May 13, 2019

Administrator Augustana HCC Of Apple Valley 14650 Garrett Avenue Apple Valley, MN 55124

RE: Project Numbers H5264080C, H5264081C, H5264082C, H5264083C, H5264084C, H5264085C, H5264086C

Dear Administrator

On May 2, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health to investigate complaint number(s) H5264080C, H5264081C, H5264082C, H5264083C, H5264084C, H5264085C, H5264086C 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. The investigation resulted in no deficiencies being issued.

Also at the time of the investigation, the investigator also assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, found no violations of these rules promulgated under Minnesota Statute section 144.653 and/or Minnesota Statute section 144A.10.

The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction". This applies to federal deficiencies only. Electronically attached is your copy of the Federal Form CMS-2567 stating that no violations were noted at the time of this investigation.

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

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program

Minnesota Department of Health

Kumalu Fiske Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 07/16/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245264	B. WING			C 05/02/2019	
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY				14650	ET ADDRESS, CITY, STATE, ZIP CODE D GARRETT AVENUE LE VALLEY, MN 55124		
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F 000	survey was completed complaint investigated to be in compliance Requirements for L. The following comparison of t	gh 5/2/19, an abbreviated sted at your facility to conduct ations. Your facility was found with 42 CFR Part 483, cong Term Care Facilities. Dlaints were found to be no deficiencies cited:	FO	00			
LABORATOR	signature is not rec page of the CMS-2 correction is require acknowledge recei	led in ePOC and therefore a juired at the bottom of the first 567 form. Although no plan of ed, it is required that you pt of the electronic documents.	NATURE		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.

Electronically Signed

05/13/2019

PRINTED: 07/02/2019 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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	*****	NTION*****						
	NH LICENSING	CORRECTION ORDER						
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.						
	requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag ale number indicated below. In several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was						
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.						
	survey was conduct of state licensure.	TS: n 5/2/19, an abbreviated ted to determine compliance Your facility was found to be in a MN state licensure.						
	The following comp substantiated:	laint(s) were not found to be						

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

05/13/19 **Electronically Signed**

STATE FORM 6899 3S1G11 If continuation sheet 1 of 2

TITLE

(X6) DATE

Minnesota Department of Health

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Minnesota Department of Health STATE FORM