



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 15, 2026

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

RE: CCN: 245493

Cycle Start Date: September 2, 2026

Dear Administrator:

On September 2, 2026, 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 actual harm that was not immediate jeopardy (Level G). The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

- **Civil money penalty, (42 CFR 488.430 through 488.444).**

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 2, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS location may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

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

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245493		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/02/2026	
NAME OF PROVIDER OR SUPPLIER CHAPEL VIEW HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 615 MINNETONKA MILLS ROAD , HOPKINS, Minnesota, 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
F0000	INITIAL COMMENTS On 9/1/26 through 9/2/26, a standard abbreviated survey was conducted at your facility. Your facility was IN compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H54933978C (3180397) with a deficiency issued at F689, issued at past noncompliance. The provider implemented corrective action prior to survey, no plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.			F0000			
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure a resident remained free of an avoidable accident and injury for 1 of 3 residents (R1) reviewed when transferring with a mechanical lift R1 fell to the ground and required treatment for a head laceration. The noncompliance that began on 08/27/26 was corrected prior to the start of survey when the			F0689	"Past Noncompliance - no plan of correction required"		

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 reverse for further 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.

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

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F0689 SS = G	Continued from page 1 facility implemented a corrective action plan on 8/27/26. This is issued in past noncompliance. Findings include: R1's quarterly Minimum Data Set (MDS), dated 8/11/26 indicated he had diagnoses of dementia, depression, anxiety, muscle weakness and had contractures of his right elbow, right hand, and left hand. R1 had severe cognitive impairment and was dependent on staff for assistance with all cares, transfers, and mobility. R1's care plan, dated 11/26/25 indicated he was to be transferred with a full body mechanical lift, large sling and two staff. A facility report dated 8/27/26 indicated R1 was being transferred with a total body mechanical lift from the wheelchair to his bed by nursing assistant (NA)-A, without the assistance of another staff person. When she turned the lift to position R1 over the bed, he slipped out, fell from the sling, struck his head on the bedside table, and then fell to the floor. He was bleeding from his head and was transferred to the hospital. A hospital note, dated 8/27/26, indicated R1 sustained a laceration to the left parietal scalp which was repaired with four staples. A progress note on 8/29/26, indicated R1 had a fall while being transferred from the wheelchair to his bed at 8:00 p.m. and was sent to the hospital. A progress note on 8/29/26 indicated R1 had pain 10/10 and was treated with morphine. During an interview on 9/1/26, at 12:50 p.m., nurse manager (NM)-A stated R1's fall from the lift was preventable. He stated the second person is required for all full body mechanical lifts to double check for safety, ensuring the leg straps are crossed, and loops are connected to the lift securely. During an interview on 9/1/26, at 2:02 p.m., NA-A stated she was aware of the facility policy to have two staff present for all full body mechanical lifts but			F0689			

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F0689 SS = G	Continued from page 2 after waiting for 20 minutes, she decided to proceed on her own. She did not double-check to ensure the sling loops were secure on the total body mechanical lift when she transferred R1 independently. When she turned the lift, R1 fell to the floor, which was approximately a three-to-four-foot drop. He hit his head on the base of the over-the-bed table. She stated both upper loops of the sling came off the lift when he fell. During an interview on 9/1/26, at 3:18 p.m., licensed practical nurse (LPN)-A stated he was called into R1's room after he fell from the lift. He stated R1 was on the floor on his back. He stated he observed the sling still attached to the lift by three of the loops, with the left upper sling loop unattached. He stated NA-A did not follow R1's care plan or the facility policy when she transferred R1 by herself. During an interview on 9/2/26, at 9:40 a.m., the director of nursing (DON) stated two staff are always required for all full body mechanical lifts. She stated the purpose of the second person was to monitor safety issues. During an interview on 9/2/26, at 10:30 a.m., the EZ Way representative stated falls from the lift were preventable when used according to manufacturer instructions. During an interview on 9/2/26, at 10:20 a.m., the RN supervisor stated he was working when R1's fall from the lift occurred. He stated NA-A did not request assistance from him or address concerns of not having help available. He stated two people are always required when using the mechanical lift. He stated R1 said the fall was scary for him. The lift operator's instructions manual directed the lift was designed to be used by one caregiver. However, depending on the situation, facility policy, and the patient's condition, two caregivers may be necessary. It also directed to make a final check of all four loop attachment points to ensure each loop is sufficiently attached to the respective hook of the hangar bars. The facility Lifts and Stands policy, dated 3/10/25, directed when using a full-body lift, two staff members MUST be present.			F0689			

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F0689 SS = G	Continued from page 3 The facility Care Plan and Baseline Care Plan policy, dated 10/14/22, directed its rational was to provide a written guide for the care of the resident and to assist the resident to meet their needs for activities of daily living, health care, and psychosocial needs. The facility implemented corrective action prior to the start of the survey, this is issued at past noncompliance. Actions taken included: re-educated all nursing staff on transferring residents with a full body mechanical lift by completing demonstrations and return demonstrations, review of the lift policy, and review the safety precautions. The facility halted all lifts and initiated this education on 8/27/26 for all staff on all shifts. The facility was able to demonstrate monitoring of the corrective action and sustained compliance.			F0689			



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

Re: Event ID: 3438B9-H1

Dear Administrator:

The above facility survey was completed on September 2, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. 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. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive-like script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota Department of Health

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20000	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 9/1/26 through 9/2/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaint was reviewed during the survey: H54933978C (3180397). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal			20000			

Office of Primary Care and Health Systems Management

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Minnesota Department of Health

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20000	Continued from page 1 software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			20000			