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	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augustana Chapel View Care Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively assess and appropriately monitor 2 of 3 residents (R5, R13) with acute illnesses including but not limited to influenza that resulted in hospitalization reviewed for change of condition. Findings include: See F880 for additional information about facility's infection control and prevention practices regarding influenza. R5 R5's quarterly Minimum Data Set, dated [DATE], indicated R5 admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension, type 2 diabetes, hyperkalemia (elevated blood level of potassium), and acute and chronic respiratory failure. R5 used supplemental oxygen therapy and was cognitively intact. R5's care plan problems dated 7/7/23, identified R5 was at risk for decline in medical condition with intervention to monitor for changes in condition and notify provider and resident representative as indicated. R5's care plan identified R5 had shortness of breath (SOB) with exertion and when the head of the bed was flat and required oxygen (O2) therapy. Interventions included administer oxygen per physician orders, monitor oxygen saturation (SpO2) via pulse oximetry (device to measure blood oxygen saturation levels) per protocol and as needed, and monitor/document respiratory status per protocol and as needed. R5's care plan identified R5 was alert and oriented and included intervention to monitor for changes in cognition and notify provider as needed. R5's physician orders included the following: - Order dated 7/6/23, to check O2 saturations as needed for increased breathing difficulty. - Order dated 7/7/23, to auscultate (listen to with a stethoscope) lung sounds, make a progress note if abnormal lung sounds are present, and notify provider if indicated once a day for CHF. - Order dated 7/7/23, to note level of edema and respiratory effort daily, make a progress note if any abnormal findings, and notify provider of concerns once a day as indicated for CHF. - Order dated 4/15/24 for 3 liters (L) of continuous oxygen via nasal cannula. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Order dated 5/2/24, for vital signs weekly with bath on Thursdays. - Order dated 7/3/24, to check blood glucose (blood sugar) levels once a week on Wednesday mornings. R5's progress note dated 4/6/25 at 10:29 p.m., indicated she was alert and oriented, denied pain or SOB, and had stable O2 at her baseline of 3L. R5's progress note dated 4/8/25 at 12:21 p.m., identified R5 had a change in condition. R5 was confused to place and time, unable to express her needs, words did not come out clearly, and she only verbalized her name. The presence of a cough was noted as well as poor appetite with refusal of meals. The note indicated R5's vital signs were stable and she denied pain, SOB, fever, abdominal discomfort, nausea/vomiting, dizziness, or headache. She had no signs of respiratory distress with cares or activities. The provider was notified and ordered STAT (immediate) laboratory studies (labs) for a complete blood count (CBC), basic metabolic panel (BMP), COVID-19, respiratory syncytial virus (RSV), influenza, and a urinalysis and urine culture (UA/UC). Samples for RSV, influenza, and COVID-19, and UA/UC were collected and in the fridge for lab to pick up with CBC and BMP still pending. The note identified at this time the staff will continue to monitor, and offer more fluids. See F770 for additional information regarding lack of timely completion of ordered labs. R5's provider note by nurse practitioner (NP)-A dated 4/9/25, indicated R5 was seen for an acute visit. The note included staff noted R5 had increased confusion a day ago and she was usually alert at baseline. Labs for COVID-19, influenza A and B, RSV, a urinalysis, CBC, and BMP were ordered but results were still pending. The facility had influenza cases. On 4/9/25, R5 has declined in condition, is more confused, lethargic, face flashed [sic, flushed] with shallow breathes [sic, breaths] on 4L of oxygen. Sats [SpO2] 86-88% . has not been able to keep food down . today's BG [blood glucose] 412. Physical examination noted R5 was confused and lethargic with rales (crackle sounds heard when listening to the lungs) and shallow breaths. The plan was to send R5 to the hospital for further evaluation. R5's progress note dated 4/9/25 at 9:56 a.m., indicated R5 was confused, slow to respond, very weak, and showed signs of distress. Vital signs were blood pressure 123/76, SpO2 88% on 4L of O2, blood sugar 417, heart rate 116, and temperature 97.3 degrees Fahrenheit (F). Interventions were elevating the head of the bed and a nebulizer treatment (respiratory medication administered via inhalation). R5 was sent to the emergency room and daughter notified. R5's vital signs record from 4/8/25 through 4/9/25, included the following: - 4/8/25 at 12:16 a.m.: SpO2 95% on 3L of O2 - 4/8/25 at 7:54 a.m.: Blood pressure 108/72 - 4/8/25 at 1:14 p.m.: SpO2 92% on 3L of O2 - 4/8/25 at 10:17 p.m.: SpO2 92% on 3L of O2 - 4/9/25 at 6:26 a.m.: SpO2 93% on 3L of O2 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 4/9/25 at 8:00 a.m.: Pain score of zero, blood sugar 417 milligrams per deciliter (mg/dL), SpO2 88% on 3L of O2, blood pressure 123/76, respirations 18 breaths per minute, heart rate 116 beats per minute, and temperature 97.3 F. R5's vital signs record included a full set of vital signs taken on 4/9/25 at 8:00 a.m. but lacked any other full sets of vital signs from 4/8/25 through 4/9/25. R5's Medication and Treatment Administration Records (MAR/TAR) for April 2025 included SpO2 measurements completed once per shift (days, evening, nights) corresponding with the vital signs record. Also included blood pressure measurement taken once daily in the morning for administration of a blood pressure medication corresponding with the vital signs record. In addition, the MAR/TAR included the physician orders to auscultate lung sounds and note level of respiratory effort (and make progress note for abnormal findings) once daily between 7:00 a.m. and 3:00 p.m. These orders were marked as completed on 4/1/25 through 4/8/25 but blank on 4/9/25. There were no corresponding progress notes in R5's record documenting associated abnormal findings. R5's MAR/TAR lacked documentation of additional monitoring and assessment of R5 after staff identified her change in condition noted in progress note dated 4/8/25 at 12:21 p.m. The records lacked evidence of ongoing assessment and monitoring of vital signs, possible infection, or respiratory status. R5's assessments section of her electronic health record (EHR) lacked documentation of any assessments completed between 4/8/25 at 12:21 p.m. when R5's change in condition was identified and 4/9/25 at 9:56 a.m. when progress note indicated she was sent to the hospital. R5's Emergency Center physician hospital note dated 4/9/25, indicated R5 presented with altered mental status, hypoxia (low oxygen levels in body tissues), concern for an underlying infectious process, fever of 100.8 F, and a viral swab positive for influenza A. R5 was admitted to the hospital with diagnoses of altered mental status, influenza, hypoxia, hypercapnia (high levels of carbon dioxide in the blood), severe sepsis (extreme reaction of the body to infection causing further damage), and acute respiratory failure. R5's hospital Discharge summary dated [DATE], identified R5 was hospitalized from [DATE] through 4/18/25 with diagnoses of: influenza A with respiratory manifestation, bilateral ground-glass opacities (densities in the lungs seen on chest imaging), COPD exacerbation, pulmonary edema (accumulation of fluid in the lungs), pseudomonas (a type of bacteria) urinary tract infection, word-finding difficulty, acute on chronic respiratory failure, acute kidney injury, sepsis, acute hyperkalemia, and acute encephalopathy (disturbance of the brain's function). During an interview on 4/22/25 at 10:03 a.m., R5 stated she had been in the hospital for about a week due to a combination of her oxygen levels and a urinary tract infection. R5 stated it was a blur and she did not clearly remember what happened prior to her transfer to the hospital, but staff knew something was wrong with her and contacted emergency medical services. R5 was lying in bed with head of bed elevated and 3L of supplemental O2 delivered via nasal cannula. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/25 at 12:50 p.m., licensed practical nurse (LPN)-D stated for a resident with a change in condition she would monitor them every two hours. She would assess responsiveness, lung sounds, take vital signs, and document all in a progress note at the end of her shift. LPN-D stated staff could also enter a nursing order on the TAR which would prompt staff to monitor every two hours. LPN-D noted she was R5's nurse on 4/9/25 when R5 went to the hospital. LPN-D noted R5 normally had a once weekly vital sign and blood sugar check which was scheduled for that morning, so she had obtained a full set of vital signs. LPN-D stated she was concerned about R5's oxygen level, so she checked it every 30 minutes. LPN-D noted the nurse practitioner was on-site, saw R5, and decided to send her to the hospital. R5's record lacked documentation of monitoring every two hours and of SpO2 checks every 30 minutes. During an interview on 4/22/25 at 1:45 p.m., LPN-A stated for a resident with a change in condition, the provider would be notified and give staff monitoring orders. Providers would identify how they wanted a resident monitored and the frequency. If specific orders were not provided, LPN-A would check on a resident every two hours and for a potential respiratory illness he would monitor vital signs, fever, hypoxia, SOB, and appetite. LPN-A stated he was R5's nurse on 4/8/25, notified the provider of her change in condition, and received orders for labs. LPN-A stated no specific monitoring orders were provided, but per nursing judgement, he monitored her every two hours keeping an eye on her and would have checked vital signs every four hours, checked lung sounds and put this in a progress note at the end of his shift. R5's record lacked documentation of monitoring every two hours and of vital signs every four hours. During an interview on 4/22/25 at 3:28 p.m., registered nurse (RN)-D stated she was not sure what the protocol was for monitoring respiratory status, but guessed she would monitor vital signs, respiratory status, check oxygen levels, and check lung sounds maybe every 15 to 30 minutes. RN-D noted she would follow whatever was on the care plan. If the care plan directed to monitor per protocol, RN-D was not sure what per protocol meant. If she heard a resident had a respiratory issue in report, she should check and chart SpO2 every two hours if above 90% and check more frequently if it was lower. During an interview on 4/22/25 at 3:51 p.m., RN-E stated for respiratory status monitoring she would do a full set of vital signs. RN-E thought protocol would be every 15 minutes depending on the status of the resident and she would document in a progress note and notify the provider of anything abnormal. During an interview on 4/22/25 at 3:57 p.m., nurse manager RN-A stated respiratory status assessment should include lung sounds, SpO2 for residents on oxygen, coughing, wheezing, and SOB. For a resident with a change in condition, this should be done at least once every shift, would be noted in a provider or nursing order on the TAR, and abnormal findings relayed to the provider and documented in a progress note. For a resident who was not stable he would expect a nursing order or physician's order for monitoring at least every shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/25 at 10:33 a.m., the director of nursing (DON) stated she would expect a respiratory assessment to contain vital signs, lung sounds, oxygen use, cough, SOB, and relevant conditions like CHF or COPD. This would be charted in the MAR/TAR, observation (assessment) forms, an event form, or a progress note. After R5's change in condition was identified on 4/8/25, she would expect to see monitoring at least once a shift for respiratory monitoring, urinary monitoring, intake and output, infection, lung sounds, pain, and a full set of vital signs. The DON confirmed there was a full set of vital signs in R5's record from the morning of 4/9/25, but she did not see another full set of vital signs since R5's change in condition was noted on 4/8/25. She would expect to see a full set of vital signs from that time as well as on the overnight shift. Further, the DON stated, I don't see ongoing monitoring of her respiratory status. The DON confirmed R5 was not monitored appropriately for her change in condition and the assessment and monitoring after her change in condition was identified was not in line with policy and procedure, standards of practice, or her expectations. The DON identified potential outcomes of a lack of appropriate monitoring and assessment as a delay in care, decline, or possible death. During a return phone call interview on 4/28/25 at 10:29 a.m., NP-A stated she would expect a respiratory assessment to include vital signs, lung sounds, and symptom monitoring. If specific time parameters for monitoring were not ordered, she would expect staff to monitor at least once a shift and more frequently as needed depending on the resident's condition. This was important so treatment could be expedited as needed and a resident sent to the hospital. For R5's change in condition, NP-A would expect staff to have checked her SpO2, fever, SOB and with the facility's flu outbreak also have monitored all upper respiratory symptoms. For R5, NP-A would have expected staff check her vitals and monitor every four hours and PRN [as needed] as well. Not once a shift, because she had a change in condition. During a return phone call interview on 4/29/25 at 3:50 p.m., physician (MD)-B stated she would expect the facility to follow their protocols for assessment and monitoring. With an outbreak of influenza A at the facility, she would expect residents to be monitored for signs and symptoms including fever, cough, fatiguability, malaise, sore throat, nausea, decreased appetite, nasal congestion, headache, and altered mental status. For a respiratory assessment she would expect staff to look for respiratory distress, oxygen saturation levels, oxygen requirements if on supplemental oxygen, any respiratory symptoms, and lung auscultation. After R5's change of condition was noted on 4/8/25, MD-B would expect assessment and monitoring per the facility's protocol, especially with influenza A present in the facility, including vitals signs at least every four hours and respiratory and urinary assessments. She would expect staff to monitor and report any significant changes to her office immediately. R13 R13's annual MDS dated [DATE], indicated R13 admitted to the facility on [DATE] with diagnoses including congestive heart failure, obstructive and reflex uropathy (problems affecting the flow of urine), hypertension, dementia, and Parkinson's disease. R5 had an indwelling catheter and was cognitively impaired. R13's care plan dated 2/7/25, identified he was at risk for decline in medical condition. Interventions included administering medications and treatments per physician orders and monitoring for changes in condition and notifying provider as indicated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's physician orders included the following: - Order dated 3/27/24, to update NP if resident had a decline in condition or was not eating/drinking every shift. - Order dated 3/27/24, to auscultate lung sounds, make a progress note if abnormal lung sounds are present, and notify provider if indicated once a day for CHF. - Order dated 3/27/24, to note level of edema and respiratory effort daily, make a progress note if any abnormal findings, and notify provider of concerns as indicated once a day for CHF. - Order dated 5/9/24, for vital signs weekly on bath day on Wednesdays. R13's progress note dated 4/8/25 at 6:21 p.m., indicated he had foul smelling discolored urine and R13's son reported he seemed mentally altered with mild confusion. R13's catheter bag was changed, he was offered fluids throughout the shift, and the PM [evening] shift notified and will continue to monitor. NP was notified via a written message on the call board. R13's provider note by NP-A dated 4/9/25, indicated R13 was seen for an acute visit. The note indicated R13 had foul smelling urine and a history of urinary retention and chronic indwelling catheter. Also noted some confusion and a history of dementia. Further indicated there were two patients with confirmed influenza at the facility. The assessment and plan for confusion, foul smelling urine, hematuria, urinary retention, and indwelling foley catheter included will order UA/UC [urinalysis and urine culture] and will check for influenza/COVID-19 due to confirmed cases at the facility. R13's progress note dated 4/9/25 at 12:47 p.m., indicated he had bloody urine (hematuria) in his catheter bag and the NP was on-site and updated. Catheter was changed but there was not enough urine to sample for labs, PM nurse was updated to collect and process. Influenza swabs were not done because there were no supplies, order was changed to tomorrow. See F770 for additional information regarding lack of timely completion of ordered labs. R13's late entry progress note dated 4/10/25, was entered on 4/15/25. The note indicated a swab was collected from R13 on 4/10/25 to test for influenza, RSV, and COVID-19 and lab results came out negative. The facility's Infection Tracking Line List document indicated R13's roommate had a positive lab test for influenza A on 4/10/25. R13's roommate had developed respiratory symptoms and was tested on [DATE]. R13's physician order dated 4/10/25, had end date of 4/23/25 for Tamiflu (antiviral medication taken to prevent influenza or, at a higher dosage, to treat influenza) capsule 75 mg orally once a day at bedtime for diagnosis of encounter for other specified prophylactic measures - influenza. R13's laboratory result fax transmission form dated 4/12/25, included the result for an influenza A test ordered by NP-A. The swab for the test was collected on 4/10/25 at 11:00 a.m. and the test resulted on 4/11/25 at 9:58 p.m. The influenza A value was listed as detected (A) with a legend identifying A to mean abnormal. Per late entry progress note dated 4/10/25, this result had been negative. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	See F773 for additional information regarding lack of provider notification of abnormal lab result. R13's late entry progress note dated 4/13/25, was entered on 4/16/25. The note indicated lab results came in, the on-call NP was called and directed staff to notify R13's NP, and R13's NP was notified via the notice board. The progress note did not specify which lab results it referenced or if the results were abnormal. R13's progress note dated 4/13/25, indicated he had hematuria, vital signs were stable, and fluids provided throughout shift. R13's progress note date 4/15/25 at 8:10 p.m., indicated R13 had a change of condition. R13 complained of being tired, wanted to go to bed, was shaking, passed out during transfer, and was assisted to bed by staff. Vital signs were stable with blood pressure 95/50, temperature 97.2 F, heart rate 85 beats per minute, SpO2 92% and upon re-check 10-15 minutes later blood pressure was 108/67, heart rate 127 beats per minute, and SpO2 95%. On call provider was notified and gave order to send R13 to the hospital for evaluation. R13's vital signs record for month of April 2025, included the following: - 4/2/25 at 2:38 p.m.: SpO2 96%, blood pressure 119/74, respirations 18 breaths per minute, heart rate 71 beats per minute, and temperature 97.5 F. - 4/9/25 at 4:34 p.m.: SpO2 97%, blood pressure 124/84, respirations 19 breaths per minute, heart rate 100 beats per minute, and temperature 97.4 F. R13's vital sign included a full set of vital signs taken on 4/9/25 per physician order for weekly vital signs once daily on Wednesdays. It lacked any other recorded vital signs from 4/8/25 at 6:21 p.m. when a progress note identified a change in condition with foul smelling urine and altered mental status through 4/15/25 when R13 was sent to the hospital. Review of R13's assessments section of the EHR between 4/8/25 and 4/15/25 identified a bath visual body inspection completed on 4/9/25. It lacked documentation of any other assessments completed between 4/8/25 and 4/15/25. R13's MAR/TAR for April 2025, included administration of Tamiflu at bedtime documented as complete from 4/10/25 through 4/15/25. In addition, the MAR/TAR included the physician orders to auscultate lung sounds and note level of respiratory effort (and make progress note for abnormal findings) once daily, and to update NP for decline in condition every shift. These orders were marked as completed from 4/8/25 through 4/15/25. There were no corresponding progress notes in R13's record documenting associated abnormal findings. R13's MAR/TAR lacked documentation of additional monitoring and assessment of R13 after staff identified his change in condition noted in progress note dated 4/8/25 at 6:21 p.m. The records lacked evidence of ongoing assessment and monitoring of vital signs, possible infection, or respiratory status. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's physician History and Physical hospital note dated 4/15/25, indicated R13 had lost consciousness for a brief time at the facility, had a temperature of 101.7 F, and emergency medical services were called and transported him to the hospital. R13's active problem list included influenza A with note medication list includes Tamiflu, which leads me to believe that the care facility knew about this already, or maybe he was taking it for prophylaxis, sepsis likely from the influenza but chest x-ray suggestive of possible pneumonia, and chronic atrial fibrillation (heart rhythm disorder where the upper chambers beat irregularly) with rapid ventricular response (RVR, where the irregular beats of the upper chambers cause the lower chambers of the heart too beat too quickly) tonight. R13 was admitted to the hospital as an inpatient because of a higher risk of adverse outcome due to influenza A, sepsis. On 4/24/25, R13 remained in the hospital and had not yet been discharged . During an interview on 4/23/25 at 9:09 a.m., LPN-D stated nurses place a phone call to the on-call provider when ceded, like in an emergency. LPN-D noted the call board (a clipboard with space for staff to make notes about residents) was used for something not urgent and staff would leave a note for the NP to review when she was on-site at the facility. During an interview on 4/23/25 at 10:46 a.m., nurse manager RN-A confirmed he wrote the late entry progress note dated 4/10/25 indicating R13's RSV, influenza A and B, and COVID-19 tests were negative. RN-A reviewed the faxed lab result noting R13's influenza A test was positive and stated he was not aware R13 tested positive for influenza A until right now. During an interview on 4/23/25 at 11:33 a.m., RN-F stated she was working with R13 when he was sent to the hospital. RN-F noted he had complained of a headache and fatigue, passed out while attempting to transfer with staff, and notified her supervisor, R13's family, and R13's provider who ordered a transfer to the hospital. RN-F noted R13's appetite had been decreased and he was not eating or drinking the way he normally did throughout the day. RN-F noted she did not report this to the provider, would normally do so, and should have reported it. RN-F stated she was aware his roommate was influenza positive but did not know R13 was. RN-F did not identify assessment or monitoring for R13 implemented after his change in condition on 4/8/25. During an interview on 4/24/25 at 10:33 a.m., the DON stated she was not previously aware R13 tested positive for influenza A while at the facility and did not see evidence of provider notification. The DON stated there was a delay in the treatment of his influenza which could have resulted in death. His Tamiflu would have been changed from a prophylactic to treatment dose and could have slowed his further decline and hospitalization. The DON would expect to have seen respiratory assessments completed including vital signs, lung sounds, and SOB as well as urinary assessments including amount, color, odor, consistency, and presence of symptoms like pain/burning/frequency. She would expect to see assessments and monitoring completed every shift. The DON confirmed R13's record did not include evidence of respiratory or urinary assessments after his change in condition was identified on 4/8/25. She noted vital signs, for him, they should be done every shift, especially if you think he has an infection. She confirmed R13's EHR vital signs section contained a set of vital signs from 4/9/25, but none from his change of condition on 4/8/25 and none after 4/9/25. The DON confirmed vital sign monitoring for R13 was not completed per her expectations. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a return phone call interview on 4/28/25 at 10:29 a.m., NP-A stated staff should have contacted the on-call provider on 4/8/25 when R13's change of condition was noted and not left a message on the call board. NP-A noted a patient can decline very fast and the on-call provider needs to be notified to direct staff what to do next including monitoring symptoms, looking for signs/symptoms of respiratory infection, and possible lab orders. For a change in condition staff should call right away, the call board clipboard was for simple things she could address the following day. NP-A noted she would expect to see assessment and monitoring of R13 after his change in condition including respiratory monitoring, lung sounds, presence of fever, and vital signs every four hours and as needed. She stated R13's vital sign monitoring does not meet my expectations, not at all, it needed to be more frequent for sure. NP-A noted monitoring was important because staff need to ensure a resident is stable enough to remain at the facility. NP-A identified potential outcomes of the lack of assessment, monitoring, and timely notification as death. During a return phone call interview on 4/29/25 at 3:50 p.m., MD-B stated she would expect additional monitoring and assessment to have been put in place after R13's change in condition on 4/8/25. She would expect monitoring and assessment for R13 per the facility's protocol including symptoms of influenza and vital signs once daily at a minimum. MD-B confirmed R13's vital sign monitoring was not in line with her expectations. MD-B stated she was not aware R13 had tested positive for influenza while at the facility and noted this would have changed his course of treatment. MD-B stated monitoring and assessment were important for identifying a further decline in condition and lack of assessment and monitoring could lead to decline and a delay in implementing proper actions and interventions. Facility policy titled Change in Condition dated 3/10/25, included 1.) The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): . d. significant change in the resident's physical/emotional/mental condition; e. Critical lab values/results f. need to alter the resident's medical treatment significantly; . h. need to transfer the resident to a hospital/treatment center; . and/or j. specific instruction to notify the Physician of changes in the resident's condition. 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 (is not self-limiting); b. Impacts more than one area of the resident's health status; c. Requires interdisciplinary review and/or revision to the care plan; and d. Ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument . 5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. Facility policy titled Influenza (Prevention and Outbreak Management) dated 2/13/25, included an Influenza Outbreak section. The section included: Monitor residents for influenza-like illness: Instruct staff to be alert to signs/symptoms of influenza-like illness (fever, cough, sore throat, etc.) among residents and report resident illness to supervisors immediately; Conduct active surveillance for respiratory illness among all residents and staff until at least one week after the last confirmed case occurred.

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	245493	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augustana Chapel View Care Center	615 Minnetonka Mills Road Hopkins, MN 55343

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and document review the facility failed to ensure a system to ensure physician orders were accurately transcribed to prevent and/or mitigate risk of medication errors for 1 of 2 residents (R17) reviewed for medication errors. The facility's failures resulted in R17 received ibuprofen 66 times not in accordance with physician orders. Findings include: R17's face sheet dated 4/24/25, indicate the following diagnoses of status post stroke, and aneurysm of left internal carotid artery. R17's interagency transfer form dated 4/2/25, included an order for ibuprofen (IBU- (a nonsteroidal anti-inflammatory drug used to treat mild to moderate pain. Side effects include headache, dizziness, nausea, bleeding, and bruising)) 400 mg every 6 hours as needed (PRN) for pain. R17's provider visit summaries dated 4/4/25 and 4/14/25, included and identified an order for (IBU) 400 mg every 6 hours PRN for fever. R17's electronic health record (EHR) identified the aforementioned physician order for as needed IBU however was not accurately transcribed into the EHR system. The order that was transcribed directed staff to administer the IBU every 6 hours versus PRN. R17's EHR physician orders thru included the following orders: -Ibuprofen 400 mg every 6 hours, scheduled, dated 4/2/25 thru 4/19/25; -Ibuprofen 400 mg every 6 hours as needed, dated 4/19/25; -Eliquis (a blood thinner the prevents clot formation, not to be used with NSAID medication) 5 mg twice daily, dated 4/2/25. R17's medication administration record (MAR) reviewed from 4/1/25 thru 4/24/25, included the physician orders to administer IBU every six hours. The MAR identified R17 was administered IBU 66 times between 4/2/25 and 4/19/25. R17's facility medication error report dated 4/19/25 at 12:39 p.m., indicated from 4/2/25 thru 4/19/25, R16 received the wrong order for ibuprofen 400 mg every 6 hours and the correct order was for ibuprofen 400 mg every 6 hours as needed. This medication error was noted to be of human error due to incorrect transcription. R17 had no negative effects from the medication. Physician and family notified. R17's record did not identify that family, or provider was notified timely of medication error. R17's record further lacked if R16 had any untoward effects from the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/25 at 8:32 a.m., registered nurse (RN) -B stated when you go to administer a medication you first check the orders and compare that against the medication card. When doing this you are checking the 6 rights; resident, dose, drug, timing of medication, dose, and route of the medication. If there is a discrepancy between the MAR and the card medication label, you go with the MAR. During an interview on 4/23/25 at 10:03 a.m., director of nursing (DON) stated it was her expectation that nursing staff administered medications per physician's orders. DON verified the above medication error was due to a transcription error. DON further stated all orders were put in by the health unit coordinator and checked by the charge nurse and the double checked upon administration of the medication. During an interview on 4/29/25 at 3:50 p.m., with MD-B, stated they were not made aware of this medication incident. The maximum dose for ibuprofen daily is 2400 mg and R17 would not have received that on 400 mg every 6 hours. MD-B attempts to avoid this dosage in R17's age group, as it can lead to high risk of kidney dysfunction and has multiple stomach side effects. Facility policy entitled, Medication Incident, dated 10/8/24, indicated the following: 1. All medication incidents will be reported to the DON (or designee) and responded to promptly. 2. Observe resident for untoward effects as a result of error. Document assessment and interventions in progress notes. 3. Notify physician of medication incident and resident change in condition 4. Update the resident and family of significant incidents.

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	245493	A. Building B. Wing	04/24/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a resident was free from a significant medication error for 1 of 3 residents (R15) reviewed for medication errors. Findings include: R15's face sheet dated 4/24/25, indicated diagnoses of fractured left femur, status post hemiarthroplasty (hip replacement) left hip, acute respiratory failure with hypoxia, and acute bronchitis due to respiratory syncytial virus (RSV). R15's hospital discharge summary indicated R15 was admitted to the hospital on [DATE] and discharged to the facility on 4/17/25. The discharge orders that had been faxed to the facility on 4/17/25, identified two separate Dilaudid (opioid narcotic pain killer) orders: -Order signed by physician on 4/14/25, identified an order for Dilaudid 2mg tablets to take 1 to 2 tablets every 4 hours as needed for pain; take 1 tablet for pain rate 4-7 out of 10. Take 2 tablets for pain rate 8-10 out of 10 -Order signed by physician on 4/17/25, identified an order for Dilaudid 2 mg tablets to take 0.5 to 1 tablet every 4 hours as needed for pain; Take 1 tablet for pain rated 4-7 out of 10, and take 2 tablets for pain rated 8-10 out of 10. During an interview on 4/24/25 at 12:05 p.m., pharmacist (PhD-)-A stated the pharmacy received 2 different prescriptions for hydromorphone for R15 that was sent to the pharmacy several times which caused a lot of confusion. Per pharmacy policy, the prescription dated 4/14/25 for 2-4 mg of hydromorphone (12 tabs of whole 2 mg) was filled for delivery to the facility at 5:00 p.m. which was prior to R15's arrival. Then on 4/18/25, the order was clarified to administered 1-2 mg of hydromorphone so the pharmacy delivered 2 mg tabs cut in half (16 doses). Review of R15's medication administration record (MAR)on 4/23/25, identified R15 received Dilaudid 4 mg at 6:01 a.m. R15's progress note dated 4/23/25 at 7:38 a.m., identified R15 had abnormal, irregular, labored breathing pattern, and difficult to arouse. During an observation on 4/23/25 at 7:50 a.m., emergency medical services (EMS) arrived at the facility and walked to R15's room. R15 was lying in bed and did not respond to EMS's verbal or physical stimulus. R15's facial skin had a grayish tint, and an oxygen nasal cannula was in her nose. Licensed practical nurse (LPN)-B stated the physician gave orders to send R15 to the hospital for further evaluation. R15 left the facility per EMS at 8:10 a.m. R15's progress note dated 4/23/25 at 8:17 a.m., identified R15's respirations at 10, uneven and using assessory muscles. Unable to awaken and physician in facility ordered R15 to be sent to emergency room and 911 called and R15 left facility at 8:10 a.m. (continued on next page)

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	245493	A. Building B. Wing	04/24/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's hospital emergency department (ED) note dated 4/23/25, identified that R15 arrived in ED due to not opening eyes or responding to questions at the facility. ED physician documented a call from the facility that stated R15 received a dose of Dilaudid (narcotic pain killer) of 4 milligrams (mg) at 6:00 a.m., R15 was given Narcan (a drug to treat narcotic overdose) and mentation and level of consciousness (a state of awareness) improved, though for only 30 minutes and a subsequent dose of Narcan had to be administered with improvement in consciousness. With suspected opioid (narcotic) overdose and subsequently hospitalized . During an observation and interview on 4/23/25 at 10:25 a.m. licensed practical nurse (LPN)-B had R15's Hydromorpone medication card that had the prescription for 2-4 mg, she also had an orange sticker in her hands. LPN-B explained the order on the card was wrong according to the physician. LPN-B placed the orange sticker on the card that alerted staff the Rx on the card was incorrect and nurses were to check the physician order for the correct dose. During an interview on 4/23/25 at 10:30 a.m., LPN-E stated the morning of 4/23/25 she had recieved the report that R15 was adminsitered Hydromorphone at 6:01 a.m. for pain 10/10. LPN-E was following up on a as needed pain medication that was given to R15 by LPN-C at 6:01 a.m., between 7:30 and 7:45 a.m. and found R15 with labored mouth breathing and use of accessory muscles. LPN-E then notified LPN-B of R15's condition change. LPN-E stated if there was a question between the card medication label and the medication administration record (MAR), staff were to follow the MAR as it is the most update information. During an interview on 4/24/25 at 8:35 a.m., RN-C stated he was the supervisor the evening R15 was admitted and noticed the discrepancy between the orders received and the paper prescription R15 brought with her from the hospital dated 4/17/25. RN-C stated per policy, he went with the most recent orders, called the hospital to verify the order and he received an order verification for hydromorphone order to what the prescription stated; 1-2 mg every 4 hours as needed for pain. RN-C called the pharmacy and asked them to send the correct order, but the delivery was already en route. When the cared arrived from the pharmacy RN-C did not place an orange sticker alerting the order had changed. RN-C further stated that with the administration of medications, the nurse should verify the medication card label with the MAR orders. If there was a discrepancy, the nurse should verify the order in the chart, and if still a problem, then to verify the order with the physician. During an interview on 4/24/25, registered nurse (RN)-B stated when administering as-needed medications, the nurse was to look at the order on the MAR and compare it to the medication label on the medicine card. They should check for the 6 rights: resident, dose, drug, timing of medication, dose, and route of medication. If there was a discrepancy between the MAR and the card medication label, the staff were to follow the MAR. RN-B would follow up on pain medication within the first hour after administration to make sure the medication was effective. RN-B verified R15's 2mg hydromorphone tablet card had orange stickers over the label, and the orange sticker were a sign to staff to double check the order in eMAR. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview on 4/24/25 at 10:02 a.m., LPN-C stated she verified through the interpreter line, R15 had pain 10/10 and was showing visible signs of pain, such as moaning and grimacing. LPN-C also assessed vital signs, and R15's blood pressure was elevated at 131/61 (normal is below 120/80). LPN-C stated she gave R15 as needed hydromorphone 4 mg after verifying the medication card label with the MAR. Five rights need to be done for every medication administration, resident, dosage/drug, route, and timing. If there was a discrepancy between the MAR and the card, staff were to go back to the physician's orders to clarify the order, and if still a problem to call the physician for clarification. If the card was wrong, the staff were to take a red ink pen and cross off the label, date, and write on the card not to administer until the order was verified. LPN-C did not know she gave the wrong dose until DON called her to verify what had happened to R15 During an interview on 4/23/25 at 10:03 a.m., DON stated it was her expectation when staff receive medications from the pharmacy, the staff were to verify the packing slip with what has arrived. Staff were to verify the resident, drug, and if a narcotic, the amount received. DON further stated it was her expectation for narcotics and other pain medication to be followed up on within the hour of giving and for medications to be administered according to the most current orders for medications. DON stated that giving an excessive dose of narcotic would be counted as a significant medication error. During an interview on 4/24/25 at 1:44 p.m., MD-C stated it was his expectation that medication be administered according to the physician's orders. MD-B further stated the normal dosing for hydromorphone is 2-4 mg and could not say the 4mg dose R15 received alone would have caused the respiratory depression A facility policy titled Medication Administration, with a reviewed date of 10/8/24, indicated: 2. Medications will be administered to residents as prescribed by the primary MD/NP/PA. 4. Staff will follow the six rights of medication administration: -Right resident -Right medication -Right dose -Right dosage form -Right frequency -Right route 11. Medication incidents will be reported following the medication incident policy. A facility policy titled PRN medication, with a reviewed date of 10/8/24, indicated: 2. Check EMR for specific physician order. (continued on next page)

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	245493	A. Building B. Wing	04/24/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Licensed staff to observe response to each dose of the medication and document the response in the MAR. The policy did not state a time frame for this. A facility policy titled Medication Incident, with a reviewed date of 10/8/24, indicated: 2. Observe the resident for untoward effects because of the error. Document assessment and interventions in the progress notes.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure physician orders for laboratory studies had been obtained in a timely manner for 3 of 3 residents (R5, R13, R15) who had physician ordered labs. Findings include: R5 R5's quarterly Minimum Data Set (MDS) dated [DATE], indicated R5 had diagnoses including type 2 diabetes, hyperkalemia, congestive heart failure, and acute and chronic respiratory failure. R5's care plan dated 7/7/23, identified she was at risk for decline in medical condition. Interventions included administering medications and treatments per physician orders and monitoring for changes in condition and notifying provider as indicated. R5's progress note by licensed practical nurse (LPN)-A dated 4/8/25 at 12:21 p.m., indicated R5 had a change in condition and the provider was notified. The provider ordered STAT (immediately, without delay) laboratory (lab) studies of CBC (complete blood count, a blood draw study), BMP (basic metabolic panel, a blood draw study), COVID-19, RSV (respiratory syncytial virus, a respiratory infection), influenza, and UA/UC (urinalysis and urinary culture). The note indicated the samples for the COVID-19, RSV, influenza, and UA/UC were obtained and ready in the fridge for pick up with the CBC and CMP still pending. R5's physician orders included: - STAT CBC and BMP lab order created 4/8/25 at 11:45 a.m. with start date 4/8/25 and discontinued on 4/8/25 at 10:45 p.m. with discontinue reason left blank. - STAT CBC and BMP lab order created 4/8/25 at 10:46 p.m. with start date of 4/9/25. R5's Medication and Treatment Administration Records (MAR/TAR) for dates 4/1/25 through 4/22/25, included an order for CBC and BMP labs with start date and end dates of 4/8/25 with frequency of STAT - immediately. The administration record for 4/8/25 included a note Not Administered: Other Comment: to be done tomorrow. R5's provider note by nurse practitioner (NP)-A dated 4/9/25 at 10:28 a.m., indicated R5 was seen for acute visit. The note included Staff noted that patient has increased confusing [sic] a day ago. Patient is usually alert at baseline. Ordered PCR [type of lab test] for COVID-19, Influenza A/B and RSV, CBC/BMP and urinalysis, labs still pending. Today, patient has declined in condition. The assessment and plan for altered mental status, confusion, hyperglycemia (high blood sugar), and shortness of breath was labs still pending. Will send patient to the hospital for further evaluation. R5's lab result fax dated 4/9/25, indicated the BMP ordered on 4/8/25 was collected on 4/9/25 at 6:37 a.m. and resulted at 2:41 p.m. (continued on next page)

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	245493	A. Building B. Wing	04/24/2025

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's lab result fax dated 4/9/25, indicated the CBC ordered on 4/8/25 was collected on 4/9/25 at 6:37 a.m. and resulted at 2:11 p.m. During an interview on 4/22/25 at 1:45 p.m., LPN-A stated he worked with R5 on 4/8/25, notified the provider of her change in condition, and received STAT lab orders for COVID-19, influenza, RSV, UA/UC, CBC, and BMP. LPN-A stated he collected the samples for the COVID-19, influenza, RSV, and UC/UA labs. LPN-A stated staff normally called the facility's outside lab provider to notify them of STAT orders. The lab staff typically came early in the morning to do blood draws, and when he received orders for a STAT CBC and BMP between 11:30 a.m. and 12:00 p.m. for R5 they had already left, so the health unit coordinator (HUC) called the lab to come back and do the blood draw. By 3:00 p.m., the end of his shift, the lab had not shown up to collect the STAT CBC and BMP. LPN-A told the oncoming nurse in report R5 had STAT lab orders, lab had been called around noon, and they were still waiting for someone to come. LPN-A did not indicate additional follow-up with the lab was completed at this time or provider was notified of the delay. During an interview on 4/23/25 at 10:06 a.m., clinical manager registered nurse (RN)-A stated nurses were expected to call the lab if they had a STAT order. For a blood draw, we call them to come and draw the blood . call and request they send someone to collect it STAT. RN-A stated the expectation was a STAT lab would be collected within two hours and, if there was a delay, staff would notify the provider and call the lab to follow up. During an interview on 4/24/25 at 10:33 a.m., the director of nursing (DON) stated she would expect STAT labs to be completed right away, and it was not acceptable to collect a STAT lab the day after it was ordered. During a return phone call interview on 4/28/25 at 10:29 a.m. NP-A stated STAT labs should be collected by facility or lab staff immediately, staff are supposed to do them right away. NP-A noted staff call the lab to tell them they need to come right away. NP-A stated if there was a delay in completing ordered STAT labs, staff are supposed to notify me and monitor a resident's condition so if they are declining, they can be sent to the hospital. NP-A stated she was not notified of delays in completing R5's ordered STAT labs, she became aware when I came in the following morning and I was told her condition was declining and I sent her to the hospital. During a return phone call interview on 4/29/25 at 3:50 p.m., physician (MD)-B stated she would expect STAT labs to be collected on the same day they were ordered. MD-B would expect her office to be informed if there was a delay so we can reassess and plan accordingly. R13 R13's facesheet dated 4/24/25, indicated he had diagnoses including congestive heart failure, cough, hematuria (blood in urine), elevated white blood cell count, and urinary tract infection. R13's care plan dated 2/7/25, identified he was at risk for decline in medical condition. Interventions included administering medications and treatments per physician orders and monitoring for changes in condition and notifying provider as indicated. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's provider note by NP-A dated 4/9/25, indicated R13 was seen for an acute visit. The note indicated R13 had foul smelling urine and some confusion and there were two patients with confirmed influenza at the facility. The assessment and plan for confusion, foul smelling urine, hematuria, urinary retention, and indwelling foley catheter included will order UA/UC and will check for influenza/COVID-19 due to confirmed cases at the facility. R13's physician orders included a lab order dated 4/9/25 created at 11:33 a.m., for COVID-19, influenza, and RSV tests scheduled for completion on 4/9/25 between 3:00 p.m. and 11:00 p.m. R13's physician orders included a lab order dated 4/10/25 created at 11:02 a.m., for influenza and RSV tests scheduled for completion on 4/10/25 between 7:00 a.m. and 3:00 p.m. R13's progress note dated 4/9/25 at 12:47 p.m., indicated the nurse practitioner had been on-site and was updated regarding R13 having hematuria. The note included influenza swabs not done, order changed to tomorrow because there is [sic] no supplies. R13's MAR for dated 4/1/25 through 4/23/25, included an order directing swab for influenza, RSV, and covid scheduled for day shift on 4/9/25. The administration record for 4/9/25 day shift included a note Not Administered: Other Comment: Will be done tomorrow, no supplies. R13's late entry progress note 4/10/25, identified it was entered 4/15/25. The note indicated R13 was swabbed for influenza, RSV, and COVID-19 lab tests on 4/10/25. R13's lab result fax dated 4/12/24, indicated the influenza A, influenza B, and RSV tests ordered on 4/9/25, were collected on 4/10/25 at 11:00 a.m. and resulted on 4/11/25 at 9:58 p.m. R13's lab result fax dated 4/11/24, indicated the COVID-19 test ordered on 4/9/25 was collected on 4/10/25 at 11:00 a.m. and resulted on 4/11/25 at 10:36 p.m. During an interview on 4/23/25 at 10:36 a.m., the health unit coordinator (HUC)-A stated anyone could order lab supplies, but the HUC's usually did it if they were there. Nurses would notify the HUC's if they needed more of something and the HUC's would fill out and fax a lab order sheet. HUC-A stated the HUC's did not have time to routinely monitor supply levels and relied on nurses to notify them when something was running low. During an interview on 4/23/25 at 10:06 am, clinical manager RN-A stated the HUC's and infection control nurse were responsible for tracking lab supplies and if nurses see they are running low or out of supplies they should notify the HUC. During an interview on 4/24/25 at 10:33 a.m., the DON stated labs ordered for a change in condition should be completed as soon as possible, I would say the same shift as they were ordered. The DON would expect the physician to be notified if there was a delay in obtaining labs. During an interview on 4/28/25 at 10:29 a.m., NP-A stated she would expect to be notified if there was a delay in completing ordered lab studies. NP-A stated she was not aware the respiratory labs she ordered on 4/9/25 for R13 were delayed and not collected until 4/10/25. NP-A stated she should have been notified so if there was a further change in condition the resident could be sent to the hospital. Further, NP-A stated she was not aware the lab results were positive for influenza A. (continued on next page)

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	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augustana Chapel View Care Center	615 Minnetonka Mills Road Hopkins, MN 55343

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	See F773 for additional information regarding lack of provider notification of abnormal lab result. During a return phone call interview on 4/29/25 at 3:50 p.m., MD-B stated she was not notified of the delay in collection of R13's respiratory labs, which was not in line with her expectations. R15 R15's face sheet dated 4/24/25, indicated diagnoses of fractured left femur, s/p hemiarthroplasty left hip, acute respiratory failure with hypoxia, acute bronchitis due to respiratory syncytial virus (RSV), diabetes, dementia. R15 was admitted to facility on 4/17/25 for a rehabilitation stay following surgery. R15's physician orders indicated the following: -lab other test, RSV, Covid and influenza swab, one time, dated 4/22/25 to be completed between 3:30 p.m. and 10:00 p.m. (order in twice for the same times). R15's progress notes dated 4/22/25 at 9:57 p.m., indicated R15 had elevated fever and cough noted. Influenza a and B, Covid and RSV test performed. PCR sample in the fridge lower level waiting to be picked up. R15's Mar dated 4/1/25 through 4/23/25, included an order directing swab for influenza, RSV and covid scheduled evening shift on 4/22/25. R15's faxed lab results dated 4/23/25, indicated the COVID-19 tests were ordered on 4/22/25, were collected on 4/22/25 at 9:13 a.m. and resulted on 4/23/25 at 8:87 p.m. R15's record lacked a faxed lab result for influenza A, influenza B and RSV. During an interview on 4/22/25 at 12:23 p.m., director of nursing (DON) stated all COVID, Influenza and RSV swabs were to be considered STAT labs as the affect these viruses could have the facility population. During a clarification interview on 4/23/25 at 3:50 p.m., DON was not aware of where the lab specimen fridge was located on first floor. During an interview on 4/22/25 at 3:55 p.m., LPN-B was able to show me the lab specimen on first floor and noted there were no specimens in the fridge. Unknown when lab comes to pick up specimens. During an interview on 4/23/25 at 2:50 p.m., LAB-A stated the lab facility does not track STAT lab orders, the facility is to call them if they have STAT lab orders, so lab can come out and collect or draw the STAT lab orders and not place the swabs in fridge to wait for lab to come and pick up on next run. During an interview on 4/23/25 at 10:03 a.m., MD-A stated STAT lab are considered STAT by medical staff are not always considered STAT by lab personnel. If medical staff order STAT labs, his expectation would be for nursing staff to call the lab facility to either come draw the labs or come and pick up specimen. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/25 at 1:44 p.m., MD-C stated was his expectation that STAT labs be treated as such and completed within 2 hours. Facility policy titled Maintenance of Clinical laboratory results dated [DATE], included 1.) Physician orders for lab/radiology studies are entered in the Orders module of the EHR [electronic health record] and are transcribed per transcription of orders policy. 2.) If an order requires immediate action, the person processing the order must contact the vendor by telephone to obtain urgent service. 3.) Follow facility procedures for timely notification of the prescriber about the results of lab and radiology studies. Facility policy titled Influenza (Prevention and Outbreak Management) dated 2/13/25, included a Facility Supplies and Prevention section. The section noted, Develop a plan for collecting respiratory specimens and performing rapid influenza testing (e.g., rapid diagnostic test, immunofluorescence) and viral cultures for influenza. Obtain influenza testing supplies (e.g. synthetic or non-cotton Dacron swabs and viral transport media). Identify a system to transport specimens to laboratory for laboratory testing. Ensure that your facility has adequate infection prevention supplies. Facility policy titled Maintenance of Clinical laboratory results dated [DATE], included 1.) Physician orders for lab/radiology studies are entered in the Orders module of the EHR [electronic health record] and are transcribed per transcription of orders policy. 2.) If an order requires immediate action, the person processing the order must contact the vendor by telephone to obtain urgent service. 3.) Follow facility procedures for timely notification of the prescriber about the results of lab and radiology studies. Facility policy titled Influenza (Prevention and Outbreak Management) dated 2/13/25, included a Facility Supplies and Prevention section. The section noted, Develop a plan for collecting respiratory specimens and performing rapid influenza testing (e.g., rapid diagnostic test, immunofluorescence) and viral cultures for influenza. Obtain influenza testing supplies (e.g. synthetic or non-cotton Dacron swabs and viral transport media). Identify a system to transport specimens to laboratory for laboratory testing. Ensure that your facility has adequate infection prevention supplies.

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	245493	A. Building B. Wing	04/24/2025

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to promptly notify the ordering physician of an abnormal laboratory result for 1 of 3 residents (R13) who had laboratory orders. Findings include: R13's nurse practitioner (NP) note dated 4/9/25, indicated R13 was seen for an acute visit by NP-A regarding a new problem. Assessment and plan included will check for influenza/COVID-19 due to confirmed cases at the facility. R13's laboratory (lab) result fax transmission form dated 4/12/25, included the result for an influenza A test ordered by NP-A. The swab for the test was collected on 4/10/25 at 11:00 a.m. and the test resulted on 4/11/25 at 9:58 p.m. The influenza A value was listed as detected (A) with a legend identifying A to mean abnormal. R13's late entry progress note dated 4/10/25, identified it was entered on 4/15/25 by nurse manager registered nurse (RN)-A. The note indicated a swab was collected from R13 on 4/10/25 to test for influenza, RSV, and COVID-19 and lab results came out negative. During an interview on 4/23/25 at 10:46 a.m., RN-A confirmed the laboratory resulted on 4/11/25 included result of influenza A detected, that means it was present, positive. RN-A reviewed his progress note dated 4/10/25, and stated he believed he made an error in what he documented and was not aware R13's test result had been positive for influenza A. RN-A noted there was no evidence of R13's positive influenza A test on 4/11/25 except the scanned copy of the faxed lab result and could not confirm he had notified NP-A of this abnormal result. During an interview on 4/24/25 at 10:33 a.m., the director of nursing (DON) confirmed R13's influenza A test from 4/10/25 was positive and noted she was not aware of this result until notified by surveyors. The DON confirmed she expected the provider to have been notified of the positive result and confirmed she did not see any indication of this. The DON further noted this could have resulted in a delay in treatment. During a return phone call interview on 4/28/25 at 10:29 a.m., NP-A stated she was not aware R13 had tested positive for influenza A while at the facility and had not been notified of the positive lab result from the swab collected on 4/10/25. NP-A stated expected she would have been notified and she would have treated him for influenza A at that point. NP-A stated the lack of timely notification could have resulted in death or a delay in sending R13 to the hospital when he was declining in condition. During a return phone call interview on 4/29/25 at 3:50 p.m., physician (MD)-B stated she was not aware R13 had tested positive for influenza A while at the facility, though this may have been communicated to NP-A and not reported to her directly. MD-B stated if R13's providers were aware, this would have changed his treatment. He would have been changed from the prophylactic (preventative) dose of Tamiflu (anti-viral medication used to prevent or treat influenza) to a treatment dose. (continued on next page)

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	245493	A. Building B. Wing	04/24/2025

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled Maintenance of Clinical laboratory results dated [DATE], indicated results of clinical laboratory studies were monitored by facility staff, reported to the attending physician or designee, and maintained in the medical record. Staff were to follow facility procedures for timely notification of the prescriber about the results of lab studies. Facility policy titled Change in Condition dated 3/10/25, indicated nurses would notify the resident's attending physician or physician on-call in circumstances including: when there had been a significant change in the resident's physician/emotional/mental condition, critical lab values/results, or need to alter the resident's medical treatment significantly.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and document review, the facility failed to maintain a complete, accurately documented, and readily accessible medical record in accordance with accepted professional standards and practices for 1 of 1 resident (R5) reviewed for documentation. Findings include: R5's facesheet indicated her current admission to the facility began on 7/6/23 with most recent return to the facility date of 4/18/25. R5's progress note dated 4/9/25, indicated R5 was confused, slow to respond, very weak, showed signs of distress, and was sent to the hospital. R5's progress note dated 4/18/25, indicated R5 was re-admitted to the facility from the hospital at 1:26 p.m. via emergency medical services. R5's electronic health record (EHR) reviewed on 4/22/25, did not include NP-A's visit note dated 4/9/25 nor a hospital discharge summary or physician history and physical (H&P) from R5's hospitalization 4/9/25 to 4/18/25. During an interview on 4/22/25 at 12:32 p.m., health unit coordinator (HUC)-A stated provider visit notes typically came in the same day as the visit or the next day. Provider notes were faxed to the facility electronically from the business office of the provider's practice and uploaded into the EHR. HUC-A utilized R5's primary care provider's outside medical records system to verify the presence of a visit note from NP-A dated 4/9/25. HUC-A confirmed the visit note from NP-A on 4/9/25 was not present in R5's EHR and stated this was a good example of one [note] that didn't get faxed from the business office. HUC-A stated she tracked regulatory provider visits to ensure notes were uploaded after completion but did not track notes for off notes like this, an acute visit. HUC-A was not sure how or who tracked non-regulatory provider visits to ensure completed notes were uploaded into residents' EHR's, this was a good question. HUC-A stated she would expect the note to be uploaded into R5's chart the same or next day as the provider visit on 4/9/25. During an interview on 4/22/25 at 4:15 p.m., HUC-A stated after a resident returns from the hospital, documents with clinical information such return orders, discharge summaries, and H&P notes, are uploaded into resident EHR's. HUC-A confirmed the discharge summary and H&P documents from R5's hospitalization from 4/9/25 through 4/18/25 were not present in her EHR and should be there. HUC-A noted the discharge orders document from this hospitalization was uploaded, but the additional documentation was absent from R5's record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/25 at 8:44 a.m., the director of nursing (DON) stated provider notes should be in residents' medical records. The DON noted medical records staff were responsible for making sure provider visit notes were uploaded into the EHR. The DON confirmed she would expect R5's discharge summary from hospitalization with discharge date of 4/18/25 and provider visit note dated 4/9/25 to be present in her record by surveyor EHR review on 4/22/25. The DON noted R5's EHR was not accurate and complete, it was missing two things. The DON stated it was important for medical records to be accurate and complete because you need to know all the information to provide care for the resident, you need the whole picture. Facility policy titled Legal Health Record Contents dated 1/15/25, included The resident's Legal Health Record (medical record) serves the following purposes: 1.) It contains documentation of the resident's health history relating to the past, present or future physical or mental health or condition of a resident. It provides a record of the resident's health status and may include observations, measurements, history, and prognosis and serves as the legal document describing the health care services provided to the resident. The medical record provides evidence of the quality of resident care . 3.) It provides a method for clinical communication and care planning among the individual healthcare practitioners serving the resident. The procedure section noted the resident's Legal Health Record may consist of the following components and included consultation reports to the extent they were relied on to provide health care to the resident including clinic and outside medical providers and hospital/emergency departments. Additional components included history and physical examination - uploaded as documents or inputted directly into the system, and multidisciplinary progress notes.

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	245493	A. Building B. Wing	04/24/2025

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to implement infection control strategies for respiratory protection to mitigate the risk and spread of Influenza A. As a result, the facility developed an outbreak where 13 residents (R1, R2, R3, R4, R5, R6, R7, R9, R13, R8, R10, R11 and R12) tested positive for Influenza A. Five residents (R1, R2, R5, R10 and R15) were sent to ED and admitted to hospital, These practices resulted in an immediate jeopardy (IJ) due to the likelihood of spread to the remaining 80 residents in the facility. The IJ began on 3/31/25, when the facility failed to implement ongoing monitoring, screening of residents with respiratory symptoms and implement transmission-based precautions and was identified on 4/18/25. The Administrator, director of Nursing (DON), and regional nurse consultant (RNC), were notified of the immediate jeopardy at 11:50 a.m. on 4/23/25. The immediate jeopardy was removed on 4/19/25 and the deficient practice corrected on 4/19/25, prior to the completion of the survey and was therefore issued at Past Noncompliance. Findings include: Definitions: Influenza: a contagious respiratory illness caused by a virus. Isolation: Isolation separates sick people with a contagious disease from people who are not sick. Quarantine separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick. Personal protective equipment (PPE): refers to protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission. These items may include a gown, gloves, eye protection and face mask. Enhanced barrier precautions (EBP): refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Gowns and gloves are used as PPE. Transmission based precautions (TBP): refers to actions (precautions) implemented in addition to standard precautions that are based upon the means of transmission (airborne, contact, and droplet) to prevent or control infections. Airborne, contact, and droplet are the three subcategories under TBP. Contact precautions: refers to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. Use with gloves, and gowns as PPE. Droplet precautions: refers to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions, masks, gowns, gloves, and eyewear are used as PPE. (continued on next page)

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	245493	A. Building B. Wing	04/24/2025

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Upon entrance to the facility on 4/18/25 at 08:15 a.m. there was signage posted on the front door informing visitors the facility was experiencing an outbreak of influenza, and all visitors and staff were to wear masks. During entrance conference on 4/18/25 at 8:33 a.m., director of nursing (DON), stated there were currently only two residents on TBP for influenza and those that could come off today (4/18/25) were already off. The outbreak started a few weeks ago, positive cases were only in the transitional care unit (TCU) however, DON was unaware of total number of residents who had tested positive for influenza since the initial case but was unsure of the date when the outbreak started. During an interview on 4/18/25 at 1:08 p.m., administrator and DON stated the facility had identified system break downs within the infection control program earlier this week and were working on a correction plan. R1 symptom onset 3/31/2025 and hospitalized from [DATE] until 4/3/25. R1's face sheet dated 4/24/25, indicated diagnoses of hemiplegia (paralysis on one side of body) and hemiparesis (weakness on one side of body) following stroke, acute respiratory failure with hypoxia (lack of oxygen), and diabetes. R1's progress notes dated 3/31/25 at 12:08 p.m. indicated R1 complained of not feeling good, and did not eat breakfast. R1 had a sore throat and had congestion in his upper lobes on inspiration. Vital signs were 98. 2 (normal is 96.3-98.6) pulse was 63 (normal is 60-100), respirations were 18 (normal is 12-20), blood pressure was 129/70 (normal is below 120/80) and oxygen sats were 89-90% on room air (normal is 95 -100). Tested negative for COVID. Provider updated awaiting orders. Progress note at 1:52 p.m. indicated R1 was gasping for air, oxygen sats 82% on room air, oxygen applied and elevated head of bed. R1 started to shake, provider updated again, and order received to send to emergency department (ED). R1's physician visit dated 4/4/25, indicated R1 was hospitalized from [DATE] thru 4/3/25 with diagnoses of influenza A and B with respiratory manifestations, chronic congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and sepsis (a life threatening condition) due to pseudomonas (a common cause of sepsis) species with encephalopathy (viral infection of the brain) and sepsis due to undetermined organism with metabolic encephalopathy. R1 was discharged back to the facility on 4/3/25 at 4:48 p.m., with orders for oxygen, antibiotic, and antiviral medication. R1's progress note dated 4/4/25 at 3:21 p.m., indicated R1 was on droplet precautions R1's record did not identify when TBP's were removed. During an interview on 4/22/25 at 1:41 p.m., infection preventionist (IP)-A stated R1 came back from the hospital on 4/3/25 and was put on TBP, TBP was removed on 4/7/25. IP-A verified the TBP were removed after seven days and not based on an assessment and monitoring for symptom resolution. IP-A stated residents who tested positive for influenza were kept on TBP according to the facility policy that directed TBP for 7 days following the onset of symptoms or 24 hours after resolution of fever without analgesics whichever is longer. However, there was no monitoring of symptoms prior to the removal. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R2 symptom onset 4/1/25, tested positive 4/6/25. R2's face sheet dated 4/24/25, indicated diagnoses of dementia, COPD, hemiplegia, and hemiparesis following a stroke, aphasia. R2's progress notes on 4/1/25, 11:48 a.m., noted vital signs were taken and R2 had an elevated temperature at 100.9, pulse elevated at 128, respirations 22 and blood pressure at 132/74, oxygen saturations at 96% on room air. Rapid Covid test negative. Physician and family updated. R2's record did not identify if TBPs were initiated with symptom onset. R2's progress notes dated 4/1/25 at 12:49 p.m., orders received for stat chest x-ray and nebulizer. Progress notes at 10:55 p.m. included chest x-ray was completed but there was no report at this time. R2's progress note dated 4/4/25 at 11:06 p.m., (3 days after symptoms onset) indicated a swab for COVID and Influenza was completed and in fridge waiting lab to pick up. R2's progress notes dated 4/6/25 at 2:52 p.m., (5 days after symptom onset) R2 tested positive for Influenza A. R2's progress note dated 4/7/25 at 7:12 a.m., indicated precautions were initiated (6 days after symptom onset). R2's progress note dated 4/9/25, identified TBP were removed, but there was no comprehensive respiratory assessment to ensure R2's symptoms were resolved prior to removal of TBP's. R3 symptom onset 4/2/25 and tested positive on 4/3/25. R3's face sheet dated 3/31/25, indicated diagnoses of dementia, and diabetes. R3's record did not identify respiratory symptom screening after R3's roommate (R1) tested positive for influenza A on 3/31/25. Additionally, review of IC records did not identify additional prevention strategies were implemented to mitigate the risk of viral illness spread. R3's progress notes dated 4/2/25 at 3:45 p.m., indicated R3 was not feeling well, cough with runny nose. R3 was swabbed for Covid and Influenza. R3's record did not identify TBP's were implemented upon onset of symptoms. R3's progress notes date 4/3/25 at 11:43 p.m., indicated R3 was very weak, continued to have cough and runny nose. Labs returned positive for influenza A and physician notified, and orders received. R3 was put on droplet precautions (one day after symptom onset). R3's record did not identify when R3's TBP were removed. Review of R3's record did not identify comprehensive assessments and monitoring to ensure R3's symptoms were resolved prior to the removal of TBP. During an interview on 4/22/25 at 1:41 p.m., IP-A stated R2 should have had TBP in place with the diagnosis of roommate on 3/31/25. IP-A verified the TBP were removed after seven days and not based on a comprehensive respiratory assessment. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R4 symptom onset 4/7/25, tested positive on 4/8/25. R4's face sheet dated 4/24/25, indicated the following diagnoses of morbid obesity (severe overweight), and kidney disease. R4's record did not identify respiratory symptom screening from 3/31/25 through 4/6/25, even though the facility had positive Influenza cases. R4's progress notes dated 4/7/25 at 3:56 p.m., R4 reported to nurse practitioner (NP) shivering for about 30 minutes. Vitals signs were taken and R4 was swabbed for Covid and influenza. In review of R4's record there was no indication TBP's were implemented with onset of symptoms. R4's progress note dated 4/8/25 at 10:34 a.m., R4 tested positive for Influenza A. R4 on room isolation, however R4's record did not specify type of TBP was required. R4's late entry progress note dated 4/21/25 for 4/16/25, indicated R4 was removed from droplet precautions per infection control nurse, however, review of R4's record did not identify comprehensive assessments and monitoring to ensure R1's symptoms were resolved prior to the removal of TBP's. R5 symptom onset 4/8/25, tested positive 4/9/25. R5's face sheet dated 4/24/25, indicated diagnoses of obesity, acute/chronic respiratory failure with hypoxia, diabetes, CHF, and COPD. R5's record did not identify respiratory symptom screening from 3/31/25 through 4/7/25, even though the facility had a positive Influenza case. R5's progress note on 4/8/25 at 12:21 p.m., indicated R5 had confusion to place and time, words did not come out clearly, and unable to express needs clearly but able to verbalize her name. R5 also had a cough and poor appetite. Physician notified and labs ordered that included RSV/FLU/COVID. In review of R5's record there was no indication TBP's were implemented with onset of symptoms. R5's progress note on 4/9/25 at 9:56 a.m., indicated resident confused, slow to respond, and showed signs of distress. BP 123/76, 02 88% on 4L, Pulse 116, T. 97.3. BG 417. R5 sent to the hospital for further eval. R5's hospital summary identified R5 admitted to the hospital on [DATE] and discharged back to the facility on 4/18/25 with diagnoses that included influenza. Per hospital summary, upon admission to ED, R5 could not provide history due to acute hypoxic respiratory failure on BIPAP and acute encephalopathy. Further identified per nursing facility, multiple cases/exposures to influenza A of other residents this week. R5's record did not identify if R5 returned from the hospital on TBP and/or an assessment that determined precautions were no longer necessary. During an interview on 4/22/25 at 1:41 p.m., IP stated with the onset of symptoms R5 should have been put on TBPs, tested, and had respiratory assessments completed per facility protocol upon return to facility. (continued on next page)

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 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R6 symptom onset 4/8/2025; tested positive on 4/10/25. R6's face sheet dated 4/24/25, indicated the following diagnoses of diabetes, status post kidney transplant, immunodeficiency, and morbid obesity. R6's record did not identify any respiratory symptom screening from 3/31/25 through 4/7/25, even though the facility had a positive Influenza case. R6's progress notes dated 4/8/25 at 5:44 p.m., indicated R6 had requested cough syrup during AM shift due to coughing. R6 was assessed and a low-grade temperature of 99.5, blood pressure was 128/67, pulse 59. Rapid Covid test performed and was negative. Written message to physician on call board. In review of R6's record there was no indication TBP's were implemented with onset of symptoms. R6's progress notes dated 4/9/25 at 12:56 p.m., indicated R6 continued to have a cough with audible wheezing and lethargy. Temp 99.4, oxygen saturations 87-89%, so administered oxygen at 2 liters per minute (LPM). Physician on site and order received for swab for Influenza, RSV, and Covid, urinalysis with urine culture and chest x-ray. Chest x-ray not completed on the day shift and there were no Influenza swabs available. Order moved to tomorrow, 4/10/25. R6's progress notes dated 4/10/25 at 2:15 p.m. indicated physician was notified of positive Influenza A test. Review of R6's record did not identify when TBP was removed nor comprehensive assessments and monitoring to ensure R6's symptoms were resolved prior to the removal of TBP. R7 symptom onset 4/8/25 tested positive 4/14/25. R7's face sheet dated 4/24/25, indicated the following diagnoses of status post coronary artery by-pass graft, acute respiratory distress, pleural effusion (build up fluid in the lungs). R7's record did not identify respiratory symptom screening from 3/31/25 through 4/7/25, even though the facility had positive Influenza cases. R7's progress notes dated 4/8/25 at 9:30 p.m., indicated R7 had an occasional cough and diminished lung sounds without shortness of breath. Vital signs obtained and documented with no signs of fever. In review of R7's record there was no indication TBP's were implemented with onset of symptoms. Review of R7's progress notes between 4/9/25 and 4/13/25, identified R7 continued to have symptoms that included cough, difficulty breathing, and poor appetite. R7's progress notes dated 4/14/25 at 9:54 a.m., indicated R7 had influenza infection, strict in room isolation. R7 complained of feeling weak and had been coughing over the weekend and not feeling well. Physician notified and rapid Covid and influenza tests ordered. R7's progress notes dated 4/17/25 at 11:45 a.m., R7 was discharged to home with family. R9 symptom onset 4/8/2025, tested positive on 4/10/25. (R9 is roommates with R13 (continued on next page)

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	245493	A. Building B. Wing	04/24/2025

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R9's face sheet dated 4/24/25, indicated the following diagnoses; dementia, and malnutrition. R9's record did not identify any respiratory symptom screening from 3/31/25 through 4/7/25, even though the facility had positive Influenza cases. R9's progress notes dated 4/8/25 at 5:04 p.m., R9 had been coughing throughout AM shift. Rapid Covid test was negative. Physician notified via communication board. In review of R7's record there was no indication TBP's were implemented with onset of symptoms. R9's late entry dated 4/14/25 at 11:17 a.m. for 4/10/25, indicated R9 was having nasal congestion and occasional nonproductive cough. R9 was swabbed for Influenza A and RSV. R9 was put on droplet precautions and isolated to his room. Lab results were obtained evening of 4/11/25 which identified R9 was positive for Influenza A. R9's record did not identify when and/or if TBP's were removed. R13 symptom onset 4/8/25; influenza positive 4/11/25, (roommate to R9) R13's face sheet dated 4/24/25, indicated the diagnoses Parkinson's disease and CHF. R13's record did not identify any respiratory symptom screening from 3/31/25 through 4/7/25, even though the facility had positive Influenza cases. Furthermore, R13's record did not identify if TBPs were implemented. R13's progress notes dated 4/8/25, indicated R13 had foul smelling urine and son reported mild confusion. Physician notified via call board. R13's progress notes dated 4/9/25, indicated physician on site, orders received and swab for influenza not done, as out of supplies. Order changed to tomorrow 4/10/25. R13's progress notes dated 4/15/25, indicated late entry for 4/10/25 at 10:39 a.m., R13 was swabbed for Influenza, RSV and Covid and results were negative. R13's laboratory results fax transmission dated 4/12/25, included the results for influenza A test, collected 4/10/25 at 11:00 a.m. and the test resulted on 4/11/25 at 9:58 p.m., as positive for influenza A. During an interview on 4/23/25 at 10:46 a.m., registered nurse (RN)-A confirmed he wrote the late entry progress note and verified also that he was not aware R13 tested positive for Influenza A until 4/23/25, at 10:46 a.m. R13's progress note date 4/15/25 at 8:10 p.m., indicated R13 had a change of condition. R13 complained of being tired, wanted to go to bed, was shaking, passed out during transfer, and was assisted to bed by staff. Vital signs were stable with blood pressure 95/50, temperature 97.2 F, heart rate 85 beats per minute, SpO2 92% and upon re-check 10-15 minutes later blood pressure was 108/67, heart rate 127 beats per minute, and SpO2 95%. On call provider was notified and gave order to send R13 to the hospital for evaluation. (continued on next page)

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	245493	A. Building B. Wing	04/24/2025

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R13's hospital physician History and Physical hospital note dated 4/15/25, indicated R13 had lost consciousness for a brief time at the facility, had a temperature of 101.7 F, and emergency medical services were called and transported him to the hospital. R13's active problem list included influenza A with note medication list includes Tamiflu, which leads me to believe the care facility knew about this already, or maybe he was taking it for prophylaxis, sepsis likely from the influenza but chest x-ray suggestive of possible pneumonia, and chronic atrial fibrillation (heart rhythm disorder where the upper chambers beat irregularly). R13 was admitted to the hospital as an inpatient because of a higher risk of adverse outcome due to influenza A, sepsis. R13 remained in hospital with no return date anticipated. R8 symptom onset 4/10/25, tested positive on 4/11/25. R8's face sheet dated 4/24/25, identified the following diagnoses, fibromyalgia, and asthma. R8's record did not identify any respiratory symptom screening from 3/31/25 through 4/9/25, even though the facility had positive Influenza cases. R8's late entry note documented on 4/14/25 for 4/10/25 indicated R8 was having nasal congestion and occasional nonproductive cough. Rapid Covid 19 was negative. Orders received to swab R8 for Influenza A and RSV. R8 was put on droplet precautions and isolated to room on 4/10/25. Lab results returned 4/11/25 in the evening and positive for Influenza A. R8's late entry note dated 4/21/25 for 4/18/25 at 1:28 p.m., indicated R8 was removed from droplet precautions. However, R8's record did not include ongoing respiratory assessments and monitoring to determine the appropriate duration of precautions to mitigate the risk of viral spread. R10 symptom onset 4/13/2025, tested negative on 4/13/25 and then positive on 4/15/25. R10's face sheet dated 4/24/25, identified the following diagnoses, rheumatoid arthritis, urinary tract infection and asthma. R10's record did not identify any respiratory symptom screening from 3/31/25 through 4/10/25, even though the facility had positive Influenza cases. R10's progress notes dated 4/11/25 at 9:59 p.m., indicated R10 was more tired and weak this evening. R10's daughter had called facility and requested intravenous (IV) fluids as she was concerned R10 was dehydrated. Vital signs blood pressure 111/52, temperature 97.9, heart rate 85, respirations 18, and oxygen saturation 92% on room air. Lung sounds slightly diminished. R10 reported being nauseated, was unsteady and could not ambulate far. COVID swab negative. R10's record did not identify if TBPs were implemented. R10's progress notes dated 4/12/25 at 3:17 p.m., indicated R10 stayed in her room and only ate bites for breakfast and refused lunch. (continued on next page)

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	245493	A. Building B. Wing	04/24/2025

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In review of R10's progress notes dated 4/13/25 through 4/15/25, identified R10 had respiratory symptoms that included cough, shortness of breath, weakness, lethargy, and low oxygen saturations. On 4/13/25, the provider was notified and ordered oxygen, chest x-ray and labs. On 4/14/25, rapid tests for influenza and Covid were negative. R10's progress notes dated 4/15/254 at 10:46 p.m., indicated Influenza A detected. Currently on droplet precautions, on strict isolation (the record did not identify when TBP were implemented). Physician notified and orders for Tamiflu given. R10's progress notes dated 4/23/25 at 1:52 p.m., indicated continued illness, R10 transferred to ED for further evaluation. R10's record did not include hospitalization information. R11 symptom onset 4/14/2025, tested positive on 4/15/25. R11's face sheet dated 4/24/25, indicated the following diagnoses, diabetes, s/p open reduction internal fixation of left lower leg, morbid obesity, and obstructive sleep apnea. R11's record did not identify any respiratory symptom screening from 3/31/25 through 4/13/25, even though the facility had positive Influenza cases. R11's progress notes dated 4/14/25 at 10:02 p.m., indicated R11 was complaining of a severe headache and non-productive cough was medicated with scheduled Tylenol 1,000 mg and cough syrup which was effective. R11's record did not identify TBPs were implemented with onset of symptoms. R11's progress notes dated 4/15/25 at 10:22 a.m., indicated influenza A positive and on strict room isolation with droplet precautions was initiated today (one day after symptom onset) and to go through 4/21/25. R11's progress note dated 4/21/25, identified R11 was removed from TBP, however there was no indication comprehensive assessments and monitoring were completed to ensure symptom resolution prior to removal. R12 symptom onset 4/15/2025, tested positive on 4/17/25. R12's face sheet 4/24/25, indicated the following diagnoses infectious encephalopathy, acute left kidney infection, sepsis, and bacteremia with acute pulmonary edema. R12's record did not identify any respiratory symptom screening from 3/31/25 through 4/14/25, even though the facility had positive Influenza cases. R12's progress notes dated 4/15/25 at 10:27 p.m., indicated R12 complained of headache and was medicated with as needed Tylenol. Nasal swab was performed for COVID and Influenza, lab notified via fax. Currently on strict isolation precautions. R12's progress notes dated 4/16/25 at 9:04 p.m., indicated no complaints of headache, pain, shortness of breath or cough. Lung sounds diminished. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R12's progress notes dated 4/17/25 at 9:24 a.m., indicated isolation/Influenza positive. R12 placed in strict room isolation for seven days. During a continuous observation on 4/18/25 between 12:15 p.m. and 12:25 p.m., nursing assistant (NA)-M was observed delivering meal trays to R12 and R10, who had contact and droplet precautions signage posted on the doors. NA-M, without putting on any PPE, entered R12's room and delivered the meal tray and used hand sanitizer after leaving the room. NA-M then walked into R10's room without PPE, delivered meal tray, then performed hand hygiene. Unidentified housekeeper was cleaning resident rooms of the 200 hallway, entered R12's room with a mask on, but did not put gloves, gown, or eye protection as the sign directed. Housekeeper took a bag out of room with clothing in and put it on the floor outside the door in the hallway. Housekeeper used a cloth to wipe down the surfaces in the room. Housekeeper took the same the cloth and put in a bag tied to her cart in the hallway. Housekeeper mopped the floor in R12's room. Housekeeper exited the room and placed the dirty mop head into a bag tied to her cart. She then walked down the hallway and entered R18's room with the same mask on and did not perform any hand hygiene throughout the observation. During an interview on 4/18/25 at 12:22 p.m., NA-M stated residents who were on precautions were due to either a dressing change or they had a catheter. NA-M stated R10 tested positive for influenza A on 4/15/25. NA-M verified R10 had a sign on the door that directed droplet and contact precautions, however stated he only needed to wear a mask to enter R10's room despite the signage that directed R10 required gown, gloves, and eye protection in addition to the mask. During interviews on 4/18/25 three licensed staff, (LPN-E at 11:03 a.m., RN-G at 11:53 a.m. and LPN-A at 12:34 p.m.) were able to articulate sign/symptoms of respiratory viruses and when to implement TBP and test symptomatic residents. LPN-A, LPN-E, and RN-G all indicated even though they were performing assessments and illness monitoring they were not documenting their assessment findings in the resident's medical record. During a clarification interview on 4/24/25 at 10:33 a.m., DON stated she would expect a respiratory assessment to contain vital signs, lung sounds, oxygen use, and cough. Since 4/19/25, the facility has assigned a nurse to complete all of the necessary screening, assessments, and monitoring. DON's expectation is that TBP's were put into place and resident is tested per orders. Residents should remain in TBP until symptoms resolve. During an interview on 4/22/25 at 1:41 p.m., IP-A stated she determined if precautions could be removed by talking to staff and reviewing the records, however, confirmed there was no documentation of this determination. IP-A also stated there were residents who were symptomatic but tested negative and were not monitored for improvement or worsening conditions. IP-A explained the Infection Tracking Line List document was not started until 4/3/25 and this was also when the facility posted outbreak signage for staff and visitors. Infection Tracking Line List dated 4/18/25, was missing the start and end date of TBPs, was not completed in real time, and did not include all residents who had and were having respiratory symptoms. During an interview on 4/24/25 at 1:44 p.m., MD-C stated it was his expectation that the facility followed their policy/protocol for outbreak status. Facility policy titled Influenza (Prevention and Outbreak Management) dated 2/13/25, included an Influenza Outbreak section that indicated: (continued on next page)

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