Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 19, 2023

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

RE: CCN: 245264
Cycle Start Date: May 12, 2023

Dear Administrator:

On May 12, 2023, a survey was completed at your facility by the Minnesota Department of Health, 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 August 12, 2023 (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).

In addition, if substantial compliance with the regulations is not verified by November 12, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	**14650 GARRETT AVENUE APPLE VALLEY, MN 55124**

(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 5/11/23 through 5/12/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities The following complaint was reviewed: H52642132C (MN93412) with a deficiency issued at F580 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 580	Continued From page 1 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician and family of a	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 580	Continued From page 2 change of condition in a timely manner for 1 of 1 (R1) residents reviewed. Findings include: R1's Diagnoses List indicated R1 had diagnoses of acute kidney failure, protein-calorie malnutrition, pancreatic mass, diabetes. R1's admission Minimum Data Set (MDS) assessment dated 5/4/23 indicated R1 was cognitively intact, was diabetic and was on insulin. R1's care plan dated 5/1/23 indicated R1 was at risk for decline in her medical condition and she had long term use of hypoglycemic drugs: Metformin. R1's Physician's Orders dated 5/3/23, indicated Novolog FlexPen insulin U (units)-100; 100unit/ml (milliliter): If blood sugar is 140 - 189, give 1 unit; if blood sugar is 190 - 239, give 2 units; if blood sugar is 240 - 289, give 3 units; if blood sugar is 290 - 339, give 4 units; if blood sugar is greater than 339, give 5 units subcutaneous (injection under the skin) three times a day before meals at 8:00 a.m., 11:30 a.m., and 5:30 p.m. Novolog insulin order was put on hold 5/5/23. R1's Physician's Orders dated 5/4/23 indicated Lantus U-100 insulin; 100 unit/ml: 70 units subcutaneous once a day at hs (bedtime). Lantus insulin order was discontinued 5/5/23. R1's Physician's Orders dated 5/2/23 indicated to check blood sugar twice a day, at 7:00 a.m. and 5:00 p.m. R1's medication administration record indicated	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 580	Continued From page 3 she received a first time dose of 70 units of Lantus insulin, on 5/4/23, between 7:00 p.m. to 10:00 p.m. (bedtime). R1's documented blood sugars on 5/5/23, were 37 at 7:00 a.m., 35 at 7:30 a.m., 86 at 8:00 a.m., 130 at 9:55 a.m., 214 at 12:00 p.m., 120 at 2:00 p.m., and 62 at 4:00 p.m. On 5/5/23, at 4:07 a.m. a progress note indicated R1 was sweaty and shaky with a blood glucose level (blood sugar) of 31 (critical low, normal blood glucose is 70-120). R1 was given a glass of apple juice, a glass of orange juice, and glass of cranberry juice. Writer then re-took blood glucose, it was 48. R1 was given a chocolate bar she had in her room. R1's progress note indicated staff would continue to monitor. R1's medical record lacked information the physician or a family member was made aware of the critically low blood glucose levels. On 5/5/23, at 10:04 a.m. a progress note indicated R1's family member was onsite, and her low blood sugars were discussed. The floor nurse was currently in with patient and managing blood sugar. PA (physician assistant) was aware and discontinued the new order for Lantus insulin which resident received last evening, Novolog SSI (sliding scale insulin) has been also placed on hold. On 5/11/23 at 3:49 p.m., licensed practical nurse (LPN)-A stated she started her shift at 6:30 a.m. on 5/5/23. She said LPN-B told her R1 was hypoglycemic overnight. LPN-A stated she gave R1 two cups of juice with five packets of sugar, chocolate pudding, and glucose gel. LPN-A	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 580	Continued From page 4 stated R1's blood sugar was 86 at 8:00 a.m. LPN-A stated she informed the provider at 8:30 a.m. of R1's change of condition. On 5/11/23 at 4:10 p.m., the physician assistant (PA)-A stated the triage team had received a message on 5/5/23, at 8:30 a.m. from LPN-A that R1 had been hypoglycemic overnight. On 5/12/23 at 9:56 a.m., family member (FM)-A stated she was not notified when R1's blood glucose levels dropped. FM-A confirmed that she was R1's emergency contact. FM-A stated she expected she would have been called for the change in her mother's condition. FM-A stated she had never made a request not to be notified during nighttime hours. On 5/12/23 at 10:10 a.m., FM-B she stated she came to the facility to visit R1 around 9:45 a.m. on 5/5/23. FM-B was immediately concerned about her mother upon her arrival. FM-B had not been advised of R1's change of condition prior to her arrival at the facility to visit. On 5/12/23, at 10:47 a.m. FM-C stated she arrived at the facility at 11:15 a.m., on 5/5/23. FM-C stated she was not advised of R1's change of condition prior to her arrival at the facility. FM-C stated she would have wanted her mother to be sent to the emergency room, if she had known. On 5/12/23, at 11:16 a.m. LPN-B stated at 3:00 a.m. on 5/5/23, she was made aware R1 felt warm. She took R1's vital signs and blood sugar. R1's blood sugar was 31, and she gave R1 orange juice. LPN-A checked the blood sugar again, it was 48. An hour later the blood sugar was 74. LPN-A stated she did not notify the	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 580	Continued From page 5 charge nurse on duty, the physician, or the family of R1's change of condition. LPN-A stated she advised the day shift nurse to keep an eye on R1, and notify the provider when LPN-A arrived for her shift on 5/5/23 at 6:30 a.m. On 5/12/23, at 11:45 a.m. the director of nursing (DON) stated it was her expectation for nurses to notify the provider at the time of the resident ' s change of condition, as well as to notify the facility charge nurse, and the family member. The DON confirmed the episode of low blood sugar would be considered a change of condition. Document review of Change of Condition Policy, dated 5/4/22 indicated: 1. The nurse will notify the resident ' s attending physician or physician on-call when there has been a(n): a) Accident or incident involving the resident c) Adverse reaction to medication d) Significant change in the resident ' s physical/emotional/mental condition e) Critical lab values f) Need to alter the resident ' s medical treatment significantly 2. A "significant change" of condition is a major decline or improvement in the resident ' s status that: a) Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions b) Impacts more than one area of the res health status 4. Unless otherwise instructed by the resident, a nurse will notify the resident ' s representative when:	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 580	Continued From page 6 a) The resident is involved in any accident/incident that results in injury b) There is a significant change in the resident ' s physical, mental, or psychosocial status 7. Facility staff will also notify the RN in charge or the RN on call as indicated when changes in resident condition occur.	F 580		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 19, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: NDVA11

Dear Administrator:

The above facility was surveyed on May 11, 2023 through May 12, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	**14650 GARRETT AVENUE APPLE VALLEY, MN 55124**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/11/23 through 5/12/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	**14650 GARRETT AVENUE APPLE VALLEY, MN 55124**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed: H52642132C (MN00093412) with a licensing order issued at 4658.0085 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician and family of a change of condition in a timely manner for 1 of 1 (R1) residents reviewed. Findings include: R1's Diagnoses List indicated R1 had diagnoses of acute kidney failure, protein-calorie malnutrition, pancreatic mass, diabetes. R1's admission Minimum Data Set (MDS) assessment dated 5/4/23 indicated R1 was cognitively intact, was diabetic and was on insulin. R1's care plan dated 5/1/23 indicated R1 was at risk for decline in her medical condition and she had long term use of hypoglycemic drugs: Metformin. R1's Physician's Orders dated 5/3/23, indicated Novolog FlexPen insulin U (units)-100; 100unit/ml (milliliter): If blood sugar is 140 - 189, give 1 unit; if blood sugar is 190 - 239, give 2 units; if blood sugar is 240 - 289, give 3 units; if blood sugar is 290 - 339, give 4 units; if blood sugar is greater than 339, give 5 units subcutaneous (injection under the skin) three times a day before meals at 8:00 a.m., 11:30 a.m., and 5:30 p.m. Novolog insulin order was put on hold 5/5/23.	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 4 R1's Physician's Orders dated 5/4/23 indicated Lantus U-100 insulin; 100 unit/ml: 70 units subcutaneous once a day at hs (bedtime). Lantus insulin order was discontinued 5/5/23. R1's Physician's Orders dated 5/2/23 indicated to check blood sugar twice a day, at 7:00 a.m. and 5:00 p.m. R1's medication administration record indicated she received a first time dose of 70 units of Lantus insulin, on 5/4/23, between 7:00 p.m. to 10:00 p.m. (bedtime). R1's documented blood sugars on 5/5/23, were 37 at 7:00 a.m., 35 at 7:30 a.m., 86 at 8:00 a.m., 130 at 9:55 a.m., 214 at 12:00 p.m., 120 at 2:00 p.m., and 62 at 4:00 p.m. On 5/5/23, at 4:07 a.m. a progress note indicated R1 was sweaty and shaky with a blood glucose level (blood sugar) of 31 (critical low, normal blood glucose is 70-120). R1 was given a glass of apple juice, a glass of orange juice, and glass of cranberry juice. Writer then re-took blood glucose, it was 48. R1 was given a chocolate bar she had in her room. R1's progress note indicated staff would continue to monitor. R1's medical record lacked information the physician or a family member was made aware of the critically low blood glucose levels. On 5/5/23, at 10:04 a.m. a progress note indicated R1's family member was onsite, and her low blood sugars were discussed. The floor nurse was currently in with patient and managing blood sugar. PA (physician assistant) was aware and discontinued the new order for Lantus insulin which resident received last evening, Novolog	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 5 SSI (sliding scale insulin) has been also placed on hold. On 5/11/23 at 3:49 p.m., licensed practical nurse (LPN)-A stated she started her shift at 6:30 a.m. on 5/5/23. She said LPN-B told her R1 was hypoglycemic overnight. LPN-A stated she gave R1 two cups of juice with five packets of sugar, chocolate pudding, and glucose gel. LPN-A stated R1's blood sugar was 86 at 8:00 a.m. LPN-A stated she informed the provider at 8:30 a.m. of R1's change of condition. On 5/11/23 at 4:10 p.m., the physician assistant (PA)-A stated the triage team had received a message on 5/5/23, at 8:30 a.m. from LPN-A that R1 had been hypoglycemic overnight. On 5/12/23 at 9:56 a.m., family member (FM)-A stated she was not notified when R1's blood glucose levels dropped. FM-A confirmed that she was R1's emergency contact. FM-A stated she expected she would have been called for the change in her mother's condition. FM-A stated she had never made a request not to be notified during nighttime hours. On 5/12/23 at 10:10 a.m., FM-B she stated she came to the facility to visit R1 around 9:45 a.m. on 5/5/23. FM-B was immediately concerned about her mother upon her arrival. FM-B had not been advised of R1's change of condition prior to her arrival at the facility to visit. On 5/12/23, at 10:47 a.m. FM-C stated she arrived at the facility at 11:15 a.m., on 5/5/23. FM-C stated she was not advised of R1's change of condition prior to her arrival at the facility. FM-C stated she would have wanted her mother to be sent to the emergency room, if she had known.	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 6 On 5/12/23, at 11:16 a.m. LPN-B stated at 3:00 a.m. on 5/5/23, she was made aware R1 felt warm. She took R1's vital signs and blood sugar. R1's blood sugar was 31, and she gave R1 orange juice. LPN-A checked the blood sugar again, it was 48. An hour later the blood sugar was 74. LPN-A stated she did not notify the charge nurse on duty, the physician, or the family of R1's change of condition. LPN-A stated she advised the day shift nurse to keep an eye on R1, and notify the provider when LPN-A arrived for her shift on 5/5/23 at 6:30 a.m. On 5/12/23, at 11:45 a.m. the director of nursing (DON) stated it was her expectation for nurses to notify the provider at the time of the resident ' s change of condition, as well as to notify the facility charge nurse, and the family member. The DON confirmed the episode of low blood sugar would be considered a change of condition. Document review of Change of Condition Policy, dated 5/4/22 indicated: 1. The nurse will notify the resident ' s attending physician or physician on-call when there has been a(n): a) Accident or incident involving the resident c) Adverse reaction to medication d) Significant change in the resident ' s physical/emotional/mental condition e) Critical lab values f) Need to alter the resident ' s medical treatment significantly 2. A "significant change" of condition is a major decline or improvement in the resident ' s status that: a) Will not normally resolve itself without intervention by staff or by implementing standard	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	**14650 GARRETT AVENUE APPLE VALLEY, MN 55124**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 7 disease related clinical interventions b) Impacts more than one area of the res health status 4. Unless otherwise instructed by the resident, a nurse will notify the resident ' s representative when: a) The resident is involved in any accident/incident that results in injury b) There is a significant change in the resident ' s physical, mental, or psychosocial status 7. Facility staff will also notify the RN in charge or the RN on call as indicated when changes in resident condition occur. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise the change of condition policy. The DON or designee could provide education to all nursing staff. The DON or designee could complete audits on staff knowledge, and present the result of these to the QAPI committee. TIME FOR CORRECTION: Twenty one (21) days.	2 265		