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	04/16/2026

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 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to follow practitioner orders for 1 of 3 residents (R3) reviewed for respiratory care when R3 was sent to an off-site appointment without oxygen, resulting in a change in her condition requiring hospitalization.The noncompliance that began on 1/27/26 was corrected prior to the start of survey when the facility implemented a corrective action plan on 1/27/26. This is issued in past noncompliance. Findings include:R3's quarterly Minimum Data Set MDS), dated [DATE], indicated she had diagnoses of morbid obesity with alveolar hypoventilation (a condition where breathing is shallow or slow), hypertensive kidney disease, lymphedema (tissue swelling caused by fluid that is usually drained by the body's lymphatic system), atrial fibrillation, (an irregular heart rhythm), venous insufficiency and hypoxemia (low levels of oxygen in the blood).R3's care plan, dated 1/23/26, directed administer oxygen (O2) per orders.A nurse practitioner (NP) visit note, dated 1/26/26, directed continuous O2 at 2 liter per minute (LPM) to keep O2 saturation over 90%.R3's January medication administration record (MAR) directed check O2 saturation every four hours and as needed. If saturation is less than 90%, it is okay to titrate 1-6 LPM. Another O2 order, dated 1/26/26, was present on the MAR directing O2 use 2 LPM via nasal cannula (NC) continuous to keep sat over 90%.The MAR included O2 saturation levels: 1/27/26 at 12:00 a.m. = 92% on 2 L O2 1/27/26 at 4:00 a.m. = 90% on 2.5 L O2 1/27/26 at 8:00 a.m. = 90% on 1 L O2A progress note, dated 1/27/26, indicated R3 was 93% on 1 L/NC before going to her wound appointment. The nursing assistant (NA) assisted R3 to get ready. R3 left for her appointment without her O2 on. Later NA reported tank was broken. Wound clinic called to report to the patient was sent to the ER for hypoxia.A clinic note dated 1/27/26, at 10:35 a.m., indicated R3 was less alert than normal, unable to keep her eyes open or finish a sentence. Her oxygen (O2) saturation was 70 percent (normal range is 95-100%) on room air. R3 was placed on supplemental O2 and brought to the emergency department (ED). She was noted to have difficulty breathing.R3's hospital notes, dated 1/27/26, indicated R3 was sent to the wound clinic without O2 and became short of breath and somewhat confused. R3 was sent to the ED where her O2 saturation level was 75% and she was tachycardic (fast heart rate) at 137 [beats per minute] (normal heart rate range is 60-100). R3 was placed on BiPAP (Bilevel Positive Airway Pressure, a non-invasive ventilator used to treat breathing difficulties by delivering pressurized air through a mask). No clear indication of immediate prior illness or acute cardiac issues. Lack of O2 may have precipitated acute event.R3's hospital Discharge summary, dated [DATE], indicated R3 had acute on chronic respiratory failure with hypoxia and hypercapnia, improved chronic CO2 retention, persistent atrial fibrillation.During an interview on 4/16/26, at 10:16 a.m., nurse manager (NM)-A stated NA-A got R3 ready and sent her to her appointment without her O2. He stated NA-A was unaware R3 needed continuous O2 and R3 was in a rush to get to her appointment.During an interview on 4/16/26, at 10:38 a.m., the assistant director of nursing (ADON) stated R3's orders for O2 were changed the day before R3 left for her appointment and she expected R3 would have left the building with her O2.During an interview on 4/16/26, at 3:00 p.m., physical therapist (PT)-A from the wound care clinic stated when she walked into the room to see R3 on 1/27/26, R3 was lethargic and had a hard time keeping her eyes open. She initiated an emergency response team call. R3 did not (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0695 Level of Harm - Actual harm Residents Affected - Few	have supplemental O2, and her O2 saturation level was 70%. R3 was sent to the ED.During an interview on 4/17/26, at 9:44 a.m., the NP stated she saw R3 on 1/26/26 for shortness of breath and right sided pain. Continuous O2 was ordered at 2 LPM/NC. NP expected R3 would have been sent to her appointment with supplemental O2. NP stated, she had an ongoing medical condition but now needed to be on the O2. The fact that she needed to be on O2 and she wasn't on it made her symptoms worse.During an interview on 4/17/26, at 10:50 a.m., NA-A stated she assisted R3 to get ready for her appointment on 1/27/26. R3's portable O2 tank was not working properly, as it was making a hissing noise, and R3 refused her O2 while she was getting ready. She stated, I still should have sent her to the appointment with her O2. NA-A stated she was not informed R3's O2 order was changed and needed to be continuous.The facility Oxygen: Liquid Stationary policy, dated 3/10/25, directed oxygen will be administered per order.The facility Oxygen portable liquid tanks policy, dated 3/10/25, directed to turn regulator to prescribed flow and NA's may switch resident from one oxygen source to another as long as they do not adjust the liter flow.Action taken include: The facility reviewed their oxygen-related policies. The facility provided education to all nursing staff regarding the use of oxygen, filling portable tanks, reporting oxygen equipment malfunction, checking with the nurse prior to leaving the facility, conducting shift to shift report, transcribing orders and verification process, and coordinating changes in plan of care with providers. The facility conducted shift to shift report audits twice weekly between shifts, including NA's. The facility conducted an audit of all residents on oxygen. The facility reported the incident to the Quality Assessment Performance Improvement (QAPI) committee, including root cause analysis and action steps taken.The facility was able to demonstrate monitoring of the corrective action and sustained compliance.