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: P8ON
Facility ID: 00727

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245493**

2. STATE VENDOR OR MEDICAID NO. (L2) **470843100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **01/04/2018** (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 **108** (L18)

13.Total Certified Beds **108** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	108			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Eva Loch, Unit Supervisor 01/16/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/16/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **01/17/2018** (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

CMS Certification Number (CCN): 245493

January 17, 2018

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

Dear Ms. Sparling:

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

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

Effective December 26, 2017 the above facility is certified for:

108 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 108 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
January 17, 2018

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

RE: Project Number S5493028

Dear Ms. Sparling:

On December 6, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 16, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On January 4, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 16, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 26, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 16, 2017, effective December 26, 2017 and therefore remedies outlined in our letter to you dated December 6, 2017, 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

An equal opportunity employer.

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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Facility ID: 00727

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(L4) **615 MINNETONKA MILLS ROAD**
(L5) **HOPKINS, MN** (L6) **55343**

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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 **11/16/2017** (L34)

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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
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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

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From (a) :
To (b) :

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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

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18 SNF	18/19 SNF	19 SNF	ICF	IID
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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Christine Giancola, HFE NEII 12/15/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/11/2018 (L20)

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

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____ 2. Facility is not Eligible
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08/01/1987
(L24)

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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

Electronically delivered
December 6, 2017

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

RE: Project Number S5493028

Dear Ms. Sparling:

On November 16, 2017, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gloria.derfus@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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 26, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 16, 2018 (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 16, 2018 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

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 ______	11/16/2017

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 On November 13, 14 15, and 16, 2017, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePoC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePoC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the PoC will be used as verification of compliance. Upon receipt of an acceptable electronic 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		
F 246 SS=D	REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES CFR(s): 483.10(e)(3) 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a call light was	F 246	F246 – Immediate Plan of Correction	12/26/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/14/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING ______ B. WING ______	11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 246	Continued From page 1 within reach for 1 of 1 resident (R102) reviewed for call light concerns. Findings include: R102's Face Sheet, dated 4/7/17, indicated current diagnoses of left femur fracture and history of falling. R102's Care Area Assessment (CAA) dated 4/15/17, indicated R102 triggered for falls with the potential for falls/injury due to multiple physical and mental deficits, including falling at home and new placement in the nursing home. R102's care plan dated 7/13/17, directed staff to encourage call light use PRN (as needed) and to make sure call light was within reach when in room/restroom. R102's quarterly Minimum Data Set (MDS) dated 10/11/17, indicated R102 had moderate cognition with the ability to express ideas and wants. MDS further indicated extensive one-person physical assist when moving between locations in her room. During an observation on 11/14/17, at 8:58 a.m. R102's call light was observed hanging down while wrapped around the side rail, while R102 was sitting in her wheelchair. R102's bedside table was in front of resident and the resident's four-wheel walker on her left side making it difficult to move the bed side table and get to the call light. R102 attempted to reach the call light but was unable to. Surveyor notified staff. On 11/14/17, at 8:58 a.m. nursing assistant (NA)-C verified call light was wrapped around the grab bar and resident could not reach it. NA-C stated "even if she can't, it's gotta be within reach." During an interview with NA-D on 11/15/17, at	F 246	The call light for R102 was placed within reach when identified during survey. Identification of Other Residents A facility wide audit was conducted of call light cords to ensure all were accessible for residents. Measures Put in Place Facility staff have been re-educated on this practice. Monitoring Mechanisms To prevent recurrence, random audits will be conducted weekly on 10 residents for two months to ensure ongoing compliance moving forward. Results of audits will be reviewed by the Quality Improvement Committee. Clinical Managers and DON responsible.	

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 ______	11/16/2017

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

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F 246	Continued From page 2 1:41 p.m. NA-D stated R102 was able to use the call light on her own. During an interview on 11/16/17, at 2:14 p.m. director of nursing stated the call light should be within reach. The facility policy titled "Call Lights" dated 3/2017, directed facility staff to "Place call light so it is accessible to the resident at all times. Secure the call light to stay within access of the resident."	F 246		
F 247 SS=D	RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE CFR(s): 483.10(e)(6) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide written notice of roommate arrival for 1 of 3 residents (R13) surveyed for roommate change notification. Findings include: On 11/13/17, at 6:44 p.m., R13 said on 10/14/17, the admissions director (AD) and the social services director (SSD) told her she would be getting a room-mate. R13 said she felt she did not have a choice about getting a roommate and did not sign anything at the time	F 247	F247 – Immediate Plan of Correction It was noted that this notice was not provided in writing, nor was the verbal notice given to resident morning of survey properly documented in the resident's medical record. Facility has taken measures to correct this action. Identification of Other Residents This was an isolated incident with one resident Measures Put in Place Staff involved with the coordination of	12/26/17

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 ______	11/16/2017

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AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

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F 247	Continued From page 3 R13 was admitted to the facility on 10/13/17, per the Face Sheet, with diagnoses including chronic obstructive pulmonary disease (a disease that makes it hard to breathe), muscle weakness and pain in right knee obtained from the resident face sheet. The admission Minimum Data Set (MDS) dated 10/20/17, indicated R13 had intact cognition. R13's Progress Note dated 11/13/17, at 11:43 p.m. indicated R13 "did not seem to be adjusting to the new situation and did not wish to interact with the new roommate." R13's Progress Note dated 11/16/17, at 8:19 a.m. by the admission director indicated "Late entry to 11/13/17, at 9:45 a.m." The SSD and the AD "went into the room of resident [R13] to ask if she would accept a roommate into the room that late afternoon due to an admission. The resident [R13] responded to me that did she have an option." The note was completed during the survey process. During an interview on 11/16/17, at 7:59 a.m., the director of nursing defined the procedure for notification, which involved a member of the social services department notified the resident before getting a roommate. She said the facility varied the time of notification for each individual resident because some residents would become anxious or forget the information. She said she expected a member of the social services department to document the notification in the facility progress notes. During an interview on 11/16/17, at 9:15 a.m., the long term care social worker said it was facility practice to verbally communicate with each	F 247	room/roommate changes has received in-service education on the facility policy regarding roommate changes. They have received a written copy of this policy and a copy of the written notice to be provided to all resident's receiving a new roommate. Education included acknowledgement of the requirement for verbal and written notice as well as the requirement for proper documentation to be entered into medical record prior to the roommate change occurring. Monitoring Mechanisms Social service director will conduct audits of all roommate notifications for the next 30 days and results will be reviewed by the Quality Improvement Committee. Social Service Director, admissions director and social workers responsible.	

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F 247	Continued From page 4 resident regarding room-mate notification, then document the conversation in the facility Progress Notes. During an interview on 11/16/17, at 10:13 a.m. the AD said she thought she had informed R13 at approximately 11:00 a.m. on 10/14/17, of the arrival of a roommate. She said R13 was upset about getting a roommate and discharged on 11/15/17, to her home with her son because of her distress about the roommate. During an interview on 11/16/17, at 10:38 a.m. the SSD said she and the AD met with R13 and her son because they were both upset about the roommate. The SSD said, per facility policy, documentation of notification should be found in the facility Progress Notes. SSD acknowledged the note was made as a late entry on 11/16/17. R13 was not provided written notice regarding the roommate change. Facility Policy and Procedure, number 193, Subject: Roommate Notification, last reviewed on 4/16, directed staff to notify of a change or a new roommate as soon as possible to allow for a good transfer /admit of the new roommate. It also directs social services, admission or their designee to document in the medical record and for social services to monitor the change of roommate for any initial adjustment issues that may occur.	F 247		
F 248 SS=D	ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES CFR(s): 483.24(c)(1) (c) Activities.	F 248		12/26/17

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F 248	Continued From page 5 (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure activities were offered to 1 of 1 resident (R34) who was at risk for social isolation reviewed for activities. Findings include: On 11/13/17, at 1:14 p.m. to 3:30 p.m. R34 was observed seated on the couch. During the observation R34 was observed to be agitated and attempted to self-transfer himself and staff redirected. None staff in the area offered any activities. There was a newspaper available on the table across from R34 to look at however, none of the staff offered that activity. On 11/14/17, at 9:00 a.m. R34 was observed propel his wheelchair into the lounge area and when he got to the couch he was observed attempt to self-transfer and one of the nurse's intervened and asked another staff to transfer him. Between 9:30 a.m. to 9:37 a.m. R34 was observed to attempt to stand from the couch and staff kept redirecting and not addressing his need to stand up. At 9:39 a.m. registered nurse (RN)-F approached R34, applied the transfer belt around the waist, and transferred R34 to the wheelchair.	F 248	F248 – Immediate Plan of Correction Resident was reassessed for activity needs. Care plan was updated with changes, staff will encourage attendance while honoring resident's choice to participate or not participate in activity programs and pursue preferred choice of resting or interacting with family during regular visits. In addition, staff education will be provided in presenting opportunity to engage in group programs and pursuits of choice. Identification of Other residents All residents with low activity attendance were reassessed for activity needs and interests, care plans were updated as needed. Measures Put in Place Identified resident will be interviewed weekly for the next 30 days to ensure satisfaction with activity routine, as well as confirming family's input in effectiveness of programming. Monitoring Mechanisms	

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F 248	Continued From page 6 R34 was toileted. At 9:46 a.m. the staff was observed wheel R34 back to the couch again. R34 went back to sleep. At 9:48 a.m. the activity director (AD) approached the lounge area and offered several residents to attend the hymn singing at the chapel. R34 still asleep on the couch and R34 was not offered the activity. At 9:53 a.m. the activity director approached R34 offered the hymn activity however, R34 was heard state "hearing is bad I can't understand" as he pointed to his right ear. The activity director left the area. At 10:01 a.m. R34 again was observed attempt to self-transfer surveyor intervened and called the health information management (HIM) director. At that time, HIM director was heard ask licensed practical nurse (LPN)-B if R34 was able to ambulate by himself. Both staff left the area. At 10:02 a.m. R34 was again observed attempt again to get up at that time and LPN-B ran over to intervene. At that time R34 stated, "I want to go upstairs." Staff re-directed R34, left R34 sitting on the couch, and then left the area. Never offered the newspaper or alternative activities. At 10:05 a.m. R34 remained in the area holding his head with the left hand just looking around. At 10:06 a.m. R34 got agitated when a staff approached him and asked if he wanted to go for a walk. R34 started to curse, "son of b****** you." At 10:08 a.m. staff approached with a glass of water and R34 stated in agitated loud voice "I don't want nothing." At 10:09 a.m. another staff approached R34 who was calm at that time offered help but R34 declined and left the area. During the entire observation no staff offered R34 an activity and R34 was observed not watching the television, even once, which was on CNN (cable news network) channel. On 11/14/17, at 2:20 p.m. to 2:48 p.m. R34 sat at	F 248	Residents identified with low activity attendance will be reviewed by the QAPI committee to ensure appropriate and resident-centered activity plans of care are in place. A log book was implemented to document daily acceptance or refusals of offered activities to engage in during resident's chosen periods of 'downtime', for all staff on unit to utilize. Weekly and Monthly interviews with identified resident R34 will be reviewed by the Quality Improvement Committee to monitor on-going satisfaction with activity programs offered and attended. Recreation therapy director and assistant responsible.	

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F 248	Continued From page 7 the couch looking around during that time a Bingo activity was going on. During the observation multiple staff approached and offered to bring R34 to the toilet and a snack but R34 decline. At 2:49 p.m. R34 was observed attempt to stand off the couch and that time staff approached and offered the toilet and he stated he would go. Staff applied the transfer belt and ambulated with him to the common toilet by the nursing station. At 3:08 p.m. R34 returned to the lounge area sat on the couch with staff assistance. No activity was offered, not even the newspaper which was available to read. At 3:17 p.m. R34 was observed attempt to stand off the couch and RN-B approached again and that time she re-directed him to wait as she got the transfer belt. R34 sat down until RN-B came back applied the transfer belt, cued R34 to stand and RN-B ambulated beside R34 approximately 97.5 feet to his bed and assisted R34 to get in bed. On 11/15/17, at 7:40 a.m. to 8:15 a.m. R34 was observed seated on the wheelchair at the table located in the lounge area across from the nursing station. At that time R34 was asleep the entire time even though the television was on. The newspaper was not at the table. At 8:15 a.m. to 8:46 a.m. R34 was observed in the dining room eat independently after staff set up. At 8:47 a.m. RN-A was observed wheel R34 out of the dining room to the lounge area and then was observed cue R34 to stand off the wheelchair using the walker and assisted him to sit on the couch. At 8:49 a.m. to 9:39 a.m. R34 sat on couch asleep with his left hand supporting the head. No staff approached and offered activities. At 9:40 a.m. R34 woke up then attempted to stand up but was not able to then sat back. At that same time family member approached and sat next to R34.	F 248		

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F 248	Continued From page 8	F 248		

On 11/15/17, at 2:48 p.m. R34 was observed in bed asleep as the baking activity went on.

On 11/16/17, at 9:00 a.m. to 10:40 a.m. R34 remained in the lounge area asleep, no staff offered the resident the newspaper or any activity to do.

R34's communication Care Area Assessment (CAA) dated 9/25/17, identified R34 was at risk for social isolation or change in mood due to decreased cognitive skills related to current diagnosis of delirium and dementia and limited communication. The CAA directed staff to provide time necessary to respond, provide repetition-rephrasing as needed and encourage attendance to out of room activities or one on one to minimize the opportunity for change in mood and social withdrawal.

R34's admission Minimum Data Set (MDS) dated 9/25/17, Section F: Preferences for Customary Routine and Activities revealed R34's family member had been interviewed to complete the assessment. The assessment indicated R34's current leisure interest/daily routine included "reading the paper, watching TV, jigsaw puzzles and worship service." In addition, the assessment indicated family member had indicated it was somewhat important to have newspapers and magazines to read, very important to be around animals such as pets, somewhat important to keep up with the news and do things with groups of people and it was very important to do his favorite activities "chapel" and to participate in religious services or practices. R34's diagnoses included aphasia, dementia, cerebrovascular accident (CVA).

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F 248	Continued From page 9	F 248		

R34's therapeutic care plan revised 10/2/17, indicated R34 needed strong encouragement to attend group programming. The care plan goals indicated "Patient will maintain social skills, while engaging in a leisure routine of choice via attending group programs of interest and (I) reading the newspaper, watching TV and interacting with spouse during visits as desired during the following quarter." The care plan directed staff to "provide activity schedule, extend invites-reminders with strong encouragement and assist with additional leisure resources."

During review of the Augustana Chapel View Care Center Activity Attendance the following were revealed:
-September 2017, log indicated since R34's admission 9/18/17, resident had participated in activities on three of 13 days of the month so far. With 10 days of no activities so far which included all weekends.
-October 2017, log indicated resident had declined one activity, was never offered or participated in other activities for 31 days except for four family visits.
-November 2017, log indicated resident had only attended activities for five of 16 days, with 11 days of no activities.
The logs and medical record lacked documentation, R34 had refused activities offered and if resident had been re-assessed to ensure the interventions in place were effective.

On 11/15/17, at 12:21 p.m. LPN-A stated R34 would be agitated at times and hard to re-direct due to dementia. LPN-A stated R34 was at times able to tell staff what he wanted and other times he is not able to let staff know. LPN-A also stated

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F 248	Continued From page 10 R34's family member visited at times which was difficult when it was time to go as R34 did not want family member to leave. On 11/16/17, at 12:49 p.m. when asked about R34's activity attendance/participation and observations of no activities being offered from 11/13/17, through 11/16/17, the activity director stated R34's behaviors or mood determined if he came to any activity. "When I talk to him she talks for him she charms in and answers for him at times and would say he is not going to activities and they would sit there. There is not a lot of consistency to attendance we still invite him and he would refuse." The activity director verified the medical record and logs lacked documentation of the refusals. When asked if staff had thought about doing 1:1 activity's or small groups for R34 which were individualized and person centered she stated "with therapy and all the meetings including care conference it has been a challenge" She acknowledged the activity department had not done anything for resident individualized activities. The activity director also stated resident had gotten accustomed to sitting on the couch and waiting for family member. When asked if any of the listed activities which had been indicated on the assessment including reading the newspaper, doing a jigsaw puzzle and worship service had been offered she stated "no." The facility One to One Therapeutic Activity Programming policy revised 5/16, directed "5. Residents in isolation will be provided with one to one programming and or supplies per need and/or request..." The facility Group Activity	F 248		

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F 248	Continued From page 11 Programming/Standards of Practice revised 5/16, directed "8. Group activity involvement will always be structured per resident's choice. Refusal to attend group programs will be monitored to determine need for different type of group programs or as an indication of resident choice to participate..." The facility Attendance Charting/Activity Participation revised 5/16, directed "6. Resident activity participation will be recorded to monitor attendance and participation levels as related to resident's plan of care. 7. Resident's showing unusual or unexplained changes or fluctuations in activity involvement will be further assessed to assure activity needs are being met and if care plan changes are needed..."	F 248		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 failed to ensure activities were offered according to the plan of care for 1 of 1 resident (R34) who was at risk for social isolation reviewed for activities. Findings include:	F 282	F282 – Immediate Plan of Correction Resident was reassessed for activity needs. Care plan was updated with changes, staff will encourage attendance while honoring resident’s choice to participate or not participate in activity	12/26/17

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F 282	Continued From page 12 On 11/13/17, at 1:14 p.m. to 3:30 p.m. R34 was observed seated on the couch. During the observation R34 was observed to be agitated and attempted to self-transfer himself and staff redirected. None staff in the area offered any activities. There was a newspaper available on the table across from R34 to look at however, none of the staff offered that activity. On 11/14/17, at 9:00 a.m. R34 was observed propel his wheelchair into the lounge area and when he got to the couch he was observed attempt to self-transfer and one of the nurse's intervened and asked another staff to transfer him. Between 9:30 a.m. to 9:37 a.m. R34 was observed to attempt to stand from the couch and staff kept redirecting and not addressing his need to stand up. At 9:39 a.m. registered nurse (RN)-F approached R34, applied the transfer belt around the waist, and transferred R34 to the wheelchair. R34 was toileted. At 9:46 a.m. the staff was observed wheel R34 back to the couch again. R34 went back to sleep. At 9:48 a.m. the activity director (AD) approached the lounge area and offered several residents to attend the hymn singing at the chapel. R34 still asleep on the couch and R34 was not offered the activity. At 9:53 a.m. the activity director approached R34 offered the hymn activity however, R34 was heard state "hearing is bad I can't understand" as he pointed to his right ear. The activity director left the area. At 10:01 a.m. R34 again was observed attempt to self-transfer surveyor intervened and called the health information management (HIM) director. At that time, HIM director was heard ask licensed practical nurse (LPN)-B if R34 was able to ambulate by himself. Both staff left the area. At 10:02 a.m. R34 was again observed attempt	F 282	programs and pursue preferred choice of resting or interacting with family during regular visits. In addition, staff education will be provided in presenting opportunity to engage in group programs and pursuits of choice. Identification of Other Residents All residents with low activity attendance were reassessed for activity needs and interests, care plans were updated as needed. Measures Put in Place Identified resident will be interviewed weekly for the next 30 days to ensure satisfaction with activity routine, as well as confirming family's input in effectiveness of programming. Monitoring Mechanisms Residents identified with low activity attendance will be reviewed by the QAPI committee to ensure appropriate and resident-centered activity plans of care are in place. A log to document daily acceptance or refusals of offered activities to engage in during resident's chosen periods of 'downtime', for all staff on unit to utilize. Weekly and Monthly interviews with identified resident R34 will be reviewed by the Quality Improvement Committee to monitor on-going satisfaction with activity programs offered and attended. Recreation Therapy Director and assistant responsible.	

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F 282	Continued From page 13 again to get up at that time and LPN-B ran over to intervene. At that time R34 stated, "I want to go upstairs." Staff re-directed R34, left R34 sitting on the couch, and then left the area. Never offered the newspaper or alternative activities. At 10:05 a.m. R34 remained in the area holding his head with the left hand just looking around. At 10:06 a.m. R34 got agitated when a staff approached him and asked if he wanted to go for a walk. R34 started to curse, "son of b****** you." At 10:08 a.m. staff approached with a glass of water and R34 stated in agitated loud voice "I don't want nothing." At 10:09 a.m. another staff approached R34 who was calm at that time offered help but R34 declined and left the area. During the entire observation no staff offered R34 an activity and R34 was observed not watching the television, even once, which was on CNN (cable news network) channel. On 11/14/17, at 2:20 p.m. to 2:48 p.m. R34 sat at the couch looking around during that time a Bingo activity was going on. During the observation multiple staff approached and offered to bring R34 to the toilet and a snack but R34 decline. At 2:49 p.m. R34 was observed attempt to stand off the couch and that time staff approached and offered the toilet and he stated he would go. Staff applied the transfer belt and ambulated with him to the common toilet by the nursing station. At 3:08 p.m. R34 returned to the lounge area sat on the couch with staff assistance. No activity was offered, not even the newspaper which was available. At 3:17 p.m. R34 was observed attempt to stand off the couch and RN-B approached again and that time she re-directed him to wait as she got the transfer belt. R34 sat down until RN-B came back applied the transfer belt, cued R34 to stand and RN-B ambulated beside R34	F 282		

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 ______	11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 14	F 282		

approximately 97.5 feet to his bed and assisted R34 to get in bed.

On 11/15/17, at 7:40 a.m. to 8:15 a.m. R34 was observed seated on the wheelchair at the table located in the lounge area across from the nursing station. At that time R34 was asleep the entire time even though the television was on. The newspaper was not at the table. At 8:15 a.m. to 8:46 a.m. R34 was observed in the dining room eat independently after staff set up. At 8:47 a.m. RN-A was observed wheel R34 out of the dining room to the lounge area and then was observed cue R34 to stand off the wheelchair using the walker and assisted him to sit on the couch. At 8:49 a.m. to 9:39 a.m. R34 sat on couch asleep with his left hand supporting the head. No staff approached and offered activities. At 9:40 a.m. R34 woke up then attempted to stand up but was not able to then sat back. At that same time family member approached and sat next to R34.

On 11/15/17, at 2:48 p.m. R34 was observed in bed asleep as the baking activity went on.

On 11/16/17, at 9:00 a.m. to 10:40 a.m. R34 remained in the lounge area asleep, no staff offered resident the newspaper or any activity to do.

R34's therapeutic care plan revised 10/2/17, indicated R34 needed strong encouragement to attend group programming. The care plan goals indicated "Patient will maintain social skills, while engaging in a leisure routine of choice via attending group programs of interest and (I) reading the newspaper, watching TV and interacting with spouse during visits as desired during the following quarter." The care plan

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F 282	Continued From page 15	F 282		

directed staff to "provide activity schedule, extend invites-reminders with strong encouragement and assist with additional leisure resources."

During review of the Augustana Chapel View Care Center Activity Attendance the following were revealed:
-September 2017, log indicated since R34's admission 9/18/17, resident had participated in activities on three of 13 days of the month so far. With 10 days of no activities so far which included all weekends.
-October 2017, log indicated resident had declined one activity, was never offered or participated in other activities for 31 days except for four family visits.
-November 2017, log indicated resident had only attended activities for five of 16 days, with 11 days of no activities. The logs and medical record lacked documentation, R34 had refused activities offered and if resident had been re-assessed to ensure the interventions in place were effective.

On 11/16/17, at 12:49 p.m. when asked about R34's activity attendance/participation and observations of no activities being offered from 11/13/17, through 11/16/17, the activity director stated R34's behaviors or mood determined if he came to any activity. "When I talk to him she talks for him she charms in and answers for him at times and would say he is not going to activities and they would sit there. There is not a lot of consistency to attendance we still invite him and he would refuse." The activity director verified the medical record and logs lacked documentation of the refusals. When asked if staff had thought about doing 1:1 activity's or small groups for R34 which were individualized and person centered she stated "with therapy and all the meetings

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	245493	A. BUILDING _______ B. WING _______	11/16/2017

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F 282	Continued From page 16 including care conference it has been a challenge" She acknowledged the activity department had not done anything for resident individualized activities. The activity director also stated resident had gotten accustomed to sitting on the couch and waiting for family member. When asked if any of the listed activities which had been indicated on the assessment including reading the newspaper, doing a jigsaw puzzle and worship service had been offered she stated "no." The facility One to One Therapeutic Activity Programming policy revised 5/16, directed "5. Residents in isolation will be provided with one to one programming and or supplies per need and/or request..." The facility Group Activity Programming/Standards of Practice revised 5/16, directed "8. Group activity involvement will always be structured per resident's choice. Refusal to attend group programs will be monitored to determine need for different type of group programs or as an indication of resident choice to participate..." The facility Attendance Charting/Activity Participation revised 5/16, directed "6. Resident activity participation will be recorded to monitor attendance and participation levels as related to resident's plan of care. 7. Resident's showing unusual or unexplained changes or fluctuations in activity involvement will be further assessed to assure activity needs are being met and if care plan changes are needed..."	F 282		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		12/26/17

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 ______	11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 17 CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure grab bars on resident beds, used for positioning/transfers, were maintained to assure stability for 1 of 3 residents (R35) observed with grab bars reviewed for accidents. Finding include: R35's fall Care Area Assessment (CAA) dated	F 323	F323 – Immediate Plan of Correction Day of survey when rail discovered to be loose 10 degrees. Maintenance staff made immediate repair. Identification of Other Residents All house audit of bed side rails/assist bars completed by maintenance staff.	

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F 323	Continued From page 18 5/26/17, identified R35 was at risk for falls/ injury due to multiple physical and mental deficits. CAA indicated R35 required staff assist with all cares, had decreased mobility in general due to deconditioning. R35's diagnoses included hemiplegia and hemiparesis following unspecified cerebrovascular disease (CVD) obtained from the 14-day Minimum Data Set (MDS) dated 9/10/17. In addition, the MDS indicated R35 had moderately impaired cognition and required extensive physical assistance with activities of daily living (ADLs), was unsteady and had impaired limited range motion of one side on both upper and lower extremities. R35's care plans for bed mobility and transfers revised 10/12/17, identified R35 needed and received physical staff assist with transfers and bed mobility due to cerebrovascular accident (CVA) with right hemiparesis. Both care plan indicated R35 used grab bars to assist for bed mobility and transfers. On 11/13/17, at 1:44 p.m. during the room observations and interview R35's bed was observed with two grab bars affixed to the bed. When checked to see if rails fit the bed properly so the resident cannot get caught between the side rails and the mattress, the right grab bar was noted to be loose and wiggly approximately 10 degrees of flexibility back and forth. When asked if he used it, R35 stated he had noticed it was loose and did use it to turn side to side when in bed and when transferring in/out of bed. On 11/14/17, at 10:30 a.m. the right grab bar remained loose. On 11/15/17, at 7:03 a.m. to 7:19 a.m. nursing assistant (NA)-A was observed provide morning cares for R35 which included pericare and putting	F 323	Measures Put in Place Bed side rails/assist bars shall be inspected and documented on a monthly basis to ensure the side rails/assist bars are installed according to the manufacturer’s recommendation. All mounting hardware shall be inspected to ensure side rails/assist bars are tight to the bed frames and are in proper working order. Policy and procedure reviewed and updated, along with in-service and demonstration to ensure the proper procedure for monthly audits. Audit form reviewed and revised to be more comprehensive when inspecting side rails/assist bars. All staff informed at mandatory all staff meeting of expectation to inform maintenance of any issues concerning bed side rails/assist bars. Monitoring Mechanisms Monthly audits to be completed and first month audit results will be reviewed with the Quality Improvement Committee. Maintenance director responsible.	

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	245493	A. BUILDING ______ B. WING ______	11/16/2017

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F 323	Continued From page 19 on pants. During the observation NA-A was observed turn R35 to the right and R35 had to reach out for the grab bar with his left hand and was observed pull inward approximately 15 degrees. NA-A never acknowledged the grab bar being loose. On 11/15/17, at 12:02 p.m. licensed practical nurse (LPN)-B verified the grab bar was loose after she compared it with the left one which was firm and affixed to bed. At 12:03 p.m. registered nurse (RN)-C clinical manager stated the staff were supposed to let the maintenance know if the grab bar was loose. RN-C stated he was going to put a work order for it and was also going to call the maintenance director to let them know. At 12:05 p.m. RN-C went to R35's room which was located across from his office and came back was heard state to the maintenance director "the right grab bar is too loose." When asked who checked the grab bars to make sure they were properly affixed to the bed frame, RN-C stated the maintenance staff had a log of when they checked them and if any staff observed a concern with them they were supposed to report. On 11/16/17, at 11:01 a.m. the maintenance director stated "we do a monthly audit on those and I received a call that room 252 was loose and I came and tightened it." He further stated he had talked to the other maintenance staff to make sure when doing the audit, he had to make sure the grab bars were "firm and tighten." At 11:10 a.m. director of maintenance approached provided the facility Side Rail Inspection Sheet which revealed R35's grab bar had been inspected and documented on 11/7/17, as "ok" the audit did not indicate if a visual inspection had been done.	F 323		

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F 323	Continued From page 20 During review of R35's Restraints/Adaptive Equipment --Augustana Physical Device Assessment Quarterly Review dated 11/9/17, it was revealed R35 used grab bars to help increase resident mobility and turn side to side holding the railing with little help. The assessment did not indicate if the staff had assessed the grab bars to make sure they were properly affixed to the bed frame. The facility Grab Bar or Assist Bar revised 9/15, directed "6. Maintenance monitors all grab bars or assist bars monthly for gaps between mattress and side rail, checks the mechanics of each grab bar or assist bar. Repair or replacement of the grab bar or assist bar is completed by the maintenance department and reports any deviance from the policy to the director of nursing. 7. If staff notices a loose grab bars or assist bars, maintenance is notified..."	F 323		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F 329		12/26/17

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F 329	Continued From page 21 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure monitoring of heart rate (HR) for 1 of 5 residents (R63) reviewed for unnecessary medications. Findings include: R63's Face Sheet dated 6/4/15, indicated current diagnoses hypertension (high blood pressure), diabetes mellitus (high blood sugar) and a history of falling. R63's care plan dated 6/26/17, indicated R63 had antihypertensive medication	F 329	F329 – Immediate Plan of Correction The eMAR for R 63 was amended to require a documentation of heart rate prior to administration of Tenormin. Identification of Other Residents A facility wide audit of other residents with medication orders with parameters associated was conducted and necessary modifications were made. Measures Put in Place Health Unit Coordinators and Nurse	

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F 329	Continued From page 22 (medication to lower blood pressure) per NP/MD (nurse practitioner/doctor of medicine) orders. R63's annual Minimum Data Set (MDS), dated 8/9/17, indicated R63 had intact cognition with clear speech and able to make needs know without difficulty. Review of Physician Orders dated 11/7/17, with medication start date of 12/28/15, identified the use of Tenormin (atenolol medication used to treat high blood pressure) which directed staff to hold medication for heart rate (HR) <60 (less than 60). Review of documented vitals report taken by licensed staff from the months of January 2017 and February 2017 indicated no heart rate was recorded within the scheduled medication administration of 8:00 a.m. for Tenormin and no records were found after February 2017 for documentation of R63's HR. Review of facility Medication Administration Records (MAR) from August 2017 through November 2017, noted the Tenormin was administered everyday with no documentation of R63's heart rate in the MAR. Review of facility vitals report dated August 2017 through November 2017, indicated the only heart rate for R63 that were documented were taken by nursing assistants (NA) or trained medication administrator (TMA): -8/2/17 at 10:02 a.m. HR 52 -8/9/17 at 10:03 a.m. HR 52 -8/16/17 at 1:36 p.m. HR64 -8/30/17 at 11:09 a.m. HR 63 -9/9/17 at 11:09 a.m. HR 57	F 329	Supervisors were educated on this practice of order transcription. Monitoring Mechanisms To ensure compliance, audits will be conducted of medication orders with parameters attached monthly. Results will be reviewed with the Quality Improvement Committee. Consulting Pharmacist/Clinical Manages/DON/Director of Health Information responsible.	

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F 329	Continued From page 23 -9/6/17 at 11:09 a.m. HR 57 -9/20/17 at 10:06 a.m. HR 68 -9/27/17 at 10:21 a.m. HR 64 -10/4/17 at 10:15 a.m. HR59 -10/11/17 at 11:05 a.m. HR 72 -10/18/17 at 1:29 p.m. HR 68 -10/25/17 at 11:29 a.m. HR 68 -11/1/17 at 10:02 a.m. HR 59 -11/8/17 at 1:38 p.m. HR 58 -11/15/17 1:38 p.m. HR 69 During an interview on 11/16/17, at 8:17 a.m., licensed practical nurse (LPN)-E she verified R63 had special instructions to hold Tenormin if heart rate was less than 60 and had vitals done weekly. LPN-E verified HR was not documented in the MAR and stated there were no an area on the MAR to document the HR. LPN-E further stated she had edited the MAR so that from now on it would prompt the licensed staff to fill in the HR after concern was brought to her attention. When asked when R63's vitals were taken LPN-E stated once a week when R63 received a shower and on occasion when R63's oxygen level was taken. During an interview on 11/16/17, at 9:03 a.m., registered nurse (RN)-E stated he spoke with the two licensed staff on the floor and that they checked the HR before they gave the medication but they did not document it on the MAR because "the computer is not asking them to." When asked his expectation of staff he stated "we have to follow the doctors order" and would expect to hold the medication and notify the doctor if the heart rate was not within the parameters. During an interview on 11/16/17, at 10:01a.m., RN-E verified the vital records documentation	F 329		

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 ______	11/16/2017

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

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F 329	Continued From page 24 was done by NA/TMA, would not use those results and the vitals record documentation in January 2017 and February 2017, which was done by licensed staff, was not done before the scheduled medication administration time of 8:00 a.m. During an interview on 11/16/17, at 12:02 p.m., R63's MD stated the order implied to take the heart rate before giving the medication but not that they document it. The MD further stated he assumed the vitals were taken daily and not weekly. Facility policy titled "Pharmaceutical (Medication) Administration Policy" with revision date of 5/2017, "Medications shall be administered to residents as prescribed by the primary physician/NP." "10. Administration of Medications: a. All medication will be given per physician's order."	F 329		
F 428 SS=D	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.45(c)(1)(3)-(5) c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 428		12/26/17

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F 428	Continued From page 25 (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the consultant pharmacist (CP) failed to	F 428	F428 – Immediate Plan of Correction	

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	245493	A. BUILDING ______ B. WING ______	11/16/2017

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F 428	Continued From page 26 ensure 1 of 5 residents (R63) pulse was checked as ordered prior to administering a Beta blocker (Atenolol) reviewed for unnecessary medications. Findings include: R63's Face Sheet dated 6/4/15, indicated current diagnoses hypertension (high blood pressure), diabetes mellitus (high blood sugar) and a history of falling. R63's care plan dated 6/26/17, indicated R63 had antihypertensive medication (medication to lower blood pressure) per NP/MD (nurse practitioner/doctor of medicine) orders. R63's annual Minimum Data Set (MDS), dated 8/9/17, indicated intact cognition with clear speech and able to make needs know without difficulty. Review of Physician Orders dated 11/7/17, with medication start date of 12/28/15, identified the use of Tenormin (atenolol medication used to treat high blood pressure) which directed staff to hold medication for heart rate (HR) <60 (less than 60). Review of documented vitals report taken by licensed staff from the months of January 2017 and February 2017 indicated no heart rate was recorded within the scheduled medication administration of 8:00 a.m. for Tenormin and no records were found after February 2017 for documentation of R63's HR. Review of consultant pharmacist communication to physician dated 9/15/117, 10/14/17 and 10/19/17, indicated no recommendations regarding lack of monitoring for R63's HR. Review of facility Medication Administration	F 428	The drug regimen of each patient/resident is reviewed monthly by the Consulting Pharmacist. As previously stated, the eMAR for R 63 was amended to require a documentation of heart rate prior to administration of Tenormin. Identification of Other Residents A facility wide audit of other residents with medication orders with parameters associated was conducted and necessary modifications were made. Measures Put in Place Health Unit Coordinators and Nurse Supervisors were educated on this practice of order transcription. Monitoring Mechanisms To ensure compliance, Medication reviews will include this criteria in monthly audits. Results will be reviewed with the Quality Improvement Committee. Consulting Pharmacist/Clinical Manages/DON.	

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F 428 — F 428

Continued From page 27
Records (MAR) from August 2017 through November 2017, noted the Tenormin was administered everyday with no documentation of R63's heart rate in the MAR.

Review of facility vitals report dated August 2017 through November 2017, indicated the only heart rate for R63 that were documented were taken by nursing assistants (NA) or trained medication administrator (TMA):

-8/2/17 at 10:02 a.m. HR 52
-8/9/17 at 10:03 a.m. HR 52
-8/16/17 at 1:36 p.m. HR64
-8/30/17 at 11:09 a.m. HR 63
-9/9/17 at 11:09 a.m. HR 57
-9/6/17 at 11:09 a.m. HR 57
-9/20/17 at 10:06 a.m. HR 68
-9/27/17 at 10:21 a.m. HR 64
-10/4/17 at 10:15 a.m. HR59
-10/11/17 at 11:05 a.m. HR 72
-10/18/17 at 1:29 p.m. HR 68
-10/25/17 at 11:29 a.m. HR 68
-11/1/17 at 10:02 a.m. HR 59
-11/8/17 at 1:38 p.m. HR 58
-11/15/17 1:38 p.m. HR 69

During an interview on 11/16/17, at 8:17 a.m., licensed practical nurse (LPN)-E verified R63 had special instructions to hold Tenormin if heart rate was less than 60 and had vitals done weekly. LPN-E verified HR was not documented in the MAR and stated there were no an area on the MAR to document the HR. LPN-E further stated she had edited the MAR so that from now on it would prompt the licensed staff to fill in the HR after concern was brought to her attention by surveyor. When asked when R63's vitals were taken LPN-E stated once a week when R63

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F 428	Continued From page 28 received a shower and on occasion when R63's oxygen level was taken. During an interview on 11/16/17, at 9:03 a.m., registered nurse (RN)-E stated he had spoken with the two licensed staff on the floor and that they checked the HR before they gave the medication but they did not document it on the MAR because "the computer is not asking them to." When asked his expectation of staff he stated "we have to follow the doctors order" and would expect to hold the medication and notify the doctor if the heart rate was not within the parameters. During an interview on 11/16/17, at 10:01 a.m. RN-E verified the vital records documentation was done by NA/TMA, would not use those results and the vitals record documentation in January 2017 and February 2017, which was done by licensed staff, was not done before the scheduled medication administration time of 8:00 a.m. During an interview on 11/16/17, at 12:52 p.m. consultant pharmacist indicated would expect staff to follow the order including the special instructions. Pharmacist further stated there was no way to know if it's being done if it was not documented, if the order says it they should be checking and documenting it somewhere. Pharmacist verified no documentation of R63's HR in the MAR. Pharmacist stated she periodically checks the vitals and MAR for recommendations and was not aware that R63's heart rate was not being monitored daily. Facility policy titled Drug Regimen Review revision date 11/2017, indicated "The consultant	F 428		

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F 428	Continued From page 29 pharmacist shall review the medication regimen of each resident at least monthly. This review includes a review of the resident's medical chart." In addition, the policy directed the pharmacist to make sure "i. Side effects, adverse reactions, and interactions are evaluated an modifications or alternatives are considered."	F 428		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals.	F 431		12/26/17

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F 431	Continued From page 30 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. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 2 of 7 medication carts were free of expired medications for 3 of 3 residents (R50, R31, R60). Findings include: On 11/16/17, from 11:45 a.m. through 2:00 p.m. the medication carts were reviewed. On inspection of the medication cart on the 1 north hall, the medication cart had an expired multi-use Insulin vial for R50. The multi-use vial of Novolog (Aspart) was opened on 10/16/17, and remained on the cart ready for use (fast-acting insulin used	F 431	F431 – Immediate Plan of Correction Expired medications were removed from med carts. Identification of Other Residents All medication carts were audited for expired meds. Measures Put in Place Education was provided to Licensed Nursing Staff and new table of Medication Storage and Expiration Guidelines was placed on each medication cart. Monitoring Mechanisms Each medication cart will be audited twice	

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F 431	Continued From page 31 to treat blood sugar). Once opened the vial was good for 28 days. LPN-E confirmed at 12:20 p.m. the Novolog (Aspart) had been opened 31 days ago and should have been discarded. R50 had a Physician's Order, 8/12/17, for Novolog (Aspart) 100 units/milliliter (ml) be administered per sliding scale subcutaneous (SQ) with meals. The medication cart on 1 East was check with RN-A at 12:45 p.m. on 11/16/17. RN-A confirmed the dates of expired medications. During the cart check on 1 East the following medications were expired: R31 had Aspercreme that had expired on 11/11. Aspercreme was a pain relieving heat gel/lotion. R60 had Minerin Creme had expired on 10/23/17. Minerin Creme was a therapeutic moisturizing creme designed to soothe and moisturize very dry sensitive skin. A policy and procedure for outdated medications was requested on 11/16/17, and received. The Pharmaceutical (Medication) Administration Policy, dated 5/17, indicated that insulin vials will be dated when opened and replaced in 28 days from the date opened. All items not required to be dated with date to discard sticker will be discarded per manufacturer expiration date. Expired or discontinued meds will be removed from the med room and destroyed or stored for recycling pick-up as indicated. Per A-S Medications Solutions package insert dated 12/7/16, read opened NovoLog vials should be thrown away after 28 days, even if they still	F 431	weekly for 1 month and then weekly for one month and then randomly to prevent recurrence. Audit outcomes will be reviewed by facility Quality Improvement Committee. Clinical Manager and DON responsible.	

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F 431	Continued From page 32 have insulin left in them.	F 431		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a	F 441		12/26/17

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F 441	Continued From page 33 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement appropriate infection control practices for 1 of 3 residents (R35) who was observed for personal cares. Findings include: On 11/15/17, at 6:56 a.m. nursing assistant	F 441	F441 – Immediate Plan of Correction Re-education was conducted immediately with NA-R identified at survey as not following principles of infection control. Measures Put in Place Re-education was provided to other NA-R's to ensure consistent practice.	

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F 441	Continued From page 34 (NA)-A was observed go into R35's room and shut the door. At 6:57 a.m. upon knocking at the door and going into R35's room, NA-A was observed set up R35's clothing and then NA-A washed their hands. At 7:01 a.m. NA-A approached R35 applied socks and pants as R35 was observed lift his left leg to help. At 7:03 a.m. NA-A then provided front pericare then cued R35 to turn to the left then was observed provide pericare in the bottom then gathered the soiled incontinent pad with wash towels she had used and threw them on the floor directly by the night stand. NA-A then removed gloves threw them on the floor. NA-A then went over to the sink area and applied another pair of gloves then came back to R35's bedside fastened the clean pad, pulled the pants up as R35 was observed reach out to the right grab bar to turn. At 7:07 a.m. NA-A approached the electric wheelchair with gloves and wheeled it close to bed then removed gloves tossed them to the floor again never washed hands applied a transfer belt and cued R35 to stand and was observed pivot and sat on the wheelchair. At 7:10 a.m. NA-A then applied another pair of gloves which were lying on the bed, maneuvered R35 wheelchair to in front of the sink area set up the tooth brush then folded the footrest and wheeled R35 close to sink. At 7:12 a.m. R35 was observed brush his teeth and rinsed his mouth. At 7:13 a.m. NA-A was observed pick the soiled linen and incontinent pad with gloves off the floor. When asked what the facility policy was for handling soiled linen and products, NA-A stated she was not supposed to throw the soiled linen, pad and used gloves on the floor. NA-A replied, "I did not have a bag." At 7:15 a.m. NA-A approached R35 assisted to wash the upper torso and face then maneuvered R35's wheelchair to his bed side and was	F 441	Monitoring Mechanisms Five random audits will be conducted weekly of hand washing/gloving/linen handling procedure for 2 months to ensure sustained compliance. Results will be reviewed with the Quality Improvement Committee. Staff Development/DON/ Clinical Managers responsible.	

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F 441	Continued From page 35 observed assist to apply the under shirt and top shirt. 7:19 a.m. NA-A removed the gloves never washed her hands since providing pericare. At 7:21 a.m. NA-A assisted R35 to maneuver the wheelchair to the entrance door then came back to the room got the soiled linen and soiled incontinent pad and left the room. As NA-A she left the room NA-A grabbed a paper towel and used it to turn off the staff light on the way out of the room. At 7:23 a.m. NA-A left the room went into soiled utility room and disposed the linen and garbage in the cans and then foamed out. At 7:25 a.m. when approached and asked about hand washing after removing gloves and doing pericare NA-A stated to her understanding if she stayed with the same resident providing cares it was okay to remove the gloves and apply another one without washing hands. She indicated she had done it that way for years. At 7:27 a.m. registered nurse (RN)-C stated it was not okay for NA-A to throw soiled linen, used gloves and incontinent pad on the floor. On 11/15/17, at 11:53 a.m. the infection control RN was interviewed about the observation of the handwashing, gloving and linens on the floor. The infection control RN indicated that should not happen. At 11:54 a.m. the director of nursing (DON) stated, "We pulled the nursing assistant aside and provided education." The DON further stated staff was supposed to wash hands after removing gloves and in between cares. The facility Handwashing/Sanitizing Procedure revised 10/17, directed staff to perform hand washing/sanitizing before and after providing care to the resident, after removing gloves and after each resident contact.	F 441		

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

F5493027

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245493	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 11/16/2017

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on November 16, 2017. At the time of this survey, Augustana Chapel View Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Augustana Chapel View Care Center is a 2-story split level building with a partial basement was determined to be built of Type II(111) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 108 beds and had a census of 102 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.