that morning, was found on the floor lying on left side of body, next to bed. R231 was assisted to bed five minutes prior by the OTR, the bed was not lowered all the way to the floor, and the blue mat was not placed next to the bed as well. The facility incident report dated 11/19/13, indicated that the fall may have been preventable if all fall interventions were in place at the time of the incident. Document review revealed that R231 had suffered from a previous stroke resulting in right sided hemiplegia (partial paralysis), and aphasia. R231 was in the transitional care unit of the facility and was receiving ongoing physical, speech and occupational therapies. The	F 323	F323 As previously stated, fall interventions continue for R231. OTR involved in the fall was coached on the importance of determining what interventions are required for each patient and where to find the information. To prevent recurrence, fall interventions are now included on all Therapy Progress Notes to ensure all therapy staff have access to this information. The information is updated weekly during Rehab Rounds. Fall interventions continue to be included in kardex/care plan/assignment sheet for Nursing Staff. Therapy and Nursing Department staff have been educated. Weekly audits of 5 residents/patients will be done for 3 months to ensure ongoing compliance. DON/Clinical Manager/Therapy Manager responsible.	12-31-13

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F 323	Continued From page 24 physicians orders dated 10/27/13, included orders for a hi-low bed and floor mats to both sides of bed every shift continuous. The minimum data set care area assessment dated 11/8/13, listed R231 to be at a high risk for falls due to multiple risk factors. The current care plan dated 11/15/13, listed R231's high risk for falls with the goal to remain free from falls/injury during stay at the facility. The care plan listed multiple interventions including floor mat to both sides of bed and placing the hi-low bed in the lowest position. When interviewed on 11/21/13, at 10:24 a.m. the facility director of rehabilitation (DOR) explained that the OTR who placed R231 back to bed on 11/19/13, was a float therapist and that the float OTR had been immediately retrained. The DOR also explained that it was expected that an OTR check the three ring binder titled, TCU Care Card, at the nurses station to see if there are any precautions when returning a resident from therapy. The DOR also said it was protocol for all OTR's to also check with the nurse before putting them back to bed. The DOR said that the OTR had not followed the protocol on 11/19/13. When asked for a copy of the protocol the DOR said that there was no written protocol. When interviewed on 11/21/13, at 10:16 a.m. the assistant director of nursing (ADON) confirmed that interventions had not been put into place by the OTR and that the supervisor was aware of the situation. The ADON was in the process of conducting an investigation into the accidental fall. When interviewed on 11/21/13, at 9:39 a.m. the facility director of nursing confirmed the fall and	F 323		

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F 323	Continued From page 25 explained that the fall protocol was being implemented and an investigation of root cause analysis was being conducted to prevent future occurrences. The facility fall protocol titled, Fall and Injury Reduction Program, dated as revised on January 2013, indicated that residents who are assessed as having a risk for falls will have interventions implemented to reduce those risks.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify adequate indications for use, adequately monitor psychoactive medications, and document a clinical rationale why a gradual dose reduction was not indicated for 1 of 5 residents (R36) reviewed for unnecessary medication use. Findings include: R36 received Wellbutrin and Seroquel for anxiety disorder, depression, and psychotic disorder per the November 2013 medication administration record. The medical record lacked evidence of any dose reduction, monitoring and indications for use. Review of the Progress Notes revealed: -1/30/13, noted a Patient Health Questionnaire (PHQ9) score of zero on 1/18/13, and when asked if she felt depressed, R36 responded "No, I don't think so" and that R36's favorite place was in bed. -3/1/13, noted no longer making statements of wanting to die and would no longer be monitored for that. Also noted a potential medication reduction would be discussed with consultant pharmacist/physician as one had not been done in a while. -4/12/13, noted a PHQ9 score of zero on 1/18/13 and 4/12/13, which indicated no signs or symptoms of depression. When R36 was asked if she felt depressed, R36 responded not really." -4/15/13, noted resting in bed provided comfort to her. -4/25/13, noted R36 no longer exhibited	F 329	F329 NP and Pharmacist have again reviewed medication regime for R36 on 12-6 and 12-10 respectively. Wellbutrin was decreased and no further recommendation to adjust Seroquel is indicated at this time. DISCUS was done 11/26. Indications for use and monitoring remain in place. DISCUS schedule has been reviewed and is up to date and current for residents receiving psychotropic medications. Education provided to IDT. To prevent recurrence, ongoing medication regime review inclusive of DISCUS will continue to be done by both pharmacist and IDT quarterly and as needed. DON/Clinical Manager/Pharmacist responsible.	12-3-13

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F 329	Continued From page 27	F 329		

aggressive/angry behavior and questioned hospice about position on reducing psychotropic medications. The hospice nurse reported R36 slept well at night and felt it was due to Seroquel at bedtime.

A Dyskinesia Identification System: Condensed User Scale (DISCUS) dated 2/8/13, (greater than six months prior to survey dates) was noted in the record with a score of two. A DISCUS within the prior six months was requested.

A Physician's Progress note dated 3/18/13, noted R36 denied feeling sad or down, just felt like she had lived a good long life and was ready to go when the time comes.

The mood care plan dated 4/12/13, included antipsychotic and antidepressant use and directed non-pharmacological interventions for staff to utilize. The care plan identified extrapyramidal reaction and postural hypotension as possible side effects of Seroquel. The care plan directed a DISCUS.

The Quarterly Psychoactive Medication Review dated 4/19/13, indicated R36 had been on Wellbutrin 100 milligrams (mg) twice a day since 8/17/09, and Seroquel 12.5 mg since 3/17/12.

A Hospice note dated 5/7/13, indicated a request was made to decrease Wellbutrin and noted R36 was "no longer in need of medication." The note further indicated there was no physician response to the recommendation faxed on 4/26/13.

A Physician's Progress note dated 5/10/13, noted R36's affect appeared stable and staff reported no concerns with mood or affect. The note did not

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F 329	Continued From page 28 include a clinical rationale why a gradual dose reduction was not indicated for Wellbutrin or Seroquel. A Physician's Progress note dated 7/20/13, noted R36 continued to have a slow decline secondary to advanced dementia. The mood Care Area Assessment (CAA) dated 7/9/13, did not include a summary of mood concerns. The psychotropic medication use CAA dated 7/12/13, indicated R36 had a dose reduction failure of Seroquel in 2009 with successful dose reductions on 9/8/11 and 3/16/12 with no dose reductions since that time. A review of the Monitoring Results log for blood pressure from 9/22/13 through 11/16/13, revealed no orthostatic blood pressure readings had been obtained. When interviewed on 11/21/13, at 10:35 a.m. licensed practical nurse (LPN)-E stated any orthostatic blood pressures would be documented on the Monitoring Results log and R36 was on hospice and did not have to have vitals taken. The quarterly Minimum Data Set (MDS) dated 9/27/13, for R36 included diagnoses of dementia, anxiety disorder, depression, psychotic disorder and adult failure to thrive. The MDS included a Brief Interview of Mental Status (BIMS) score of three, which indicated severe cognitive impairment. A PHQ9 was also completed with the MDS and revealed a score of zero, which indicated no depression. The MDS indicated R36 had no behaviors or delusions during the observation period. The Quarterly Psychoactive Medication Review dated 11/11/13, noted a behavior/mood problem	F 329		

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F 329	Continued From page 29 of irritable/angry and isolating self for Wellbutrin and Seroquel. The medical record lacked evidence that a gradual dose reduction of Seroquel was requested after 3/7/12, or a clinical rationale why a dose reduction would be contraindicated. The Physician Orders dated 11/18/13, revealed orders for Wellbutrin SR 100 mg twice a day and Seroquel 12.5 mg daily. Both medications were noted as being given for major depression with anxiety and psychotic features. The Mood and Behavioral Record for September through November 2013, were reviewed. The records indicated R36 was being monitored for easily irritable/angry, and sarcastic mood. The only documentation for 9/13, was on 9/12/13 and 9/13/13 and the mood/behavior was noted to have occurred x 1 on those days and the intervention used was effective. For October 2013, documentation occurred on 10/1, 10/2, 10/6, 10/21, 10/25, 10/29 and 10/30. On those days R36 was noted to have been irritable x 2 on 10/1 and 10/2. The documentation for November 2013, revealed the target mood/behavior did not occur on the days documented. On 11/21/13, at 11:02 a.m. LPN-A stated no DISCUS had been completed since 2/8/13, and it "must have gotten missed." LPN-A was interviewed on 11/20/13, at 2:43 p.m. and stated she had talked to Hospice about Seroquel for R36 and thought that was why Hospice requested a dose reduction of Wellbutrin. When interviewed on 11/21/13, at 9:03 a.m.	F 329		

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F 329	Continued From page 30 LPN-A stated the request to discontinue the Wellbutrin came from the hospice pharmacist and the physician declined to change the order. LPN-A was asked to provide documentation regarding the rationale from the physician. Upon interview on 11/21/13, at 10:25 a.m. LPN-A also stated the hospice nurse told her the physician never responded to the request and no one ever followed up. LPN-A stated she was unable to provide documentation regarding why the Wellbutrin was not discontinued. The Psychotropic Medication Monitoring policy dated 11/92 and reviewed 1/2013, directed any unnecessary drugs being utilized require dosage reductions and/or documentation justifying its usage outside of the regulatory guideline. The policy also directed orthostatic blood pressures to be checked monthly for antipsychotic medications. The policy also directed a DISCUS should be completed: however, it did not provide guidance on the frequency required.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		

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F 371	Continued From page 31 by: Based on observation, interview and document review, the facility failed to properly handle food in a sanitary manner. This had the potential to affect 14 of 14 residents who were served in the two north dining room of the 97 resident who reside in the facility. Findings include: During observation of the dinner meal on 11/18/13, at 5:13 p.m. a dietary aide (DA)-A was noted to prepare food service for the residents in the two north dining room. DA-A arrived in the dining room pushing a cart with hot foods on it and had gloves on his hands. DA-A placed the hot food items on the steam table and left the dining room with his gloves on. DA-A returned to the unit with a cart of cold foods and used his gloved hands to open the gate. DA-A again left the dining room with his gloves on and returned to the dining room with gloves on and touched the gate. DA-A began to serve the meal to the residents. With the same gloves, DA-A touched the slices of bread for all 14 residents in the dining room. When interviewed on 11/18/13, at 5:33 p.m. DA-A verified he had worn the same pair of gloves throughout the entire observation. Upon interview 11/21/13, at 12:54 p.m. the dietary manager (DM) stated staff are expected to change gloves when they get to a new dining room and are not to wear their gloves throughout the building. The DM stated staff was expected to change their gloves if they touch the gates, carts etc. Review of the facility policy titled, Use of Plastic Gloves, dated 12/08, directed anytime a contaminated surface is touched, the gloves must be changed.	F 371	F371 It is the practice of CV to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions. To prevent recurrence Dietary staff has been educated on the use of plastic gloves, and directed anytime a contaminated surface is touched, the gloves must be changed. This includes if they touch gates, carts and etc. Random weekly audits will be done by Dietary Director for three months to make sure of compliance by 12/31/13. Dietary Director responsible.	

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F 428 F 428 SS=D	Continued From page 32 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's pharmacy consultant failed to report medication irregularities to the facility, or the physician for 1 of 5 residents (R36) reviewed for unnecessary medications. Findings include: The consultant pharmacist did not identify adequate monitoring for Seroquel (an anti-psychotic) was missing, a gradual dose reduction had not been attempted for Seroquel, and documentation of rationale for continuing Seroquel and Wellbutrin (an antidepressant) was lacking. A review of the progress notes from 11/26/12 through 10/9/13, revealed the consultant pharmacist had reviewed R36's medications monthly and reported no irregularities to the facility or physician. Review of the Progress Notes dated 1/30/13, going forward revealed:	F 428 F 428	F428 As previously stated, NP and Pharmacist have again reviewed medication regime for R36 on 12-6 and 12-10 respectively. Wellbutrin was decreased and no further recommendation to adjust Seroquel is indicated at this time. DISCUS was done 11/26. Indications for use and monitoring remain in place. DISCUS schedule has been reviewed and is up to date and current for residents receiving psychotropic medications. Education provided to IDT. To prevent recurrence, ongoing medication regime review inclusive of DISCUS will continue to be done by both pharmacist and IDT quarterly and as needed. Audits will be done at care conference weekly for 3 months to ensure ongoing compliance. DON/Clinical Manager/Pharmacist responsible.	12-31-13

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F 428	Continued From page 33 -1/30/13, noted a Patient Health Questionnaire (PHQ9) score of zero (which indicated no signs or symptoms of depression)on 1/18/13 and when asked if she felt depressed, R36 responded "No, I don't think so" and that R36's favorite place was in bed. - 3/1/13, noted no longer making statements of wanting to die and would no longer be monitored for that. Also noted a potential medication reduction would be discussed with consultant pharmacist/physician as one had not been done in a while. - 4/12/13, noted a PHQ9 score of zero on 1/18/13 and 4/12/13 which indicated no signs or symptoms of depression. When R36 was asked if she felt depressed, R36 responded "not really." - 4/15/13, noted resting in bed provided comfort to her. - 4/25/13, noted R36 no longer exhibited aggressive/angry behavior and questioned hospice about position on reducing psychotropic medications. The hospice nurse reported R36 slept well at night and felt it was due to Seroquel at bedtime. A DISCUS (assessment for side effects) dated 2/8/13, (greater than six months prior to survey dates) was noted in the record with a score of two. A DISCUS within the prior six months was requested. A physician's progress note dated 3/18/13, going forward noted the following: - 3/18/13, noted R36 denied feeling sad or down, just felt like she had lived a good long life and was ready to go when the time comes. - 5/10/13, noted R36's affect appeared stable and staff reported no concerns with mood or affect. The note did not include a clinical rationale why a	F 428		

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F 428	Continued From page 34 gradual dose reduction was not indicated for Wellbutrin or Seroquel. - 7/20/13, noted R36 continued to have a slow decline secondary to advanced dementia. The mood care plan dated 4/12/13, included antipsychotic and antidepressant use and directed non-pharmacological interventions for staff to utilize. The care plan identified extrapyramidal reaction and postural hypotension as possible side effects of Seroquel (an antipsychotic medication). The care plan directed a DISCUS per facility protocol. The Quarterly Psychoactive Medication Review dated 4/19/13, indicated R36 had been on Wellbutrin 100 milligrams (mg) twice a day since 8/17/09 and Seroquel 12.5 mg since 3/17/12. A Hospice note dated 5/7/13, indicated a request was made to decrease Wellbutrin and noted R36 was "no longer in need of medication." The note further indicated there was no physician response to the recommendation faxed on 4/26/13. The mood Care Area Assessment (CAA) dated 7/9/13, did not include a summary of mood concerns. The psychotropic medication use CAA dated 7/12/13; indicated R36 had a dose reduction failure of Seroquel in 2009 with successful dose reductions on 9/8/11 and 3/16/12 with no dose reductions since that time. A review of the Monitoring Results log for blood pressure from 9/22/13 through 11/16/13, revealed no orthostatic blood pressure readings had been obtained. The quarterly Minimum Data Set (MDS) dated	F 428		

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F 428	Continued From page 35 9/27/13, for R36 included diagnoses of dementia, anxiety disorder, depression, psychotic disorder and adult failure to thrive. The MDS included a Brief Interview of Mental Status (BIMS) score of three, which indicated severe cognitive impairment. A PHQ9 was also completed with the MDS and revealed a score of zero, which indicated no depression. The MDS indicated R36 had no behaviors or delusions during the observation period. The Mood and Behavioral Record for September through November 2013, were reviewed. The records indicated R36 was being monitored for easily irritable/angry, sarcastic. The only documentation for 9/13, was on 9/12/13 and 9/13/13 and the mood/behavior was noted to have occurred x 1 on those days and the intervention used was effective. For October 2013, documentation occurred on 10/1, 10/2, 10/6, 10/21, 10/25, 10/29 and 10/30. On those days R36 was noted to have been irritable x 2 on 10/1 and 10/2. The documentation for November 2013, revealed the target mood/behavior did not occur on the days documented. The Quarterly Psychoactive Medication Review dated 11/11/13, noted a behavior/mood problem of irritable/angry and isolating self for Wellbutrin and Seroquel. The Physician Orders dated 11/18/13, revealed orders for Wellbutrin SR 100 mg twice a day and Seroquel 12.5 mg daily. Both medications were noted as being given for major depression with anxiety and psychotic features. The medical record lacked evidence that a gradual dose reduction of Seroquel was requested after 3/7/12, or a clinical rationale why a dose reduction would	F 428		

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F 428	Continued From page 36 be contraindicated. Licensed practical nurse (LPN)-A was interviewed on 11/20/13, at 2:43 p.m. and stated she had talked to hospice about Seroquel for R36 and thought that was why hospice requested a dose reduction of Wellbutrin. When interviewed on 11/21/13, at 9:03 a.m. LPN-A stated the request to discontinue the Wellbutrin came from the hospice pharmacist and the physician declined to change the order. LPN-A was asked to provide documentation regarding the rationale from the physician. Upon interview on 11/21/13, at 10:25 a.m. LPN-A stated the hospice pharmacist told her he/she did not keep any notes regarding the physician's rationale for declining to change the Wellbutrin order. LPN-A also stated the Hospice nurse told her the physician never responded to the request and no one ever followed up. LPN-A stated she was unable to provide documentation regarding why the Wellbutrin was not discontinued. When interviewed on 11/21/13, at 10:35 a.m. LPN-E stated any orthostatic blood pressures would be documented on the Monitoring Results log and R36 was on Hospice and did not have to have vitals taken. On 11/21/13, at 11:02 a.m. LPN-A stated no DISCUS had been completed since 2/8/13, and it "must have gotten missed." The consultant pharmacist was interviewed on 11/21/13, at 1:10 p.m. and stated the hospice pharmacist had requested a dose reduction of Wellbutrin in April 2013 or May 2013. She stated	F 428		

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 _____	11/21/2013

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 428	Continued From page 37 she had not requested a dose reduction of Seroquel because the physician had denied the request for a reduction in Wellbutrin. She further indicated R36 had a failed dose reduction of Seroquel in 2009. The Psychotropic Medication Monitoring policy dated 11/92 and reviewed 1/2013, directed any unnecessary drugs being utilized require dosage reductions and/or documentation justifying its usage outside of the regulatory guideline. The policy also directed orthostatic blood pressures to be checked monthly for antipsychotic medications. The policy also directed a DISCUS should be completed: however, it did not provide guidance on the frequency required.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431		

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F 431	Continued From page 38 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 that medications were stored and labeled properly for 5 of 5 residents (R500, R26, R103, R92, R94) reviewed for medication storage. The facility failed to ensure medications were stored in a clean sanitary manner in 1 of 2 medication refrigerators. Findings include: Medication carts: 2 East On 11/18/13, at 6:55 p.m. during medication cart storage tour the following was observed: 1. R500's Trimethoprim solution polymyxin (eye drop used to treat certain eye infections caused by bacteria)and Prednisolone suspension 1 % ophthalmic (eye drop used to treat certain eye conditions due to inflammation or injury). Both eye drops were stored in the medication cart and were undated.	F 431		

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F 431	Continued From page 39 When interviewed on 11/18/13, at 6:57 p.m. registered nurse (RN)-B verified the eye drops were not dated and further stated the eye drops are supposed to be dated when opened by the nurse's per facility policy. 2 South On 11/18/13, at 7:01 p.m. during medication cart review the following medications were undated: 1. R26's Travatan Z drop 0.004% (an eye drop used to reduce elevated eye pressure). 2. R103's Systane Balance Solution Restorative Formula 0.6% (provides lasting relief from the symptoms of dry eye) 3. R92's Proair HFA-108mcg (albuterol sulfate)-used to prevent and treat wheezing and shortness of breath caused by breathing problems. When interviewed on 11/18/13, at 7:06 p.m. licensed practical nurse (LPN)-B verified the eye drops were not dated and was not able to verify when the drops had been dispensed from the pharmacy and in addition stated usually staff save the plastic container to store the eye drops for the residents when a new one is dispensed from the pharmacy. LPN-B further stated the eye drops and inhalers are supposed to be dated when opened by the nurse per facility policy. 2 North On 11/19/13, at 10:57 a.m. medication cart tour was completed with LPN-C and the following were observed: 1. R94's Hypromellose (artificial tears) 0.5% ophthalmic solution with instructions to give 1 drop four times daily to both eyes dated as opened 11/16/13, but had use and discard date of 9/22/13 and the resident still received the eye drop, R94's Prednisone acetate suspension 1.0%	F 431	F431 Medications as identified for the following residents have been replaced and dated when opened: R500, R26, R103, R92, R94. All other multi dose vials were reviewed for date opened label. To prevent recurrence, Pharmacy will place date opened stickers on all multi dose vials. Night shift has been assigned to check all multi dose vials weekly for date opened stickers. Medication Storage and Expiration Guidelines have been updated and posted again on the units and provided on each medication cart. Education provided to nursing staff. Random sample of 2 multi dose vials will be done of each med cart weekly for 3 months to ensure ongoing compliance.	12-31-13

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F 431	Continued From page 40 dated as opened 6/29/13, was still being stored in the cart and R94's Systane lubricant eye drop bottle with open date 3/2013 and undated when opened. When interviewed on 11/18/13, at 11:10 a.m. LPN-A verified all the drops were all outdated and asked the nurse to discard all the drops and re-order. LPN-A further stated the Prednisone drops should be discarded 30 days after being opened and should have not been used on the resident. The Prednisone Drug Fact sheet dated 8/27/2009, directed "Discard 4 weeks after opening." The Travatan Drug Face sheet dated 11/27/2002, directed "Do not use more than 30 days after opening." Additionally, the Hypromellose Eye Drops Consumer Medicine Information sheet copyright date 2013, directed "just keep for 4 weeks once the bottle has been opened. Make sure you have a fresh supply." Medication room Second Floor: The medication refrigerator was observed to be dirty and was not maintained in a clean and sanitary manner. On 11/19/13, at 10:43 a.m. the medication storage tour was conducted with the assistant director of nursing (ADON). The refrigerator in the medication room was noted to be unclean. The crisper drawer which held resident medication had black and brown debris in the bottom and on the sides of the drawer. The entire inside of the refrigerator was also noted to have black/brown debris. The crisper stored the following medications R2's dulcolax rectal suppositories in a baggie, R50's rectal dulcolax suppositories in a	F 431	Medication room refrigerator has been cleaned and items properly stored. To prevent recurrence, weekly completion of this task has been assigned to the night shift. Education provided to Nursing staff. Weekly audits will be done for 3 months to ensure ongoing compliance. DON/ Clinical Manager responsible.	12-31-13

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F 431	Continued From page 41 baggie, five boxes of house supply dulcolax suppositories, three un-opened vials of pneumovax in a clear plastic bag, and R136's Interferon Beta 1a subcutaneous and Acetaminophen rectal suppositories. When interviewed on 11/19/13, at 10:45 a.m. the ADON stated it was facility policy that medications are to be stored separately and not as observed. Regarding keeping the refrigerator clean, the ADON stated the night shift was responsible to clean it but was not able to provide a cleaning log when the refrigerator had been cleaned last. The ADON stated there was no log. When interviewed on 11/21/13, at 1:42 p.m. the ADON stated all eye drops and inhaler are supposed to be dated when opened by the nurses as this was the facility policy. When interviewed on 11/21/13, at 1:46 p.m. the director of nursing (DON) stated her expectation was to have all the multi-bottle eye drops and inhalers dated when opened by the nurse. In addition, the nurses are supposed to check the expiration date for the eye drops when administering them. In relation to the medication storage, rectal medications are to be stored separately and not together as observed during the medication storage tour. The facility policy titled, Pharmaceutical Administration, reviewed 11/13, directed: Discard date stickers will be applied to vials, inhalers, and refrigerated eye drops (ex xalatan), indicating the date that the item is to be discarded. The policy lacked information on who would be responsible to clean and oversee medication storage areas to ensure they are maintained in a clean and	F 431		

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F 431	Continued From page 42 sanitary manner.	F 431		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 steam tables had a cleanable surface which was used in 2 of 5 dining rooms and had the potential to affect 37 of 97 residents. Findings include: An environmental tour of the facility on 11/20/13, at 1:15 p.m. was conducted with the director of maintenance and the director of housekeeping. During the environmental tour on 2 South, the steam table in the dining room was observed to have an extended arm of pressed wall board covered with a laminate. The laminate was missing on all four corners and was crumbling. The maintenance director stated that he would remove the extended arm immediately in order to prevent anything from getting into the resident's food. The steam table was used in both the north and south dining rooms on second floor which served 37 residents. The daily cleaning schedule dated September and October 2013 indicated the steamer was to be cleaned everyday both inside and out. However, there was no place on the logs which	F 456	F456 It is the practice of CV that the facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. The facility has removed the extended Arm (tray) and it has been replaced by a new one. The Dietary Director will keep a log when equipment is cleaned and will educate dietary staff on the proper sign off procedure for cleaned items. To make sure of compliance by 12/31/13. Dietary Director responsible.	12-31-13

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F 456	Continued From page 43 indicated equipment repair.	F 456		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that 3 of 4 residents (R210, R78, R162) call lights were within reach. Findings include: R210 was observed on 11/18/13, at 3:27 p.m. laying in the bed. The bulb sensor call light was clipped to the head of the bed linens falling away from R210's reach. R210 was admitted on 10/3/13, per the admission record. R210's Minimum Data Set (MDS) dated 11/3/13, indicated R210 received hospice and required extensive assist of two for activities of daily living (ADLS). Also, during the environmental tour of the facility on 11/20/13, at 1:15 p.m. two resident call lights were observed were found to not be in reach if the residents needed to use the call light for assistance. R78's call light was observed to be hanging between the headboard of the bed and the wall. R78 was wheelchair bound and would not be capable of reaching the call light when it was hanging between the headboard and wall.	F 463		

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F 463	Continued From page 44 Even though R78 was capable of maneuvering the wheelchair in the room, R78 was still not able to reach for the call light as the bed was an obstacle between the headboard and the wall. R162 was in her room during the tour and confirmed that she would not have been able to reach her call light if she needed to call for help because she was sitting in a chair at the foot of the bed and R162 stated she would not call out for help. R162's call light was pinned to the sheet under the pillow and was not visible to the resident. At the time of the tour, both the maintenance director and the housekeeping director confirmed these two call lights (R78 and R162) were out of reach for the residents. Rgeistered nurse (RN)-E was interviewed on 1/20/13, at approximately 2:30 p.m. and confirmed that call lights should be accessible to all residents. RN-E was asked to provide a copy of the facility's call light policy. The facility's Call Light System policy was reviewed by the facility on 1/13. The policy indicated that staff were: 1) to observe resident ability to use call light and provide alternative call cord or refer to occupational therapy (OT) as resident need indicates. 2. Place call light so it is accessible to the resident at all times. 3. Observe resident's ability to use the call light on an ongoing basis. Provide reminds to the resident to use the call light as needed. The facility's call light policy was not consistently being implemented.	F 463	F 463 Call lights have been properly placed for residents identified: R210, R78, R162. Facility wide audit has been done to ensure all call lights are properly placed and have adequate length to accommodate placement. To prevent recurrence, housekeeping will include call light placement in daily room cleaning and terminal room cleaning. Nursing Department and Housekeeping staff have been educated. 5 rooms will be audited per week for 3 months to ensure ongoing compliance. DON/Clinical Manager responsible.	12-31-13

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

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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 01 - MAIN BUILDING 01 B. WING _____	11/19/2013

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K 000	INITIAL COMMENTS FIRE SAFETY 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 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Augustana Chapel View Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok JB 12-20-13 RECEIVED DEC 19 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 12-31-13

EXIT: 11-21-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Q. Kay	Administrator	12/13/13

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 98 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	K-067 It is the practice of CV to provide Heating, ventilating and air conditioning to comply with the provisions of sections 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, NFPA 90A, 19.5.2.2 1. Fire damp locations have been identified. Summit Mechanical to clean, test and inspect fire dampers within facility by 12/31/13. The Director of Maintenance will follow thru with scheduling of testing/inspection of fire dampers every 4-6 years. The Director of Maintenance will be responsible for compliance.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	2. It was found that the supply duct work is separate for the upper and lower levels. Each duct has its own fire damper where the duct work penetrates the penthouse floor to a common chase way. Fire dampers have been identified and Summit Mechanical to clean, test and inspect 12/31/13. Maintenance Director to follow thru with scheduling of testing inspection of fire dampers every 4-6 years.	

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K 067	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility's general ventilating and air conditioning system (HVAC) is not installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11 has included transfer grills in the suspended ceiling. A noncompliant HVAC system could affect all residents. Findings include: On facility tour between 10:00 AM and 12:30 PM on 11/19/2013, Observation revealed that: 1. The fire dampers for air handler unit(s) S-1 and S-2 have not been inspected within the last 6 years, 2. Due to construction, it could not be determined if there are fire dampers between the upper and lower level supply ducts leading from air handler unit(s) S-1 and S-2, 3. It could not be determined if the resident room bathroom exhaust fans shut down upon activation of the fire alarm system. The resident corridors are supplied from air handler unit(s) S-1 and S-2 with the only returns located in the resident room bathrooms. These deficient practices were verified by the maintenance director at the time of the inspection.	K 067	The Director of Maintenance will be responsible for compliance. 3. Bathroom exhaust fans shall be tied into the fire panel so that in the event of an alarm the exhaust fans shall automatically shut down. work to be completed by a licensed outside contractor by 12/31/13. A visual reminder will be placed on the Maintenance white board when duct cleaning is required.	