

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245493	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/26/2024
NAME OF PROVIDER OR SUPPLIER  Augustana Chapel View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  615 Minnetonka Mills Road Hopkins, MN 55343	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49618</p> <p>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.</p> <p>Findings include:</p> <p>R1's face sheet printed on 6/25/24 indicated R1 was admitted to the facility on [DATE] 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.</p> <p>R1's care plan printed 6/25/24 indicated R1 had cognitive loss/dementia.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>R2's face sheet printed on 6/26/24 indicated R1 was admitted to the facility on [DATE] 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.</p> <p>R2's progress note dated 11/2/24 indicated R2 was admitted to the facility while on hospice.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R2's BIMS assessment completed on 5/1/24 indicated R2 had a score of 6, which indicated R2 had severe cognitive impairment.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>R3's face sheet printed on 6/26/24 indicated R3 was admitted to the facility on [DATE] 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.</p> <p>R3's BIMS assessment completed on 4/2/24 indicated R3 had a score of 2, which indicated R2 had severe cognitive impaired.</p> <p>R3's care conference completed on 4/11/24 indicated R3's POLST was review and that she did not have an advance directive.</p> <p>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.</p> <p>R4's face sheet indicated R4 was admitted to the facility on [DATE] 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.</p> <p>R4's BIMS assessment completed on 6/4/24 indicated R4 had a score of 0, which indicated R4 had severe cognitive impaired.</p> <p>R4's care conference completed 6/13/24 indicated R4 had a POLST but did not have an advance directive.</p> <p>R4's progress note dated 12/1/23 indicated R4 was not her own responsible part and that her son manages her affairs.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>R6's face sheet printed on 6/26/24 indicated R6 was admitted to the facility on [DATE] with a primary diagnosis of Alzheimer's disease with late onset. R6's additional diagnoses included personal history of transient ischemic attack and dysphagia. R6's face sheet indicated had an emergency contact but did not indicate if the contact was R6's power of attorney.</p> <p>R6's care conference completed 3/28/24 indicated R6 had a POLST but did not indicate R6 had an advance directive.</p> <p>R6's BIMS assessment completed 6/18/24 indicated R6 had a score of 0, which indicated R6 had severe cognitive impaired.</p> <p>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.</p> <p>R7's face sheet printed on 6/26/24 indicated R7 was admitted to the facility on [DATE] 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.</p> <p>R7's BIMS assessment completed on 6/11/24 indicated R7 had a score of 15, which indicated R7 had been cognitively intact.</p> <p>R7's care conference completed on 6/20/24 indicated R7 had a POST but did not have an advance directive.</p> <p>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.</p> <p>R10's face sheet printed on 6/26/24 indicated R10 was admitted to the facility on [DATE] 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.</p> <p>R10's care conference completed on 3/28/24 indicated R10 had a POLST but did not have an advance directive.</p> <p>R10's progress note dated 6/21/24 indicated the social worker spoke with Volunteers of America</p> <p>R10's BIMS assessment completed on 6/25/24 indicated R10 had a score of 14, which indicated R10 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>An advance directive policy was requested, and none was received.</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49618</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>LPN-A's personnel record was reviewed. LPN-A's BLS certificate indicated LPN-A took an online course on [DATE] without hands-on practice or in-person skill assessment.</p> <p>During an interview with licensed practical nurse (LPN)-A on [DATE] at 2:44 p.m., LPN-A stated he was CPR certified and took his CPR course online.</p> <p>During an interview with the director of nursing (DON) on [DATE] at 3:15 p.m., the DON stated all RN's and LPN's working in the facility are CPR certified.</p> <p>During an interview with the staff development coordinator (SDC) on [DATE] 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 their BLS certificates.</p> <p>On [DATE] 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 [DATE] 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 [DATE], LPN-G BLS certificate was expired, and was told she could wait until the next BLS that was being offered in [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the SDC on [DATE] 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.</p> <p>During an interview with the DON on [DATE] 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 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.</p> <p>During an interview with the administrator on [DATE] 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.</p> <p>A BLS/CPR policy was requested from the facility, and none was received.</p>