



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 7, 2026

Administrator
Southview Acres HealthCare Center
2000 OAKDALE AVENUE
WEST SAINT PAUL, MN 55118

RE: CCN: 245189

Cycle Start Date: March 12, 2026

Dear Administrator:

On April 6, 2026, we notified you a remedy was imposed. On April 28, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 15, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 21, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 6, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 21, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 15, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



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May 7, 2026

Administrator
Southview Acres HealthCare Center
2000 OAKDALE AVENUE
WEST SAINT PAUL, MN 55118

Re: Reinspection Results
Event ID: 1E3F00-H2 and 22C023-H2

Dear Administrator:

On April 20, 2026 and April 28, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on March 12, 2026 and March 26, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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March 30, 2026

Administrator
Southview Acres HealthCare Center
2000 OAKDALE AVENUE
WEST SAINT PAUL, MN 55118

RE: CCN:245189

Cycle Start Date: March 12, 2026

Dear Administrator:

On March 12, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 12, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 12, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Melissa Poepping". The signature is fluid and cursive, with the first name "Melissa" and last name "Poepping" clearly distinguishable.

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



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March 30, 2026

Administrator

Southview Acres HealthCare Center

2000 OAKDALE AVENUE

WEST SAINT PAUL, MN 55118

Re: State Nursing Home Licensing Orders

Event ID: 1E3F00-H1

Dear Administrator:

The above facility survey was completed on March 12, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245189		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/12/2026	
NAME OF PROVIDER OR SUPPLIER Southview Acres HealthCare Center				STREET ADDRESS, CITY, STATE, ZIP CODE 2000 OAKDALE AVENUE , WEST SAINT PAUL, Minnesota, 55118			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E0000	Initial Comments On 3/9/26 - 3/12/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			04/15/2026	
F0000	INITIAL COMMENTS On 3/9/26 - 3/12/26 , a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies were cited: H51896781C (iQIES# 2749202 and 2748743) H51897907C (iQIES# 2739956 and 2739978) H51897912C (iQIES# 2710360) H51897909C (iQIES# 2639988) H51897910C (iQIES# 2563359) H51897916C (iQIES# 999707) H51897911C (iQIES# 999684) H51897914C (iQIES# 999677) H51897913C (iQIES# 999674) H51897915C (iQIES# 999663) H51897917C (iQIES# 999644)		F0000			04/15/2026	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0000	Continued from page 1 H51897918C (iQIES# 999643) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.		F0000				
F0580 SS = D	Notify of Changes (Injury/Degrade/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when		F0580	R 181 left AMA on 1/10/2026. As of this writing, there were no recorded AMA's since survey exit. Future residents who leave against medical advice, the physician will be made aware and a MARCC report initiated. Licensed nurses and IDT Team will be in-serviced on the Leave of Absence Policy with emphasis on informing the physician of resident decision to leave and that a MARCC report will be created. Social Services is responsible for compliance. Audits on resident AMA date, notification to MD and Ombudsman and MARCC report initiation will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take the audit results to QAPI for review and recommendation.		04/15/2026	

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F0580 SS = D	Continued from page 2 there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the attending physician of a change in condition for 1 of 1 resident (R181) reviewed for discharge process. Findings include: R181 was admitted to the facility on 1/8/26 with an admission diagnosis of lumbar stenosis without neurogenic claudication, and other specified postprocedural state. R181 left the facility on 1/10/26. R181's medical record was reviewed and lacked documentation about reporting R181's leaving the facility against medical advice (AMA) to his primary physician. R181's progress note dated 1/10/26 at 5:58 a.m., indicated R181's wife arrived at the facility at 4:50 a.m. and requested to get R181's medications ready because she was taking R181 home with her. The progress note indicated the nurse in charge educated R181 and his wife about AMA. The nurse in charge advised them the facility would not be able to release the medications.		F0580				

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F0580 SS = D	Continued from page 3 R181's progress note dated 1/13/26 at 3:09 p.m., documented a phone call from a spine center requesting an update about R181. The spine center wanted to verify R181 left the facility AMA, and without medications. During interview on 3/12/26 at 10:29 a.m., the assistant director of nursing/infection control preventionist (IP) reviewed R181's medical record and verified R181's primary physician was not updated about R181 leaving AMA. During interview on 3/12/26 at 10:42 a.m., the director of nursing (DON) stated the provider needed to be notified when a resident left AMA. DON stated she would look into R181's situation and provide further details. No additional information was received. Facility's policy titled Resident Leave Against Medical Advice dated 4/19/19, indicated the resident's "assigned nurse will contact the primary physician to inform of the resident's decision to leave against medical advice."	F0580		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals;	F0628	R 10 and R 17 have both returned to the facility. All current residents who were discharged or transferred from the facility, their charts were reviewed and updated as needed. Future residents who leave emergently will have a bed hold response documented in the resident chart. Licensed nurses and IDT Team will be in-serviced on the Transfer Discharge Notice policy with focus item #5 that the bed hold will be documented in the resident record. The area Ombudsman will be notified of all facility resident transfers to hospital and discharges. Social Services is responsible for compliance. Audits on bed hold documentation will be weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take the audit results to QAPI for review and recommendation.	04/15/2026

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F0628 SS = D	Continued from page 4 (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F0628		

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F0628 SS = D	Continued from page 5 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.		F0628				

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F0628 SS = D	Continued from page 6 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of	F0628		

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F0628 SS = D	Continued from page 7 illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the State Long-Term Care (LTC) Ombudsman of facility-initiated transfers to an acute care facility on an emergent basis, and failed to ensure a written notice of bed hold was provided and documented in the electronic medical record (EMR) for 2 of 2 residents (R10, R17) reviewed for hospitalizations. Findings include: R10 R10's significant change in status (SCSA) Minimum Data set dated 2/26/26, identified R10 with severe cognitive impairment, and diagnoses of liver cancer, kidney disease, dementia, and psychosis (disconnection with reality, including hallucinations and delusions). R10's progress note (PN) dated 12/15/25, identified R10 had an unwitnessed fall with injury and was sent to the emergency department (ED). PN lacked indication a bed-hold or transfer form was offered and signed. R10's PN dated 1/24/26, identified a fall with major injury and was sent to the ED.PN lacked indication a bed-hold or transfer form was offered and signed. R17 R17's quarterly MDS dated 2/11/26, identified R17 with severe cognitive impairment and diagnoses of Alzheimer's, arthritis, dementia, anxiety, depression and fibromyalgia (chronic disorder involving pain, fatigue, sleep disturbances and cognitive issues). R17's Emergency Room (ER) After Visit Summary dated 2/19/26, identified R17 was sent to eh hospital on (date) and returned on (date) for a medication-related		F0628				

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F0628 SS = D	Continued from page 8 concern. PN failed to indicate if a bed-hold or transfer form was offered to her emergency contact. During interview with registered nurse (RN)-D on 3/11/26 at 12:48 p.m., RN-D stated when a resident was transferred to the hospital, the facility was expected to obtain a signed bed-hold and transfer policy from the resident or a verbal agreement prior to resident leaving the facility. RN-D stated she was expected to obtain a copy of the signed form and give it to the Health Unit Coordinator (HUC) who was then expected to download or scan it into the residents EMR. In addition, RN-D stated she would send the resident to the hospital with a face sheet, medication list, and a copy of a current Provider Order for Life Sustaining Treatment (POLST) form. RN-D stated she would call the guardian and emergency contact to obtain verbal consent if a resident was unable to provide it and then document this in a progress note in the EMR. During interview with licensed practical nurse (LPN)-D on 3/11/26 at 12:59 p.m., LPN-D stated whenever a resident was transferred to the hospital, the facility was expected to ask family or the resident's guardian for verbal permission to approve a bed-hold and transfer notice. LPN-D stated, "I fill out form saying I have verbal permission," uploaded it into the residents EMR, wrote it in the progress note. During interview with RN-B on 3/11/26 at 1:26 p.m., RN-B stated whenever a resident was transported to the hospital that a signed bed-hold and transfer policy must be obtained each time they leave. RN-B stated a copy of the signed form is uploaded into the residents EMR and expectation was to document the bed hold in the progress note. During interview with HUC-A on 3/11/26 at 1:31 p.m., HUC-A stated bed-holds went with the resident to the emergency room and HUC-A scanned a copy of the signed form and put it in the EMR. During interview with LPN-H on 3/12/26 at 8:30 a.m., LPN-H stated when she sent a resident to the hospital she would fill out the written form to get consent, leave a copy at the facility to be scanned into the chart, and send a copy with the resident along with other paperwork to the hospital. LPN-H stated she was nurse on duty when R10 fell and broke his hip on 12/15/25 and was sent to the hospital. LPN-H stated she did not recall if she got the bed-hold and transfer form, but if she had, she would have entered it into R10's progress notes. LPN-H looked at R10's progress notes and verified there was no mention of providing or		F0628				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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F0628 SS = D	Continued from page 9 offering a bed-hold notice and transfer form to R10. During interview with health unit coordinator (HUC)-B on 3/12/26 at 8:43 a.m., HUC-B stated that when a resident was transferred to the hospital, the facility was expected to print out a resident face sheet, POLST, medication list and have the resident sign a copy of the bed-hold and transfer policy prior to leaving the facility. In instances where the resident was unable to acknowledge the bed-hold form then the guardian or emergency contact was informed, and the nurse was required to document the discussion in the progress note of the EMR. In addition, the HUC was responsible for uploading a copy of the signed bed-hold and transfer form into the EMR. During interview with LPN-I on 3/12/26 at 10:03 a.m., LPN-I stated he was the nurse on duty when R17 fell and fractured his arm on 1/24/26 and was sent to the hospital. LPN-I stated he did not recall filling out bed-hold or transfer form prior to sending R17 to the hospital. LPN-I stated, "it should be signed and scanned into the chart, but I do not recall it being done." LPN-I stated expectation of staff to print a face sheet, medication list, and POLST to accompany the resident to the hospital. During interview with registered nurse (RN)-A on 3/12/26 at 11:26 a.m., RN-A stated expectation of nursing staff to immediately provide a copy of the bed-hold policy and notice of transfer to the patient or guardian prior to transfer to hospital. In addition, the resident face sheet, medication list and current POLST to all accompany resident to the hospital. RN-A stated expectation of facility staff to upload a signed copy of the notice of transfer to the resident's electronic medical record (EMR). RN-A verified both R10 and R17's EMR lacked documentation of a bed-hold/transfer notice, and a progress note to indicate it was done. During interview with director of nursing (DON) on 3/12/26 at 11:04 a.m., DON stated expectation of staff to provide copy of bed-hold policy and notice of transfer when residents were leaving the building for hospitalizations. DON stated a signed copy should be scanned into the EMR. As for notifying the Office of the State Long-Term Care Ombudsman of discharges and transfers, DON stated the director of social services (SS)-D is responsible for that task. During interview with SS-D on 3/12/26 at 11:17 a.m., SS-D stated she was responsible for sending discharge notifications to the State Ombudsman monthly. However,	F0628		

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F0628 SS = D	Continued from page 10 SS-D stated she was unaware of needing to send notices of transfers and hospitalizations to the Office of the State Long-Term Care Ombudsman too., and stated, "I did not know that I had to". Attempts to call/contact R10 and R17's guardian and primary emergency contacts and the Ombudsman were made but no answer or call back was obtained. Undated facility policy titled Transfer or Discharge Notice identified expectation of facility to provide transfer or discharge notice to resident where, "An immediate transfer or discharge is required by the resident's urgent medical needs". In addition, "The resident and/or representative will be notified in writing of the following information" which included the facility bed-hold policy and, "A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman."	F0628		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or	F0641	R 5, R 8 and R 25's MDSs were modified. All current residents from survey exit until present, their MDS for Section J and GG were reviewed and updated as needed. Future resident MDS will be accurately coded per facility policy. Facility MDS nurses was in-serviced on the Resident Assessment Policy with emphasis on item #1 the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews and item #8 that all interdisciplinary members who sign the MDS attest to the accuracy of the assessment. Director of Nursing is responsible for compliance. Audits on MDS Section J and GG for accuracy will be weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take the audit results to QAPI for review and recommendation.	04/15/2026

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F0641 SS = D	Continued from page 11 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with the potential for inaccurate federal reimbursement and resident care planning for 3 of 5 residents (R5, R8, and R25) reviewed for MDS accuracy. Findings include: R5's Annual Minimum Data Set (MDS), dated 1/9/26 indicated R5 was admitted to the care facility on 1/13/25. Section GG Functional Abilities and Goals section of the MDS was dashed "not assessed." R8's quarterly MDS, dated 2/17/26, indicated R8 was admitted to the care facility 11/22/24. Section GG Functional Abilities and Goals section of the MDS was dashed "not assessed." R25's quarterly MDS dated 3/5/26, indicated R25 was not receiving hospice care and was admitted to the facility on 9/4/25. R25's Order Summary Report dated 9/23/25 included an active order that indicated R25 had signed on to receive hospice care on 9/4/25 with a diagnosis of Parkinson's disease. During an interview on 3/12/26 at 8:01 a.m., licensed practical nurse (LPN)-E stated that R25 was receiving hospice care and had been since his admission to the facility. During an interview on 3/12/26 at 9:20 a.m., the MDS Coordinator (MDSC)-A stated the GG section of the MDS was discussed daily at their morning team meeting and was also assessed by utilizing the resident's electronic medical record (EMR) to determine how well a resident functions and how much support they need with activities of daily living (ADLs). The MDSC-A stated they attempt to coordinate baths for each resident to fall within the 3-day lookback period but that it can		F0641				

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F0641 SS = D	Continued from page 12 be challenging with the large size of their facility. The MDSC-A confirmed R5's and R8's GG section of their most current MDS was dashed as "not assessed". The MDSC-A also stated it was their responsibility to indicated on the MDS if a resident was receiving hospice services which was determine based on a list the chaplain send out with all residents receiving hospice services listed. The MDSC-A confirmed R25's most current MDS did not indicated R25 was receiving hospice services, and it should. A facility policy titled Resident Assessments, dated 11/30/2021, indicated the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews.	F0641		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)-	F0656	R 13 care plan for pain was initiated on 3/11/2026. All current residents who are receiving pain medication, their care plans were reviewed and updated as needed. Future residents who admit will have a pain care plan initiated. Licensed nurses will be in-serviced on the Comprehensive Care Plan with emphasis on #3 that care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment that is completed. In addition, the IDT team licensed nurses will review the Care Pathway tab along with care plan triggered items to ensure care plan is complete. Director of Nursing and/or designee is responsible for compliance. Audits on MDS pain assessment completion and Section V of MDS for triggered items will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take the audit results to QAPI for review and recommendation.	04/15/2026

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F0656 SS = D	Continued from page 13 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation and document review, the facility failed to ensure a comprehensive care plan was developed and implemented for 1 of 1 resident (R13) reviewed for pain management. Findings include: R13's admission Minimum Assessment Data (MDS) dated 2/24/26, indicated R13 was cognitively intact, had no behaviors, and didn't refuse cares. MDS indicated R13 needed substantial assistance with toileting hygiene, bathing, dressing, personal hygiene, and transfers. The MDS assessment also indicated R13 received scheduled and as needed (PRN) pain medications, as well as opioid and antipsychotic medications. R13's Clinical Diagnosis Report dated 3/12/26, indicated diagnoses of chronic obstructive pulmonary disease, chronic pain, post-traumatic stress disorder, repeated falls, failure to thrive, and heart failure. R13's orders dated 3/12/25 included the following medications:Hydromorphone HCL 2 milligrams (mg) tablets. Give 0.5 tablet by mouth three times a day.Hydromorphone HCL 2 mg tablets. Give 0.5 tablet by mouth every 6 hours as needed (PRN)Acetaminophen oral tablet 500 mg. Give one tablet every 8 hours PRNLidocaine external cream 4%. Apply small amount to left chest wall twice a day.Gabapentin oral capsule 100 mg by mouth three times a day.R13's care plan dated 3/12/26, did not include a care plan for pain. During interview on 3/10/26 at 11:46 a.m., R13 stated			F0656			

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F0656 SS = D	Continued from page 14 he had chest surgery last year and since then he has experienced pain. During the interview R13 rated his pain as "7". R13 said the pain "comes and goes." During interview on 3/10/26 at 3:21 p.m., nurse manager/licensed practical nurse (LPN)-C stated R13 had problems with pain. LPN-C stated R13 scheduled an appointment to see a doctor due to severe foot pain. During interview on 3/11/26 at 10:44 a.m., LPN-C verified his pain management had not been care-planned. During interview on 3/11/26 at 10:49 a.m., the director of nursing (DON) stated R13 should have had a care plan for pain and she expected the staff would assess resident's pain and monitor for side effects and pain therapy effectiveness. A facility policy titled Comprehensive Person-Centered Care Plans dated 11/30/21, indicated the comprehensive, person-centered care plan will include measurable objectives and timeframes, and describe the services that are furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being.	F0656		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable	F0657	R 6 care plan for pain was updated on 3/30/2026. R 42 care plan for pain was updated on 03/31/2026. All current residents who are on pain medication, their care plan for pain non-pharmacological interventions were reviewed and updated as needed. Future residents who admit will have non-pharmacological interventions added to their pain care plan. Licensed nurses will be in-serviced on the Comprehensive Care Plan with emphasis on #3 that care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment that are completed. Director of Nursing and/or designee is responsible for compliance. Audits on resident care plan interventions for non-pharmacological interventions will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take the audit results to QAPI for review and recommendation.	04/15/2026

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F0657 SS = D	Continued from page 15 for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to revise the care plan to include a comprehensive pain management plan for 2 of 3 residents (R6, R42) reviewed with a history of pain. Findings include: R6's quarterly minimum data set (MDS) dated 1/15/26, indicated R6 had moderately impaired cognition and a diagnosis of heart failure, kidney failure, and dementia. The MDS indicated R6 received scheduled pain medications, did not receive as-needed pain medications, and did not receive non-medication interventions for pain during the look-back period (LBP). R6's care plan dated 10/29/25, included a pain care plan that indicated R6 had "acute pain/ chronic pain" but did not further describe R6's pain. The care plan had a goal that the resident would report satisfactory pain control. The pain care plan included one intervention, which was as follows: evaluate for non-verbal indicators of pain. The pain care plan did not indicate what non-pharmacological interventions should be utilized for managing R6's pain. R6's order summary dated 3/10/26, indicated R6 had an order for 650 milligrams (mg) of acetaminophen (an over-the-counter pain medication) three times a day for chronic pain, with a start date of 7/14/25, a discontinued date of 3/9/26, and then reordered on 3/9/26. The summary included an order for a lidocaine pain relief patch to the mid-upper back every 12 hours, started on 8/26/25, discontinued on 3/9/25, and restarted on 3/9/26. The summary indicated R6 also had an order for 500 mg of methocarbamol (a muscle relaxant) every four hours as needed for pain, with a start date of 10/17/25. During an interview on 3/11/26 at 10:11 a.m., registered nurse (RN)-D confirmed she was R6's nurse for the day. RN-D stated that R6 had a history of		F0657				

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F0657 SS = D	Continued from page 16 chronic pain and had previously been seeing a pain medicine team for this pain. RN-D stated R6's pain was sporadic and varied in location but was sometimes in his back. RN-D stated that the non-pharmacological interventions she had used to assist R6 with his pain were music, redirection, snacks, and reminiscing, and she had found these effective. During an interview on 3/12/26 at 8:04 a.m., licensed practical nurse (LPN)-B confirmed she was R6's nurse for the day and stated that when R6 had pain, it was generally in his upper back and that non-pharmacological pain interventions such as heat or ice were implemented to assist with his pain. LPN-B stated she would look at the care plan to see what pain interventions were effective for R6 but was unsure if this was on the care plan or not. During an interview on 3/12/26 at 8:47 a.m., LPN-G, the unit nurse manager, stated that R6 had a history of upper back pain and utilized pain medications. When asked what nonpharmacological pain interventions had been found helpful with R6's pain, LPN-G stated that things such as fresh air, one-on-one time, and reassurance were helpful nonpharmacological interventions to assist R6 with his symptoms. LPN-G stated she and social services worked together to update resident care plans, but when asked if these nonpharmacological pain interventions were part of his care plan, LPN-G stated she was unsure. During an interview on 3/12/26 at 9:14 a.m., the director of nursing (DON) stated that she would expect nursing staff to assess and observe for signs and symptoms of resident pain, and as they see these signs or symptoms, they should attempt non-pharmacological pain interventions. The DON stated she would expect non-pharmacological pain interventions to be outlined in the care plan but acknowledged this might take some time to develop as they get to know the residents. R42's annual Minimum Data Set (MDS), dated 1/16/26, indicated R42 was admitted to the care facility on 12/26/23, had severe cognitive impairment, and was dependent on staff for all activities of daily living (ADLs). The MDS further indicated R42 received scheduled and as needed pain medication but did not receive and non-pharmacological pain interventions. R42's Orders indicated an order, dated 3/2/26, for Oxycodone (a narcotic pain medication) 5 milligrams (mg) once a day and every 6 hours as needed, not to exceed 3 doses. R42's orders, dated 5/7/25, indicated		F0657				

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F0657 SS = D	Continued from page 17 orders for methocarbamol (a muscle relaxant) 500mg three times a day for pain, diclofenac gel to right wrist three times a day for pain and Tylenol 650 mg three times a day for pain. R42's March medication administration record (MAR), indicated R42 had received as needed oxycodone seven times in the past ten days. R42's care plan, dated 11/2/24, indicated R42 had chronic pain related to upper extremity contracture and a history of shoulder injuries. The care plan indicated an intervention to medicate R42 with as needed medications if non-medication interventions were ineffective. The pain care plan did not indicate what non-pharmacological (non-medication) interventions should be utilized for managing R42's pain. R42's electronic medical record (EMR), to include progress notes, lacked evidence of documented or care planned non-pharmacological pain interventions that should be attempted prior to administering as needed pain medication. During observation on 3/9/26 at 5:58 p.m., R42 was out in the main living area in a broda chair. R42 appeared to be leaning to the right and in distress moaning and restless. Staff approached R42 to help reposition him in his broda chair. During an interview on 3/11/26 at 7:20 a.m., nursing assistant (NA)-D stated R42 would stay in bed until near lunch time, and she believed the nurses would give him something for pain prior to transferring him out of bed to help with his pain. NA-D stated if a resident appeared in pain, including R42, there were no non-medication interventions would try, she would tell the nurse. During an interview on 3/11/26 at 10:04 a.m., registered nurse (RN)-F stated R42 was unable to verbally communicate but could at times nod "yes" or "no" to simple questions such as "are you in pain." RN-F stated staff often had to read his non-verbal signs of pain such as facial grimaces or groans. RN-F stated for non-pharmacological interventions staff would get him out of bed into his broda chair. During an interview on 3/11/26 at 1:03 p.m., nurse manager and licensed practical nurse (LPN)-C stated it was the expectation that non-pharmacological pain	F0657		

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F0657 SS = D	Continued from page 18 interventions be care planned and attempted and documented prior to as needed pain medication being administered. During a follow up interview on 3/11/26 at 2:35 p.m., nurse manager and LPN-C stated when staff notice R42 to be in pain they hold his hands, reposition him in his broda chair and if he still shows signs of pain they offer him pain medication. LPN-C confirmed that none of the non-pharmacological pain interventions were care planned or documented as attempted. The facility's Comprehensive Person-Centered Care Plans policy dated 11/30/21, indicated that a person-centered care plan would be developed for each resident. The policy indicated care plan interventions would be derived through analysis of the information gathered as part of the comprehensive assessment. The policy indicated the care plan would include services that would be furnished to attain or maintain the resident's highest practicable well-being.	F0657		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a resident was reassessed and failed to implement new interventions to prevent skin breakdown after developing a stage III pressure injury while a resident at the facility for 1 of 2 residents (R123) reviewed for pressure injuries. Findings include:	F0686	R123 wound resolved on 2/23/2026. All current residents with wounds will have their wound interventions reviewed and updated as needed. Future residents whose wounds heal and then reopen will have a new skin assessment completed, care plan reviewed, a new Braden and new treatment orders if warranted. Licensed nurses will be in-serviced on the Pressure Risk Assessment policy with emphasis on section 4c that nurses must notify the MD of new changes in skin, implement new orders and update care plans upon a change in skin status. Director of Nursing is responsible for compliance. Audits on weekly wound assessments, skin treatments and care plan interventions will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take the audit results to QAPI for review and recommendation.	04/15/2026

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F0686 SS = D	Continued from page 19 R123's quarterly Minimum Data Set (MDS) dated 1/13/26, indicated R123 required substantial staff assistance with personal hygiene, dressing and bathing and was dependent on staff for toileting. The MDS indicated R123 was at risk but did not have any pressure ulcers. R123's care plan included a focus of potential for skin impairment related to immobility and incontinence last revised 12/19/23. Interventions included use of pressure reducing wheelchair cushion and pressure reducing mattress. R123's care plan, dated 1/16/26, indicated R123 had a coccyx wound requiring wound care and to keep resident skin clean and well lubricated. The care plan lacked any new, specific pressure reducing interventions to prevent R123 from developing new (or re-opening) pressure injuries. R123's wound note, dated 1/19/26, indicated R123 had a stage III pressure injury to her coccyx that had "re-opened last week" and the plan of care in place remained effective. R123's significant change MDS, dated 2/17/26, indicated R123 received hospice services and required substantial staff assistance with personal hygiene, dressing and bathing and was dependent on staff for toileting. The MDS further indicated R123 was at risk for pressure ulcers and had one stage III pressure injury not present on admission. R123's wound note, dated 2/23/26, indicated R123's coccyx wound had resolved. During an interview on 3/11/26 at 12:37 p.m., registered nurse (RN)-F stated staff used barrier cream and a silicone dressing for R123's "bottom" even without a pressure injury. RN-F stated R123 was not on any specific turning and reposition schedule. During an interview on 3/11/26 at 1:03 p.m., clinical manager and licensed practical nurse (LPN)-C stated R123's interventions depended on who the aide was that was working, stating R123 would often refuse cares but a few aides were able to get her up and out of bed. LPN-C stated the aides who worked with the residents rotated to different units but "work well together." LPN-C confirmed the care plan needed to be updated to remove wound care and confirmed there had been no updates to the potential for skin impairment care plan since R123 developed a pressure injury in January. LPN-C stated she believed the current interventions	F0686					

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F0686 SS = D	Continued from page 20 were effective because R123. "had the one issue and hasn't had anymore." During a follow up interview on 3/12/26 at 11:02 a.m., clinical manager and LPN-C stated R123 should not be getting a silicone dressing on her coccyx as the wound resolved and there were no new orders after the wound healed for continued dressing, only barrier cream. LPN-C also confirmed R123 was not on a specific turning and repositioning schedule. During an interview on 3/12/26 at 12:10 p.m., the director of nursing (DON) stated that even though R123 was on hospice care she would expect to see new care planned interventions for pressure injury prevention and skin protection after the development of a pressure injury, stating, "we still don't want to see pressure injuries in hospice." A facility policy titled Prevention of Pressure Injuries, dated 3/6/25, instructed staff to "reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team" and to "review the interventions and strategies for effectiveness on an ongoing basis."	F0686		
F0791 SS = D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested,	F0791	R 87 was offered dental services and will await family response. R 152 accepted dental services and will be seen on next facility dental visit. All current residents who are in need dental appointments, their appointments were created and documented. Future residents who lose dentures or need dental appointments, their appointments will be made timely per facility policy. The IDT team and licensed nurses will be in-serviced on the Dental Services policy with emphasis on If dentures are damaged or lost, residents will be referred for dental services within 3 days. If the referral is not made in 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services; and the reason for the delay. All dental services are provided in the resident's medical record. Social Services is responsible for compliance. Audits on resident dental appointment dates being made and follow-up orders with documentation will begin weekly for 2 weeks, then monthly to ensure sustained compliance.	04/15/2026

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F0791 SS = D	Continued from page 21 assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to provide assessments and routine dental services to 2 of 2 residents (R87, R152) reviewed for dental care. Findings include: R152's significant change Minimum Data Set (MDS) dated 2/14/26, indicated intact cognition, diagnoses of traumatic subdural hemorrhage (brain bleed) with loss of consciousness, weakness, dysphagia, and required substantial assistance with oral hygiene. During observation and interview on 3/12/26 at 8:48 a.m., R152 was sitting on the edge of his bed in his room. He stated his mouth was sore and he opened his mouth where there were several missing teeth. He further stated he hadn't seen a dentist since he was admitted (9/16/24) and would like to. He told several staff members about his mouth pain but was unable to recall which staff members he told.			F0791	Continued from page 21 Audit results will be reviewed by the Administrator, and the Administrator will take the audit results to QAPI for review and recommendation.		

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F0791 SS = D	Continued from page 22 R152's MDS dental assessment (completed by Apple Tree Dental) dated 9/2/25, indicated R152 had broken natural teeth, requires staff supervision with oral care, recommended a routine dental referral, and non-urgent dental care needs. R152's care plan dated 2/20/26, indicated R152 required the physical assistance of one staff for personal hygiene but did not address oral care specifically. R152's medical record lacked documentation of routine dental care (i.e. dental appointment). During interview on 8:55 a.m., the Health Unit Coordinator (HUC)-C stated orders for ancillary services (dental, podiatry, vision, etc.) were put in upon admission. Then MDS does an assessment to see what services are needed and the clinical manager can prescribe orders for a referral. When there are enough residents, they (dentist) will come to the facility. HUC-C further stated the residents should be seen within 6 months of the referral. Apple Tree Dental was scheduled to come on 3/17/26 but R152 was not scheduled to be seen. HUC-C stated there was not an official list of residents for this month's visit. The surveyor asked when R152's last dental visit was and HUC-C was unable to find that information. R87 R87's quarterly Minimum Data Set (MDS) dated 1/20/26, identified R87 with severe cognitive impairment and dependent on staff for all cares including oral hygiene. In addition, R87 had diagnoses of dementia and dysphagia (difficulty swallowing). R87's care plan dated 3/3/25 identified R87 with "Impaired Dentition-edentulous, no dentures". R87's physician orders (PO) and electronic medical record (EMR) failed to indicate an order for dental services. During interview with licensed practical nurse (LPN)-H on 3/12/26 at 8:30 a.m., LPN-H stated expectations for orders to be obtained from provider and the Health Unit Coordinator (HUC) would then make the appointment and arrange transportation. During interview with HUC-B on 3/12/26 at 8:43 a.m., HUC-B stated expectation of facility to obtain a		F0791				

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F0791 SS = D	Continued from page 23 referral from a provider and HUC would then facsimile order and resident face sheet to the contracted dental provider for the facility who “comes a couple times a year” to facility to provide routine dental services. During interview with Registered Nurse (RN)-A on 3/12/26 at 10:26 a.m., RN-A stated expectation of all residents to be seen by a dentist “usually yearly or every 6 months”. RN-A looked in R87’s electronic medical record and verified “no dental assessments were done”. RN-A stated, “we should still ensure everyone has a dental visit or least offered yearly.” During interview with director of nursing (DON) on 3/12/26 at 11:09 a.m., DON stated expectation of all residents, “Should be seen annually at least and documented in the chart that it was done”. DON verified R87 EMR failed to indicate any dental services were offered or provided. Attempts at contacting R87’s responsible party were made but no answer or call back was obtained. The facility policy regarding dental services dated 2/8/22, indicated all dental services provided are recorded in the resident’s medical record.	F0791		
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).	F0851	An error occurred during the submission of the Payroll Based Journal information for Southview. There were no ill effects experienced by residents for this error. Future submissions will follow Payroll Based Journal per the quarterly set timeframe and a final submission confirmation will be provided to the facility. Human Resources, Business Office Manager and Administrator, was in-serviced on the Payroll Based Journal policy with emphasis on ensuring that the submission of staffing information is submitted by the established deadline. Human Resource and/or designee is responsible for compliance. Audits on quarterly PBJ submission confirmation will be quarterly x 2 quarters to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take the audit results to QAPI for review and recommendation.	04/15/2026

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F0851 SS = F	Continued from page 24 §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to electronically submit direct care staffing information (including agency and contract staff) per day, based on payroll and other verifiable and auditable data to Centers for Medicare and Medicaid Services (CMS). The had the ability to impact all 171 residents residing at the care facility. Findings include:		F0851				

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F0851 SS = F	Continued from page 25 The care facilities Payroll Based Journal (PBJ) Staffing Data Report for fiscal year quarter 1 2026 (October 1 - December 31), dated 3/4/26, indicated the facility failed to submit data for the quarter. During an interview on 03/0926 at 12:24 p.m., the administrator stated the PBJ information was submitted through their corporate team, and he would look into how this was missed. During a follow up interview on 12:10 p.m., the administrator stated he spoke with his corporate team, and it was discovered the wrong facility's information was uploaded in place of their facility's staffing information and it "didn't stick" in the system. A facility policy titled Payroll Based Journal, dated 3/2/25, indicated it was the policy of the facility to "adhere to the mandatory submission of staffing information based on payroll data" with a deadline of February 14th for fiscal quarter 1 submissions. The policy further indicated, "Section 6106 of the Affordable Care Act (ACA) requires facilities to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data."	F0851		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F0880	R 9 has been discharged from the facility. R 73 was placed in the proper Transmission Based Precaution. R 73 did not experience any ill effects from this deficient practice. All current residents who are on precautions, their infection control case and room door posting were reviewed and updated as needed. Future residents who are admitted to the facility will have the proper PPE worn, hand hygiene performed in the correct sequence and EBP procedures followed by facility policy. Facility nurses and nurse aides will be in-serviced on the Handwashing/Hand Hygiene policy with emphasis on completing hand hygiene before and after care, body fluids and removing gloves, the Enhanced Barrier Precaution policy with emphasis on gowns and gloves are to be worn during care, changing linens and changing briefs and the Perineal Care policy with focus on item #8 cleansing process for male and female residents. Infection Preventionist is responsible for compliance. Audits on proper PPE worn during care and proper hand hygiene before, during and after peri-care will begin weekly x 3 weeks then monthly to ensure sustained compliance.	04/15/2026

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F0880 SS = D	Continued from page 26 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F0880	Continued from page 26 Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation.	

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F0880 SS = D	Continued from page 27 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn to prevent the spread of infection for 1 of 1 residents (R9) observed for enhanced barrier precautions (EBP), (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). Facility also failed to ensure hand hygiene was performed for 1 of 2 residents (R73) reviewed for transmission-based precautions (TBP). Findings Include: Review of Centers for Disease Control (CDC) guidance dated 4/1/24, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for EBP included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. R9's significant change MDS dated 1/13/26 indicated R9 was cognitively impaired, had physical behaviors toward others with no impact to the resident, and did not refuse cares. R9's MDS indicated he had a pressure ulcer and had an indwelling catheter. MDS indicated diagnoses of atrial fibrillation, hypertension, non-Alzheimer's dementia, depression, post-traumatic stress disorder, neurogenic bladder and obstructive and reflux uropathy. R9's Profile report indicated EBPs. R9's Clinical Orders included orders for a urinary catheter and sacrum/coccyx wound care. R9's care plan titled Risk for Urinary infection indicated R9 was on EBP. R9's functional care plan revised on 12/23/25, indicated R9 required extensive assistance of 2 person for transfers, dressing and toileting hygiene. R9's functional care plan also indicated he needed total assistance of 2 for transfers with mechanical lift. During observation on 3/10/26 at 12:50 p.m., an EBP sign was observed on R9's on the wall, next to his		F0880				

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F0880 SS = D	Continued from page 28 room's door. The sign directed staff to use a gown and gloves while providing personal cares and transfers. During observation and interview on 3/10/26 at 11:54 p.m., R9 was observed being transferred by two nursing assistants (NA) from his bed to his wheelchair after personal cares. With the sling under R9, one NA hooked the straps onto the lift, they elevated him off the bed and placed him in the wheelchair with the sling under his body. Once sitting on his wheelchair, they unhooked the sling. Neither of the NAs were wearing a gown. During interview on 3/10/26 at 12:58 p.m., NA-C stated she provided catheter care and peri care after an episode of bowel incontinence. NA-C stated after she provided personal cares, she removed her gown and then placed the sling under R9 to prepare to transfer him from his bed to the wheelchair. NA-C stated, "I am supposed to wear a gown during transfers, and I did not use one." During interview on 3/11/26 at 10:21 a.m., NA-B stated she helped NA-C to transfer resident from his bed to his wheelchair the previous day. NA-B stated she didn't touch R9, she only touched the Hoyer and added "As long as I don't touch him, I don't need to wear a gown." During interview on 3/11/26 at 12:28 a.m., the director of nursing (DON) stated the staff should follow the sign instructions. DON stated the staff needed to use a gown during transfers to avoid transmitting infections. The facility's policy titled Isolation-Categories of Transmission-Based and Enhanced Precautions dated 10/2021, directed staff to wear gloves and gowns during high-contact resident care activities: Dressing Bathing/showering Transferring Providing hygiene Changing linens Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. Wound care: any skin opening requires a dressing.		F0880				

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F0880 SS = D	Continued from page 29 According to the Centers for Disease Control (CDC), Extended Spectrum Beta Lactamase (ESBL) is a group of bacteria that cause infections in healthcare settings and is resistant to many common antibiotics making infections hard to treat. “Good hand hygiene and infection prevention practices can help reduce infection risk”. R73 R73’s quarterly Minimum Data Set (MDS) dated 2/26/26, identified R73 with intact cognition and was independent in personal cares. R73’s diagnoses included anxiety and ulcerative colitis (inflammation of the inner lining of the colon). In addition, R73 had an ostomy (surgical opening in the abdominal wall that re-routes stool outside the body into a bag). R73’s physician orders (PO) dated 9/12/23, indicated “Resident may be placed in isolation precautions [sic] per facility infection control policy”. R73’s electronic medical record (EMR) banner identified R73 with “Extended Spectrum Beta Lactamase (ESBL)” with onset date of 9/7/25, with “PPE Requirements Gloves, Gown”. During medication observation and interview on 3/10/26 at 8:32 a.m., licensed practical nurse (LPN)-A stated R73 was placed on contact precautions “due to colostomy” and not ESBL despite R73s EMR banner. R73’s door frame had a Contact Precautions sign posted on it stating, “EVERYONE MUST: Clean their hands, including before entering and when leaving the room”. LPN-A obtained medications from medication cart in the hallway and crushed them per PO. During the observation LPN-A opened and closed medication cart drawers and used the laptop to identify each medication that he was preparing. After placing each medication in the pill crusher and putting them into a medication cup LPN-A then locked the medication cart and closed down his laptop screen. During this time, LPN-A did not wash or sanitize hands. Then LPN-A knocked and entered R73’s room without hand hygiene, gloves, or any other PPE. LPN-A offered R73 her crushed medications to take with applesauce. Then LPN-A exited room and sanitized hands. LPN-A verified he did not wash hands or apply gloves or PPE prior to entering R73’s room to administer her medications. During interview with LPN-C on 3/10/26 at 8:43 a.m.,		F0880				

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F0880 SS = D	Continued from page 30 LPN-C stated she was nursing manager of unit where R73 resided. LPN-C stated expectation of staff to “wear [sic] PPE when entering the room to give meds” for residents who were identified as being on Contact Precautions. LPN-C stated, “hand hygiene is important to protect both the resident and staff”. During interview with infection control preventionist (IP) on 3/10/26 at 8:49 a.m., IP stated expectations that if a resident was identified as being on contact precautions, and “if [staff] was administering medications, then there would be no need to wear any PPE but should use hand hygiene before entering the room”. Facility policy titled Administering Medications, reviewed 12/13/2021 state, “Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications”.		F0880				

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/9/26 - 3/12/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.		20000			04/15/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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20000	Continued from page 1 The following complaints were reviewed with NO licensing orders were issued: H51896781C (iQIES# 2749202 and 2748743) H51897907C (iQIES# 2739956 and 2739978) H51897912C (iQIES# 2710360) H51897909C (iQIES# 2639988) H51897910C (iQIES# 2563359) H51897916C (iQIES# 999707) H51897911C (iQIES# 999684) H51897914C (iQIES# 999677) H51897913C (iQIES# 999674) H51897915C (iQIES# 999663) H51897917C (iQIES# 999644) H51897918C (iQIES# 999643) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <a href="https://www.health.state.mn.us/facilities/regulation/in
fobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/in fobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in		20000				

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20000	Continued from page 2 the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.		20000				
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths.		20265	Corrected		04/15/2026	

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20265	Continued from page 3 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the attending physician of a change in condition for 1 of 1 resident (R181) reviewed for discharge process. Findings include: R181 was admitted to the facility on 1/8/26 with an admission diagnosis of lumbar stenosis without neurogenic claudication, and other specified postprocedural state. R181 left the facility on 1/10/26. R181's medical record was reviewed and lacked documentation about reporting R181's leaving the facility against medical advice (AMA) to his primary physician. R181's progress note dated 1/10/26 at 5:58 a.m., indicated R181's wife arrived at the facility at 4:50 a.m. and requested to get R181's medications ready because she was taking R181 home with her. The progress note indicated the nurse in charge educated R181 and his wife about AMA. The nurse in charge advised them the facility would not be able to release the medications. R181's progress note dated 1/13/26 at 3:09 p.m., documented a phone call from a spine center requesting an update about R181. The spine center wanted to verify R181 left the facility AMA, and without medications. During interview on 3/12/26 at 10:29 a.m., the assistant director of nursing/infection control preventionist (IP) reviewed R181's medical record and verified R181's primary physician was not updated about R181 leaving AMA. During interview on 3/12/26 at 10:42 a.m., the director of nursing (DON) stated the provider needed to be notified when a resident left AMA. DON stated she would look into R181's situation and provide further details. No additional information was received. Facility's policy titled Resident Leave Against Medical Advice dated 4/19/19, indicated the resident's "assigned nurse will contact the primary physician to inform of the resident's decision to leave against medical advice." SUGGESTED METHOD OF CORRECTION: The director of nursing		20265				

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20265	Continued from page 4 (DON) or designee could develop and implement measure to ensure timely notification to primary physician. The DON or designee could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. The DON or designee could perform measurable audits and report the findings of those audits to the quality assurance performance improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20265				
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with the potential for inaccurate federal reimbursement and resident care planning for 3 of 5 residents (R5, R8, and R25) reviewed for MDS accuracy. Findings include: R5's Annual Minimum Data Set (MDS), dated 1/9/26 indicated R5 was admitted to the care facility on 1/13/25. Section GG Functional Abilities and Goals section of the MDS was dashed "not assessed." R8's quarterly MDS, dated 2/17/26, indicated R8 was admitted to the care facility 11/22/24. Section GG Functional Abilities and Goals section of the MDS was dashed "not assessed." R25's quarterly MDS dated 3/5/26, indicated R25 was not receiving hospice care and was admitted to the facility on 9/4/25. R25's Order Summary Report dated 9/23/25 included an active order that indicated R25 had signed on to receive hospice care on 9/4/25 with a diagnosis of Parkinson's disease. During an interview on 3/12/26 at 8:01 a.m., licensed practical nurse (LPN)-E stated that R25 was receiving		20550	Corrected		04/15/2026	

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20550	Continued from page 5 hospice care and had been since his admission to the facility. During an interview on 3/12/26 at 9:20 a.m., the MDS Coordinator (MDSC)-A stated the GG section of the MDS was discussed daily at their morning team meeting and was also assessed by utilizing the resident's electronic medical record (EMR) to determine how well a resident functions and how much support they need with activities of daily living (ADLs). The MDSC-A stated they attempt to coordinate baths for each resident to fall within the 3-day lookback period but that it can be challenging with the large size of their facility. The MDSC-A confirmed R5's and R8's GG section of their most current MDS was dashed as "not assessed". The MDSC-A also stated it was their responsibility to indicated on the MDS if a resident was receiving hospice services which was determine based on a list the chaplain send out with all residents receiving hospice services listed. The MDSC-A confirmed R25's most current MDS did not indicated R25 was receiving hospice services, and it should. A facility policy titled Resident Assessments, dated 11/30/2021, indicated the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on MDS completion to ensure accuracy; revise any polices as needed; then educate staff to ensure accuracy and timely completion. They could then audit to ensure ongoing compliance and timely assessment completion. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	20550		
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen	20555	Corrected	04/15/2026

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20555	Continued from page 6 representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, observation and document review, the facility failed to ensure a comprehensive care plan was developed and implemented for 1 of 1 resident (R13) reviewed for pain management. Findings include: R13's admission Minimum Assessment Data (MDS) dated 2/24/26, indicated R13 was cognitively intact, had no behaviors, and didn't refuse cares. MDS indicated R13 needed substantial assistance with toileting hygiene, bathing, dressing, personal hygiene, and transfers. The MDS assessment also indicated R13 received scheduled and as needed (PRN) pain medications, as well as opioid and antipsychotic medications. R13's Clinical Diagnosis Report dated 3/12/26, indicated diagnoses of chronic obstructive pulmonary disease, chronic pain, post-traumatic stress disorder, repeated falls, failure to thrive, and heart failure. R13's orders dated 3/12/25 included the following medications:Hydromorphone HCL 2 milligrams (mg) tablets. Give 0.5 tablet by mouth three times a day.Hydromorphone HCL 2 mg tablets. Give 0.5 tablet by mouth every 6 hours as needed (PRN)Acetaminophen oral tablet 500 mg. Give one tablet every 8 hours PRNLidocaine external cream 4%. Apply small amount to left chest wall twice a day.Gabapentin oral capsule 100 mg by mouth three times a day.R13's care plan dated 3/12/26, did not include a care plan for pain. During interview on 3/10/26 at 11:46 a.m., R13 stated he had chest surgery last year and since then he has experienced pain. During the interview R13 rated his pain as "7". R13 said the pain "comes and goes." During interview on 3/10/26 at 3:21 p.m., nurse manager/licensed practical nurse (LPN)-C stated R13 had problems with pain. LPN-C stated R13 scheduled an appointment to see a doctor due to severe foot pain. During interview on 3/11/26 at 10:44 a.m., LPN-C verified his pain management had not been care-planned. During interview on 3/11/26 at 10:49 a.m., the director of nursing (DON) stated R13 should have had a care plan for pain and she expected the staff would assess resident's pain and monitor for side effects and pain therapy effectiveness.		20555				

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20555	Continued from page 7 A facility policy titled Comprehensive Person-Centered Care Plans dated 11/30/21, indicated the comprehensive, person-centered care plan will include measurable objectives and timeframes, and describe the services that are furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should create and/or review or revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20555				
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to revise the care plan to include a comprehensive pain management plan for 2 of 3 residents (R6, R42) reviewed with a history of pain. Findings include: R6's quarterly minimum data set (MDS) dated 1/15/26, indicated R6 had moderately impaired cognition and a diagnosis of heart failure, kidney failure, and dementia. The MDS indicated R6 received scheduled pain		20570	Corrected		04/15/2026	

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20570	Continued from page 8 medications, did not receive as-needed pain medications, and did not receive non-medication interventions for pain during the look-back period (LBP). R6's care plan dated 10/29/25, included a pain care plan that indicated R6 had "acute pain/ chronic pain" but did not further describe R6's pain. The care plan had a goal that the resident would report satisfactory pain control. The pain care plan included one intervention, which was as follows: evaluate for non-verbal indicators of pain. The pain care plan did not indicate what non-pharmacological interventions should be utilized for managing R6's pain. R6's order summary dated 3/10/26, indicated R6 had an order for 650 milligrams (mg) of acetaminophen (an over-the-counter pain medication) three times a day for chronic pain, with a start date of 7/14/25, a discontinued date of 3/9/26, and then reordered on 3/9/26. The summary included an order for a lidocaine pain relief patch to the mid-upper back every 12 hours, started on 8/26/25, discontinued on 3/9/25, and restarted on 3/9/26. The summary indicated R6 also had an order for 500 mg of methocarbamol (a muscle relaxant) every four hours as needed for pain, with a start date of 10/17/25. During an interview on 3/11/26 at 10:11 a.m., registered nurse (RN)-D confirmed she was R6's nurse for the day. RN-D stated that R6 had a history of chronic pain and had previously been seeing a pain medicine team for this pain. RN-D stated R6's pain was sporadic and varied in location but was sometimes in his back. RN-D stated that the non-pharmacological interventions she had used to assist R6 with his pain were music, redirection, snacks, and reminiscing, and she had found these effective. During an interview on 3/12/26 at 8:04 a.m., licensed practical nurse (LPN)-B confirmed she was R6's nurse for the day and stated that when R6 had pain, it was generally in his upper back and that non-pharmacological pain interventions such as heat or ice were implemented to assist with his pain. LPN-B stated she would look at the care plan to see what pain interventions were effective for R6 but was unsure if this was on the care plan or not. During an interview on 3/12/26 at 8:47 a.m., LPN-G, the unit nurse manager, stated that R6 had a history of upper back pain and utilized pain medications. When asked what nonpharmacological pain interventions had been found helpful with R6's pain, LPN-G stated that		20570				

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20570	Continued from page 9 things such as fresh air, one-on-one time, and reassurance were helpful nonpharmacological interventions to assist R6 with his symptoms. LPN-G stated she and social services worked together to update resident care plans, but when asked if these nonpharmacological pain interventions were part of his care plan, LPN-G stated she was unsure. During an interview on 3/12/26 at 9:14 a.m., the director of nursing (DON) stated that she would expect nursing staff to assess and observe for signs and symptoms of resident pain, and as they see these signs or symptoms, they should attempt non-pharmacological pain interventions. The DON stated she would expect non-pharmacological pain interventions to be outlined in the care plan but acknowledged this might take some time to develop as they get to know the residents. R42's annual Minimum Data Set (MDS), dated 1/16/26, indicated R42 was admitted to the care facility on 12/26/23, had severe cognitive impairment, and was dependent on staff for all activities of daily living (ADLs). The MDS further indicated R42 received scheduled and as needed pain medication but did not receive and non-pharmacological pain interventions. R42's Orders indicated an order, dated 3/2/26, for Oxycodone (a narcotic pain medication) 5 milligrams (mg) once a day and every 6 hours as needed, not to exceed 3 doses. R42's orders, dated 5/7/25, indicated orders for methocarbamol (a muscle relaxant) 500mg three times a day for pain, diclofenac gel to right wrist three times a day for pain and Tylenol 650 mg three times a day for pain. R42's March medication administration record (MAR), indicated R42 had received as needed oxycodone seven times in the past ten days. R42's care plan, dated 11/2/24, indicated R42 had chronic pain related to upper extremity contracture and a history of shoulder injuries. The care plan indicated an intervention to medicate R42 with as needed medications if non-medication interventions were ineffective. The pain care plan did not indicate what non-pharmacological (non-medication) interventions should be utilized for managing R42's pain. R42's electronic medical record (EMR), to include progress notes, lacked evidence of documented or care planned non-pharmacological pain interventions that should be attempted prior to administering as needed pain medication. During observation on 3/9/26 at 5:58 p.m., R42 was out in the main living area in a broda chair. R42 appeared to be leaning to the right and in distress moaning and restless. Staff approached R42 to help reposition him in his broda chair. During an interview on 3/11/26 at 7:20 a.m., nursing assistant (NA)-D stated R42 would stay in bed until near lunch time, and		20570				

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20570	Continued from page 10 she believed the nurses would give him something for pain prior to transferring him out of bed to help with his pain. NA-D stated if a resident appeared in pain, including R42, there were no non-medication interventions would try, she would tell the nurse. During an interview on 3/11/26 at 10:04 a.m., registered nurse (RN)-F stated R42 was unable to verbally communicate but could at times nod "yes" or "no" to simple questions such as "are you in pain." RN-F stated staff often had to read his non-verbal signs of pain such as facial grimaces or groans. RN-F stated for non-pharmacological interventions staff would get him out of bed into his broda chair. During an interview on 3/11/26 at 1:03 p.m., nurse manager and licensed practical nurse (LPN)-C stated it was the expectation that non-pharmacological pain interventions be care planned and attempted and documented prior to as needed pain medication being administered. During a follow up interview on 3/11/26 at 2:35 p.m., nurse manager and LPN-C stated when staff notice R42 to be in pain they hold his hands, reposition him in his broda chair and if he still shows signs of pain they offer him pain medication. LPN-C confirmed that none of the non-pharmacological pain interventions were care planned or documented as attempted. The facility's Comprehensive Person-Centered Care Plans policy dated 11/30/21, indicated that a person-centered care plan would be developed for each resident. The policy indicated care plan interventions would be derived through analysis of the information gathered as part of the comprehensive assessment. The policy indicated the care plan would include services that would be furnished to attain or maintain the resident's highest practicable well-being. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee review and update policies and procedures as necessary to ensure comprehensive care plans are revised in a timely manner. The director of nursing or her designee could educate all appropriate staff on these policies and procedures. The director of nursing or their designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days		20570				
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive		20900	Corrected		04/15/2026	

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20900	Continued from page 11 resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a resident was reassessed and failed to implement new interventions to prevent skin breakdown after developing a stage III pressure injury while a resident at the facility for 1 of 2 residents (R123) reviewed for pressure injuries. Findings include: R123's quarterly Minimum Data Set (MDS) dated 1/13/26, indicated R123 required substantial staff assistance with personal hygiene, dressing and bathing and was dependent on staff for toileting. The MDS indicated R123 was at risk but did not have any pressure ulcers. R123's care plan included a focus of potential for skin impairment related to immobility and incontinence last revised 12/19/23. Interventions included use of pressure reducing wheelchair cushion and pressure reducing mattress. R123's care plan, dated 1/16/26, indicated R123 had a coccyx wound requiring wound care and to keep resident skin clean and well lubricated. The care plan lacked any new, specific pressure reducing interventions to prevent R123 from developing new (or re-opening) pressure injuries. R123's wound note, dated 1/19/26, indicated R123 had a stage III pressure injury to her coccyx that had "re-opened last week" and the plan of care in place remained effective. R123's significant change MDS, dated 2/17/26, indicated R123 received hospice services and required substantial staff assistance with personal hygiene, dressing and		20900				

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20900	Continued from page 12 bathing and was dependent on staff for toileting. The MDS further indicated R123 was at risk for pressure ulcers and had one stage III pressure injury not present on admission. R123's wound note, dated 2/23/26, indicated R123's coccyx wound had resolved. During an interview on 3/11/26 at 12:37 p.m., registered nurse (RN)-F stated staff used barrier cream and a silicone dressing for R123's "bottom" even without a pressure injury. RN-F stated R123 was not on any specific turning and reposition schedule. During an interview on 3/11/26 at 1:03 p.m., clinical manager and licensed practical nurse (LPN)-C stated R123's interventions depended on who the aide was that was working, stating R123 would often refuse cares but a few aides were able to get her up and out of bed. LPN-C stated the aides who worked with the residents rotated to different units but "work well together." LPN-C confirmed the care plan needed to be updated to remove wound care and confirmed there had been no updates to the potential for skin impairment care plan since R123 developed a pressure injury in January. LPN-C stated she believed the current interventions were effective because R123. "had the one issue and hasn't had anymore." During a follow up interview on 3/12/26 at 11:02 a.m., clinical manager and LPN-C stated R123 should not be getting a silicone dressing on her coccyx as the wound resolved and there were no new orders after the wound healed for continued dressing, only barrier cream. LPN-C also confirmed R123 was not on a specific turning and repositioning schedule. During an interview on 3/12/26 at 12:10 p.m., the director of nursing (DON) stated that even though R123 was on hospice care she would expect to see new care planned interventions for pressure injury prevention and skin protection after the development of a pressure injury, stating, "we still don't want to see pressure injuries in hospice." A facility policy titled Prevention of Pressure Injuries, dated 3/6/25, instructed staff to "reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team" and to "review the interventions and strategies for effectiveness on an ongoing basis."		20900				

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20900	Continued from page 13 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.		20900				
21330	Providing Routine & Emergency Oral Health Ser CFR(s): MN Rule 4658.0725 Subp. 2 A&B Subp. 2. Annual dental visit. A. Within 90 days after admission, a resident must be referred for an initial dental examination unless the resident has received a dental examination within the six months before admission. B. After the initial dental examination, a nursing home must ask the resident if the resident wants to see a dentist and then provide any necessary help to make the appointment, on at least an annual basis. This opportunity for an annual dental checkup must be provided within one year from the date of the initial dental examination or within one year from the date of the examination done within the six months before admission. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to provide assessments and routine dental services to 2 of 2 residents (R87, R152) reviewed for dental care. Findings include:R152's significant change Minimum Data Set (MDS) dated 2/14/26, indicated intact cognition, diagnoses of traumatic subdural hemorrhage (brain bleed) with loss of consciousness, weakness, dysphagia, and required substantial assistance with oral hygiene.		21330	Corrected		04/15/2026	

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21330	Continued from page 14 During observation and interview on 3/12/26 at 8:48 a.m., R152 was sitting on the edge of his bed in his room. He stated his mouth was sore and he opened his mouth where there were several missing teeth. He further stated he hadn't seen a dentist since he was admitted (9/16/24) and would like to. He told several staff members about his mouth pain but was unable to recall which staff members he told. R152's MDS dental assessment (completed by Apple Tree Dental) dated 9/2/25, indicated R152 had broken natural teeth, requires staff supervision with oral care, recommended a routine dental referral, and non-urgent dental care needs. R152's care plan dated 2/20/26, indicated R152 required the physical assistance of one staff for personal hygiene but did not address oral care specifically. R152's medical record lacked documentation of routine dental care (i.e. dental appointment). During interview on 8:55 a.m., the Health Unit Coordinator (HUC)-C stated orders for ancillary services (dental, podiatry, vision, etc.) were put in upon admission. Then MDS does an assessment to see what services are needed and the clinical manager can prescribe orders for a referral. When there are enough residents, they (dentist) will come to the facility. HUC-C further stated the residents should be seen within 6 months of the referral. Apple Tree Dental was scheduled to come on 3/17/26 but R152 was not scheduled to be seen. HUC-C stated there was not an official list of residents for this month's visit. The surveyor asked when R152's last dental visit was and HUC-C was unable to find that information. R87 R87's quarterly Minimum Data Set (MDS) dated 1/20/26, identified R87 with severe cognitive impairment and dependent on staff for all cares including oral hygiene. In addition, R87 had diagnoses of dementia and dysphagia (difficulty swallowing). R87's care plan dated 3/3/25 identified R87 with "Impaired Dentition-edentulous, no dentures". R87's physician orders (PO) and electronic medical record (EMR) failed to indicate an order for dental services. During interview with licensed practical nurse (LPN)-H on 3/12/26 at 8:30 a.m., LPN-H stated expectations for orders to be obtained from provider and the Health Unit Coordinator (HUC) would then make the appointment and arrange transportation. During interview with HUC-B on 3/12/26 at 8:43 a.m., HUC-B stated expectation of facility to obtain a referral from a provider and HUC would then facsimile		21330				

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21330	Continued from page 15 order and resident face sheet to the contracted dental provider for the facility who “comes a couple times a year” to facility to provide routine dental services. During interview with Registered Nurse (RN)-A on 3/12/26 at 10:26 a.m., RN-A stated expectation of all residents to be seen by a dentist “usually yearly or every 6 months”. RN-A looked in R87’s electronic medical record and verified “no dental assessments were done”. RN-A stated, “we should still ensure everyone has a dental visit or least offered yearly.” During interview with director of nursing (DON) on 3/12/26 at 11:09 a.m., DON stated expectation of all residents, “Should be seen annually at least and documented in the chart that it was done”. DON verified R87 EMR failed to indicate any dental services were offered or provided. Attempts at contacting R87’s responsible party were made but no answer or call back was obtained. The facility policy regarding dental services dated 2/8/22, indicated all dental services provided are recorded in the resident’s medical record. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to dental agreements and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days		21330				
21925	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 29 Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by		21925	Corrected		04/15/2026	

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/12/2026	
NAME OF PROVIDER OR SUPPLIER Southview Acres HealthCare Center				STREET ADDRESS, CITY, STATE, ZIP CODE 2000 OAKDALE AVENUE , WEST SAINT PAUL, Minnesota, 55118			
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21925	Continued from page 16 utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the State Long-Term Care (LTC) Ombudsman of facility-initiated transfers to an acute care facility on an emergent basis, and failed to ensure a written notice of bed hold was provided and documented in the electronic medical record (EMR) for 2 of 2 residents (R10, R17) reviewed for hospitalizations. Findings include: R10 R10's significant change in status (SCSA) Minimum Data set dated 2/26/26, identified R10 with severe cognitive impairment, and diagnoses of liver cancer, kidney disease, dementia, and psychosis (disconnection with reality, including hallucinations and delusions). R10's progress note (PN) dated 12/15/25, identified R10 had an unwitnessed fall with injury and was sent to the emergency department (ED). PN lacked indication a bed-hold or transfer form was offered and signed. R10's PN dated 1/24/26, identified a fall with major injury and was sent to the ED.PN lacked indication a bed-hold or transfer form was offered and signed. R17 R17's quarterly MDS dated 2/11/26, identified R17 with severe cognitive impairment and diagnoses of Alzheimer's, arthritis, dementia, anxiety, depression and fibromyalgia (chronic disorder involving pain, fatigue, sleep disturbances and cognitive issues). R17's Emergency Room (ER) After Visit Summary dated 2/19/26, identified R17 was sent to eh hospital on (date) and returned on (date) for a medication-related concern. PN failed to indicate if a bed-hold or transfer form was offered to her emergency contact.		21925				

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21925	Continued from page 17 During interview with registered nurse (RN)-D on 3/11/26 at 12:48 p.m., RN-D stated when a resident was transferred to the hospital, the facility was expected to obtain a signed bed-hold and transfer policy from the resident or a verbal agreement prior to resident leaving the facility. RN-D stated she was expected to obtain a copy of the signed form and give it to the Health Unit Coordinator (HUC) who was then expected to download or scan it into the residents EMR. In addition, RN-D stated she would send the resident to the hospital with a face sheet, medication list, and a copy of a current Provider Order for Life Sustaining Treatment (POLST) form. RN-D stated she would call the guardian and emergency contact to obtain verbal consent if a resident was unable to provide it and then document this in a progress note in the EMR. During interview with licensed practical nurse (LPN)-D on 3/11/26 at 12:59 p.m., LPN-D stated whenever a resident was transferred to the hospital, the facility was expected to ask family or the resident's guardian for verbal permission to approve a bed-hold and transfer notice. LPN-D stated, "I fill out form saying I have verbal permission," uploaded it into the residents EMR, wrote it in the progress note. During interview with RN-B on 3/11/26 at 1:26 p.m., RN-B stated whenever a resident was transported to the hospital that a signed bed-hold and transfer policy must be obtained each time they leave. RN-B stated a copy of the signed form is uploaded into the residents EMR and expectation was to document the bed hold in the progress note. During interview with HUC-A on 3/11/26 at 1:31 p.m., HUC-A stated bed-holds went with the resident to the emergency room and HUC-A scanned a copy of the signed form and put it in the EMR. During interview with LPN-H on 3/12/26 at 8:30 a.m., LPN-H stated when she sent a resident to the hospital she would fill out the written form to get consent, leave a copy at the facility to be scanned into the chart, and send a copy with the resident along with other paperwork to the hospital. LPN-H stated she was nurse on duty when R10 fell and broke his hip on 12/15/25 and was sent to the hospital. LPN-H stated she did not recall if she got the bed-hold and transfer form, but if she had, she would have entered it into R10's progress notes. LPN-H looked at R10's progress notes and verified there was no mention of providing or offering a bed-hold notice and transfer form to R10. During interview with health unit coordinator (HUC)-B		21925				

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21925	Continued from page 18 on 3/12/26 at 8:43 a.m., HUC-B stated that when a resident was transferred to the hospital, the facility was expected to print out a resident face sheet, POLST, medication list and have the resident sign a copy of the bed-hold and transfer policy prior to leaving the facility. In instances where the resident was unable to acknowledge the bed-hold form then the guardian or emergency contact was informed, and the nurse was required to document the discussion in the progress note of the EMR. In addition, the HUC was responsible for uploading a copy of the signed bed-hold and transfer form into the EMR. During interview with LPN-I on 3/12/26 at 10:03 a.m., LPN-I stated he was the nurse on duty when R17 fell and fractured his arm on 1/24/26 and was sent to the hospital. LPN-I stated he did not recall filling out bed-hold or transfer form prior to sending R17 to the hospital. LPN-I stated, "it should be signed and scanned into the chart, but I do not recall it being done." LPN-I stated expectation of staff to print a face sheet, medication list, and POLST to accompany the resident to the hospital. During interview with registered nurse (RN)-A on 3/12/26 at 11:26 a.m., RN-A stated expectation of nursing staff to immediately provide a copy of the bed-hold policy and notice of transfer to the patient or guardian prior to transfer to hospital. In addition, the resident face sheet, medication list and current POLST to all accompany resident to the hospital. RN-A stated expectation of facility staff to upload a signed copy of the notice of transfer to the resident's electronic medical record (EMR). RN-A verified both R10 and R17's EMR lacked documentation of a bed-hold/transfer notice, and a progress note to indicate it was done. During interview with director of nursing (DON) on 3/12/26 at 11:04 a.m., DON stated expectation of staff to provide copy of bed-hold policy and notice of transfer when residents were leaving the building for hospitalizations. DON stated a signed copy should be scanned into the EMR. As for notifying the Office of the State Long-Term Care Ombudsman of discharges and transfers, DON stated the director of social services (SS)-D is responsible for that task. During interview with SS-D on 3/12/26 at 11:17 a.m., SS-D stated she was responsible for sending discharge notifications to the State Ombudsman monthly. However, SS-D stated she was unaware of needing to send notices of transfers and hospitalizations to the Office of the State Long-Term Care Ombudsman too., and stated, "I did		21925				

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21925	Continued from page 19 not know that I had to”. Attempts to call/contact R10 and R17’s guardian and primary emergency contacts and the Ombudsman were made but no answer or call back was obtained. Undated facility policy titled Transfer or Discharge Notice identified expectation of facility to provide transfer or discharge notice to resident where, “An immediate transfer or discharge is required by the resident’s urgent medical needs”. In addition, “The resident and/or representative will be notified in writing of the following information” which included the facility bed-hold policy and, “A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman.” SUGGESTED METHOD OF CORRECTION: The DON, administrator, or designee (facility) should ensure residents and/or their representatives are notified as soon as practicable before transfer or discharge. Staff should be re-educated to ensure policies and procedures are followed. The facility should have a method for monitoring the above-mentioned actions and perform measurable audits. The results of those audits should be taken to the QAPI committee ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21925				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245189		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 03/11/2026	
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K0000	INITIAL COMMENTS An annual Life Safety Code survey was conducted on 03/11/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Southview Acres Health was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us		K0000			04/15/2026	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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K0000	Continued from page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Southview Acres Health Care Center is a 4-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1961 and was determined to be of Type II(222) construction. In 1973, 1978 additions were constructed to the West Wing that was determined to be of Type II(222) construction. In 2000, additions were added to the East Wing that were determined to be of Type II (222) construction. Because the original building and the 3 additions are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The facility has a capacity of 220 beds and had a census of 171 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:		K0000				
K0345 SS = E Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in		K0345	K0345 Plan of Correction Survey Date: 03/11/2026 Tag: K0345 (Fire Alarm System – Testing and Maintenance)		04/15/2026	

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K0345 SS = E Bldg. 01	Continued from page 2 accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 14.2.1.2.2. This deficient finding could have a patterned impact on the residents within the facility. On 03/11/2026 at 10:00 AM, it was revealed by a review of available documentation that the deficiency listed below were noted on the semi annual fire alarm inspection report dated 10/07/2025 and at the time of the survey the facility did not have documentation showing that repairs had been made. Two horn strobes on the first floor not functioning. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0345	Continued from page 2 Corrective Action Two non-functioning horn strobes located on the TCU unit have been replaced. The fire alarm system components are operational and have been tested. Measures to Prevent Recurrence The facility is reinforcing an established tracking log to ensure all fire alarm inspection reports are tracked and resolved timely in accordance with National Fire Protection Association standards (NFPA 72). Monitoring Plan Monthly review of fire alarm system status (TELS – work order entry) Responsible Party(s) Maintenance Director – responsible for correction, vendor coordination, tracking, and system oversight Administrator– responsible for compliance monitoring Completion Date All corrective actions will be completed by 04/15/2026.		