Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 1, 2024

Administrator
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, MN 55343

RE: CCN: 245493
Cycle Start Date: June 26, 2024

Dear Administrator:

On July 30, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 1, 2024

Administrator
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, MN 55343

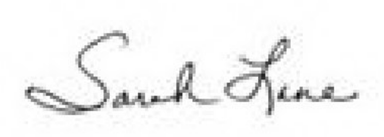
Re: Reinspection Results
Event ID: 2OBT12

Dear Administrator:

On July 30, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 26, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 3, 2024

Administrator
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, MN 55343

RE: CCN: 245493
Cycle Start Date: June 26, 2024

Dear Administrator:

On June 26, 2024, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

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

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 September 26, 2024 (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 December 26, 2024 (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,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 3, 2024

Administrator
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, MN 55343

Re: State Nursing Home Licensing Orders
Event ID: 2OBT11

Dear Administrator:

The above facility was surveyed on June 25, 2024 through June 26, 2024 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:

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

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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	C 06/26/2024

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 6/25/24 and 6/26/24, 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 complaints were reviewed. H54934736C (MN00104302) with a deficiency issued at F578 and F678. 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 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the	F 578		7/29/24

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

Electronically Signed | 07/14/2024

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
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F 578	Continued From page 1 requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed identify the preference for health care directives for seven of ten residents (R1, R2, R3, R4, R6, R7, and R10) reviewed for advanced directives. Findings include: R1's face sheet printed on 6/25/24 indicated R1 was admitted to the facility on 3/2/24 with a	F 578	It is the policy of Chapel View to comply with F578. Re: cited residents: All cited residents still in facility were offered the opportunity to make an advanced directive; R2, R3, R4, R6, R7, R10. POA paperwork has been added to R3's record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AUGUSTANA CHAPEL VIEW CARE CENTER	**615 MINNETONKA MILLS ROAD HOPKINS, MN 55343**

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F 578	Continued From page 2 primary diagnosis of multiple sclerosis. Additional diagnoses included acute diastolic heart failure, acute embolism, thrombosis of unspecified deep veins of proximal lower extremities, acute respiratory failure with hypoxia, encephalopathy, neoplasm of uncertain behavior of meninges, and chronic systolic heart failure. R1's face sheet indicated R1 was the responsible party. R1's care plan printed 6/25/24 indicated R1 had cognitive loss/dementia. R1's brief interview for mental status (BIMS) assessment completed 6/4/24 indicated R1 had a score of 13, which indicated R1 had severe cognitive impairment. R1's care conference completed on 6/13/24 indicated R1 did not have any type of advance directive. The care conference asked if R1's provider orders for life sustaining treatment (POLST) was reviewed and facility staff marked that staff reviewed R1's POLST. R1's record was reviewed for POLST and advance directive. R1 had a banner in her electronic health record that indicated R1 was a full code, but no documentation to corroborate the full code status. R1's record review indicated no progress note was made that facility staff offered advance directive or POLST planning to R1. R2's face sheet printed on 6/26/24 indicated R1 was admitted to the facility on 11/2/23 with a primary diagnosis of catatonic schizophrenia-malignant catatonia. R2's additional diagnoses included bipolar disorder, chronic obstructive pulmonary disease, unspecified injury of the head/multiple closed	F 578	Actions to identify other potential residents affected: Other residents with potential to be affected will be reviewed at care conference as scheduled and offered opportunity to complete an Advance Directive. Measures put into place to ensure deficient practice will not recur: Code status, POLST, Advance Directive policy was reviewed with Social Services. Monitoring to ensure the deficient practice is corrected: New admissions will be audited weekly for 2 months to ensure Code Status/POLST/Advance Directives are in place or have been offered and orders match wishes. Random audits will then be done to ensure ongoing compliance. Results will be reviewed quarterly by facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Social Services and Administrator responsible.	

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F 578	Continued From page 3 head injuries, and conversion disorder with seizures or convulsions. R2's face sheet indicated R2 has a power of attorney. R2's progress note dated 11/2/24 indicated R2 was admitted to the facility while on hospice. R2's BIMS assessment completed on 5/1/24 indicated R2 had a score of 6, which indicated R2 had severe cognitive impairment. R2's care conference completed on 5/16/24 indicated R2's POLST was reviewed and R2 did not have any type of advance directive. R2's medication administration record (MAR) printed on 6/26/24 indicated R2 was admitted to Allina Hospice for a diagnosis of moderate protein-calorie and a prognosis of 6 months or less. R2's record was reviewed for a POLST and advance directive. Documentation showed the facility inserted a POLST into R2's electronic medical record during the time the surveyor was at the facility, however the POLST was not signed by a provider. R2's documents showed he did not have an advance directive. R2's record review indicated no progress note was made that facility staff offered advance directive planning to R2. R3's face sheet printed on 6/26/24 indicated R3 was admitted to the facility on 7/8/22 with a primary diagnosis of agoraphobia with panic disorder. R3's additional diagnoses included mild cognitive impairment of uncertain or unknown etiology, unspecified psychosis not due to a substance or known physiological condition, and adult failure to thrive. R3's face sheet indicated	F 578		

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F 578	Continued From page 4 R3 has a power of attorney. R3's BIMS assessment completed on 4/2/24 indicated R3 had a score of 2, which indicated R2 had severe cognitive impaired. R3's care conference completed on 4/11/24 indicated R3's POLST was review and that she did not have an advance directive. R3's record was reviewed for POLST and advance directive. R3's record review indicated R3 had a POLST but did not have an advance directive. R3's record review indicated R3 did not have power of attorney paperwork, or a progress note was made that facility staff offered advance directive planning to R3. R4's face sheet indicated R4 was admitted to the facility on 11/28/23 with a primary diagnosis of adult failure to thrive. R4's additional diagnoses included acute kidney failure, hallucinations, dementia, and nonrheumatic mitral valve insufficiency. R4's face sheet indicated R4 did not have a power of attorney. R4's BIMS assessment completed on 6/4/24 indicated R4 had a score of 0, which indicated R4 had severe cognitive impaired. R4's care conference completed 6/13/24 indicated R4 had a POLST but did not have an advance directive. R4's progress note dated 12/1/23 indicated R4 was not her own responsible part and that her son manages her affairs. R4's record was reviewed for POLST and	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 578	Continued From page 5 advance directive. R4's record review indicated R4 had a POLST but did not have an advance directive. R4's record review indicated no progress note was made that facility staff offered advance directive planning to R4. R6's face sheet printed on 6/26/24 indicated R6 was admitted to the facility on 9/28/22 with a primary diagnosis of Alzheimer's disease with late onset. R6's additional diagnoses included personal history of transient ischemic attach and dysphagia. R6's face sheet indicated had an emergency contact but did not indicate if the contact was R6's power of attorney. R6's care conference completed 3/28/24 indicated R6 had a POLST but did not indicate R6 had an advance directive. R6's BIMS assessment completed 6/18/24 indicated R6 had a score of 0, which indicated R6 had severe cognitive impaired. R6's record was reviewed for POLST and advance directive. R6's record review indicated R6 had a POLST but did not have an advance directive. R6's record review indicated no progress note was made that the facility staff offered advance directive planning to R6. R7's face sheet printed on 6/26/24 indicated R7 was admitted to the facility on 7/28/23 with a primary diagnosis of an infection following a procedure. R7's additional diagnoses included fluid and electrolyte imbalanced, anemia, and chronic peripheral venous insufficiency. R7's face sheet indicated R7 had an emergency contact but did not indicate a power of attorney.	F 578		

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F 578	Continued From page 6 R7's BIMS assessment completed on 6/11/24 indicated R7 had a score of 15, which indicated R7 had been cognitively intact. R7's care conference completed on 6/20/24 indicated R7 had a POST but did not have an advance directive. R7's record was reviewed for POLST and advance directive. R7's record review indicated R7 had a POLST but did not have an advance directive. R7's record review indicated no progress note was made that the facility staff offered advance directive planning to R7. R10's face sheet printed on 6/26/24 indicated R10 was admitted to the facility on 3/26/24 with a primary diagnosis of cerebral infarction with left sided neglect. R10's additional diagnoses included dysphagia, facial weakness, atherosclerotic heart disease of native coronary artery without angina pectoris, and personal history of transient ischemic attack. R10's care conference completed on 3/28/24 indicated R10 had a POLST but did not have an advance directive. R10's progress note dated 6/21/24 indicated the social worker spoke with Volunteers of America R10's BIMS assessment completed on 6/25/24 indicated R10 had a score of 14, which indicated R10 was cognitively intact. R10's record was reviewed for POLST and advance directive. R10's record review indicated R7 had a POLST but did not have an advance directive. R7's record review indicated no	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AUGUSTANA CHAPEL VIEW CARE CENTER	**615 MINNETONKA MILLS ROAD HOPKINS, MN 55343**

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F 578	Continued From page 7 progress note was made that the facility staff offered advance directive planning to R10. During an interview with social services (SS)-A on 6/25/24 at 1:48 p.m., SS-A stated she worked with the transitional care unit (TCU) residents. SS-A stated she will review the resident's POLST and advance directive during the resident's care conference. During an interview with SS-B on 6/25/24 at 1:53 p.m., SS-B stated she worked with the long-term care residents. SS-B stated she reviewed the POLST and advance directive at the resident's care conference. During an interview with family member (FM)-A on 6/25/24 at 2:33 p.m., FM-A stated the facility's admission staff attempted to meet with himself and R1 to talk about an advance directive, but the meeting never occurred. FM-A stated he attempted to meet with the admissions team several times to make an advance directive for R1. FM-A stated R1 would not have been able to tell the facility her wishes for advance planning. During an interview with the director of nursing (DON) on 6/25/24 at 3:15 p.m., the DON stated the facility determines the resident's wishes at the end of life by looking at their code status from the admitting paperwork, which was most likely to be discharge papers from a hospital. The DON stated the facility would verify the code status with the residents during their care conference. The DON stated neither a POLST or advance directive is required for their residents. The DON stated the facility did not have any documentation of facility staff offering advance planning. The DON stated the facility management team	F 578		

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	245493	A. BUILDING _____ B. WING _____	C 06/26/2024

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F 578	Continued From page 8 attempted to get an advance directive from R1 or family, but the facility management team was never able to connect with R1. The DON stated she would expect herself and staff to ask residents in an emergency situation if they want certain treatments but was unsure what facility staff would when a resident became unresponsive. An advance directive policy was requested, and none was received.	F 578		
F 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility could not ensure staff were properly trained in basic life support (BLS) including cardiopulmonary resuscitation (CPR) to provide BLS/CPR to residents requiring such care for 18 of 62 licensed staff records registered nurse(RN)-A, RN-B, RN-C, RN-D, RN-E, RN-F, RN-G, RN-H, RN-L, licensed practical nurse (LPN)-A, LPN-B, LPN-C, LPN-D, LPN-E, LPN-F, LPN-G, LPN-H, and LPN-I) when reviewed for BLS/CPR training. The facility contacted licensed staff for proof of BLS/CPR Certification and obtained five more staff BLS/CPR certifications. Findings include:	F 678	It is the policy of Chapel View to comply with F 678 Re: cited staff: Current CPR certifications have been obtained and are on file for all licensed RN□s and LPN□s listed. One RN cited has been termed for personal reasons. Actions to identify other potential residents affected: NA Monitoring to ensure the deficient practice is corrected: Checklist has been reviewed to ensure all required elements for licensure and certification are in place upon hire.	7/29/24

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F 678	Continued From page 9 The facility provided a BLS/CPR book for staff who have a BLS/CPR certification. The book was reviewed and did not contain BLS/CPR certificates for RN-A, RN-B, RN-C, RN-D, RN-E, RN-F, RN-G, RN-H, RN-L, LPN-B, LPN-C, LPN-D, LPN-E, LPN-F, LPN-G, LPN-H, and LPN-I. LPN-A's certification was expired. LPN-A's personnel record was reviewed. LPN-A's BLS certificate indicated LPN-A took an online course on 1/17/24 without hands-on practice or in-person skill assessment. During an interview with licensed practical nurse (LPN)-A on 6/25/24 at 2:44 p.m., LPN-A stated he was CPR certified and took his CPR course online. During an interview with the director of nursing (DON) on 6/25/24 at 3:15 p.m., the DON stated all RN's and LPN's working in the facility are CPR certified. During an interview with the staff development coordinator (SDC) on 6/26/24 at 9:04 a.m., the SDC stated she knew that some of the licensed staff working in the facility have taken the CPR class but had not given her their BLS certificates. The SDC stated BLS classes offered in the facility twice a year. The SDC stated if a licensed staff BLS certificate was expiring and they did not have a BLS class yet, she would let the licensed staff wait until the next class was offered even though their BLS certificate would expire before the next class was offered. The SDC stated she sent a text message to RN-A, RN-B, RN-C, RN-D, RN-E, RN-F, RN-G, RN-H, LPN-B, LPN-C, LPN-D, LPN-E, LPN-F, LPN-G, LPN-H to obtain	F 678	Licensed staff will be required to have current CPR certification prior to date of hire. Staff Development will monitor all current and future BLS/CPR Certifications to ensure that all employees complete hands-on training, opposed to online-only courses. Measures put into place to ensure deficient practice will not recur: Checklist will be audited monthly for two months to ensure ongoing compliance. Random audits will then be conducted to ensure ongoing compliance. Results will be reviewed quarterly by facility QAPI committee and they will make the decision if further monitoring/audits are recommended. DON/Staff Development responsible.	

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F 678	Continued From page 10 their BLS certificates. On 6/26/24 at 9:12 a.m. email correspondence to SDC requesting RN-A, RN-B, RN-C, RN-D, RN-E, RN-F, RN-G, RN-H, LPN-B, LPN-C, LPN-D, LPN-E, LPN-F, LPN-G, LPN-H BLS certificates. SDS responded by email on 6/26/24 at 11:28 a.m., the SDC indicated she received BLS certificates from RN-E, RN-F, RN-G, LPN-H, and LPN-I. The SDC stated LPN-G was hired on 4/15/24, LPN-G BLS certificate was expired, and was told she could wait until the next BLS that was being offered in August 2024. During an interview with the SDC on 6/26/24 at 12:11 p.m., the SDC stated she was not going to be able to provide the remaining BLS certificates today. The SDC stated she kept "bugging" the licensed staff to get the BLS certificates to her. The SDC stated RN-A, RN-B, RN-C, and LPN-D work on-call for the facility. The SDC stated RN-D, LPN-B, and LPN-F work at the facility every other weekend. The SDC stated some of the licensed staff take their BLS class through their other jobs and the SDC reminded the employees to bring in their BLS certificates. The SDC stated all she could do was remind the licensed staff to bring in their BLS certificates. The SDC stated there was not disciplinary action against the employees for not getting the SDC their BLS certificates. The SDC stated "it is not like I am going to fire them for not getting their certificates to me". During an interview with the DON on 6/26/24 at 12:20 p.m., the DON stated the BLS instructor that held the BLS at the facility emails the employees their BLS certificate and it is the responsibility of the employee to get the facility	F 678		

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F 678	Continued From page 11 those certificates. The DON stated there was not any disciplinary action for the employees who did not bring in their BLS certificates. The DON stated she knew which licensed staff was BLS certified and who was not BLS certified by communicating with the licensed staff. During an interview with the administrator on 6/26/24 at 12:46 p.m., the administrator stated he was not sure why the BLS certificates were not in the employee's files. The administrator stated he would know which licensed staff were BLS certified, and which licensed staff were not BLS certified by completing a facility audit. The administrator stated he had not done a facility audit as he had been the administrator at the facility for two weeks. A BLS/CPR policy was requested from the facility, and none was received.	F 678		

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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 6/25/24 and 6/26/24, 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(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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

Electronically Signed | 07/14/24

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed. H54934736C (MN00104302) with a licensing order issued at (1830) 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	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of 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		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family	21830		7/29/24

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21830	Continued From page 3 member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated	21830		

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21830	Continued From page 4 emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed identify the preference for health care directives for seven of ten residents (R1, R2, R3, R4, R6, R7, and R10) reviewed for advanced directives. Findings include: R1's face sheet printed on 6/25/24 indicated R1 was admitted to the facility on 3/2/24 with a primary diagnosis of multiple sclerosis. Additional diagnoses included acute diastolic heart failure, acute embolism, thrombosis of unspecified deep veins of proximal lower extremities, acute respiratory failure with hypoxia, encephalopathy, neoplasm of uncertain behavior of meninges, and chronic systolic heart failure. R1's face sheet indicated R1 was the responsible party.	21830	Corrected.	

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21830	Continued From page 5 R1's care plan printed 6/25/24 indicated R1 had cognitive loss/dementia. R1's brief interview for mental status (BIMS) assessment completed 6/4/24 indicated R1 had a score of 13, which indicated R1 had severe cognitive impairment. R1's care conference completed on 6/13/24 indicated R1 did not have any type of advance directive. The care conference asked if R1's provider orders for life sustaining treatment (POLST) was reviewed and facility staff marked that staff reviewed R1's POLST. R1's record was reviewed for POLST and advance directive. R1 had a banner in her electronic health record that indicated R1 was a full code, but no documentation to corroborate the full code status. R1's record review indicated no progress note was made that facility staff offered advance directive or POLST planning to R1. R2's face sheet printed on 6/26/24 indicated R1 was admitted to the facility on 11/2/23 with a primary diagnosis of catatonic schizophrenia-malignant catatonia. R2's additional diagnoses included bipolar disorder, chronic obstructive pulmonary disease, unspecified injury of the head/multiple closed head injuries, and conversion disorder with seizures or convulsions. R2's face sheet indicated R2 has a power of attorney. R2's progress note dated 11/2/24 indicated R2 was admitted to the facility while on hospice. R2's BIMS assessment completed on 5/1/24 indicated R2 had a score of 6, which indicated R2	21830		

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21830	Continued From page 6 had severe cognitive impairment. R2's care conference completed on 5/16/24 indicated R2's POLST was reviewed and R2 did not have any type of advance directive. R2's medication administration record (MAR) printed on 6/26/24 indicated R2 was admitted to Allina Hospice for a diagnosis of moderate protein-calorie and a prognosis of 6 months or less. R2's record was reviewed for a POLST and advance directive. Documentation showed the facility inserted a POLST into R2's electronic medical record during the time the surveyor was at the facility, however the POLST was not signed by a provider. R2's documents showed he did not have an advance directive. R2's record review indicated no progress note was made that facility staff offered advance directive planning to R2. R3's face sheet printed on 6/26/24 indicated R3 was admitted to the facility on 7/8/22 with a primary diagnosis of agoraphobia with panic disorder. R3's additional diagnoses included mild cognitive impairment of uncertain or unknown etiology, unspecified psychosis not due to a substance or known physiological condition, and adult failure to thrive. R3's face sheet indicated R3 has a power of attorney. R3's BIMS assessment completed on 4/2/24 indicated R3 had a score of 2, which indicated R2 had severe cognitive impaired. R3's care conference completed on 4/11/24 indicated R3's POLST was review and that she did not have an advance directive.	21830		

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21830	Continued From page 7 R3's record was reviewed for POLST and advance directive. R3's record review indicated R3 had a POLST but did not have an advance directive. R3's record review indicated R3 did not have power of attorney paperwork, or a progress note was made that facility staff offered advance directive planning to R3. R4's face sheet indicated R4 was admitted to the facility on 11/28/23 with a primary diagnosis of adult failure to thrive. R4's additional diagnoses included acute kidney failure, hallucinations, dementia, and nonrheumatic mitral valve insufficiency. R4's face sheet indicated R4 did not have a power of attorney. R4's BIMS assessment completed on 6/4/24 indicated R4 had a score of 0, which indicated R4 had severe cognitive impaired. R4's care conference completed 6/13/24 indicated R4 had a POLST but did not have an advance directive. R4's progress note dated 12/1/23 indicated R4 was not her own responsible part and that her son manages her affairs. R4's record was reviewed for POLST and advance directive. R4's record review indicated R4 had a POLST but did not have an advance directive. R4's record review indicated no progress note was made that facility staff offered advance directive planning to R4. R6's face sheet printed on 6/26/24 indicated R6 was admitted to the facility on 9/28/22 with a primary diagnosis of Alzheimer's disease with late onset. R6's additional diagnoses included personal history of transient ischemic attach and	21830		

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(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
21830	Continued From page 8 dysphagia. R6's face sheet indicated had an emergency contact but did not indicate if the contact was R6's power of attorney. R6's care conference completed 3/28/24 indicated R6 had a POLST but did not indicate R6 had an advance directive. R6's BIMS assessment completed 6/18/24 indicated R6 had a score of 0, which indicated R6 had severe cognitive impaired. R6's record was reviewed for POLST and advance directive. R6's record review indicated R6 had a POLST but did not have an advance directive. R6's record review indicated no progress note was made that the facility staff offered advance directive planning to R6. R7's face sheet printed on 6/26/24 indicated R7 was admitted to the facility on 7/28/23 with a primary diagnosis of an infection following a procedure. R7's additional diagnoses included fluid and electrolyte imbalanced, anemia, and chronic peripheral venous insufficiency. R7's face sheet indicated R7 had an emergency contact but did not indicate a power of attorney. R7's BIMS assessment completed on 6/11/24 indicated R7 had a score of 15, which indicated R7 had been cognitively intact. R7's care conference completed on 6/20/24 indicated R7 had a POST but did not have an advance directive. R7's record was reviewed for POLST and advance directive. R7's record review indicated R7 had a POLST but did not have an advance directive. R7's record review indicated no	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00727	A. BUILDING: _____ B. WING _____	C 06/26/2024

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21830	Continued From page 9 progress note was made that the facility staff offered advance directive planning to R7. R10's face sheet printed on 6/26/24 indicated R10 was admitted to the facility on 3/26/24 with a primary diagnosis of cerebral infarction with left sided neglect. R10's additional diagnoses included dysphagia, facial weakness, atherosclerotic heart disease of native coronary artery without angina pectoris, and personal history of transient ischemic attack. R10's care conference completed on 3/28/24 indicated R10 had a POLST but did not have an advance directive. R10's progress note dated 6/21/24 indicated the social worker spoke with Volunteers of America R10's BIMS assessment completed on 6/25/24 indicated R10 had a score of 14, which indicated R10 was cognitively intact. R10's record was reviewed for POLST and advance directive. R10's record review indicated R7 had a POLST but did not have an advance directive. R7's record review indicated no progress note was made that the facility staff offered advance directive planning to R10. During an interview with social services (SS)-A on 6/25/24 at 1:48 p.m., SS-A stated she worked with the transitional care unit (TCU) residents. SS-A stated she will review the resident's POLST and advance directive during the resident's care conference. During an interview with SS-B on 6/25/24 at 1:53 p.m., SS-B stated she worked with the long-term care residents. SS-B stated she reviewed the	21830		

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21830	Continued From page 10 POLST and advance directive at the resident's care conference. During an interview with family member (FM)-A on 6/25/24 at 2:33 p.m., FM-A stated the facility's admission staff attempted to meet with himself and R1 to talk about an advance directive, but the meeting never occurred. FM-A stated he attempted to meet with the admissions team several times to make an advance directive for R1. FM-A stated R1 would not have been able to tell the facility her wishes for advance planning. During an interview with the director of nursing (DON) on 6/25/24 at 3:15 p.m., the DON stated the facility determines the resident's wishes at the end of life by looking at their code status from the admitting paperwork, which was most likely to be discharge papers from a hospital. The DON stated the facility would verify the code status with the residents during their care conference. The DON stated neither a POLST or advance directive is required for their residents. The DON stated the facility did not have any documentation of facility staff offering advance planning. The DON stated the facility management team attempted to get an advance directive from R1 or family, but the facility management team was never able to connect with R1. The DON stated she would expect herself and staff to ask residents in an emergency situation if they want certain treatments but was unsure what facility staff would when a resident became unresponsive. An advance directive policy was requested, and none was received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to	21830		

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21830	Continued From page 11 determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21830		