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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6CCD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00102

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245189**
2.STATE VENDOR OR MEDICAID NO.
(L2) **798240200**

3. NAME AND ADDRESS OF FACILITY
(L3) **SOUTHVIEW ACRES HEALTH CARE CENTER INC**
(L4) **2000 OAKDALE AVENUE**
(L5) **WEST SAINT PAUL, MN** (L6) **55118**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 01/31/14 (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **241** (L18)

13.Total Certified Beds **241** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	241			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor February 28, 2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 04/24/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/15/1974
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/30/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN-24-5189

On November 14, 2013, an abbreviated standard survey was completed at this facility. The most serious deficiency was cited at a S/S level of D.

On December 12, 2013, a standard survey was completed at this facility. The most serious deficiency was cited at a S/S level of F. As a result of continuous noncompliance this Department recommended the following to the CMS RO for imposition:

Mandatory Denial of Payment New Admissions (DOPNA) effective February 14, 2014

The facility was subject to a two year loss of Nursing Assistant Training Competency Evaluation Program (NATCEP).

Post Certification Revisit completed on January 31, 2014 by review of the facility's plan of correction, to verify that the facility had achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. The facility is certified for 241 skilled nursing facility beds effective January 21, 2014.

As a result of the PCR findings, Mandatory DOPNA is rescinded.

The facility is no longer subject to a loss of NATCEP.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5189 April 24, 2014

Mr. Thomas Goeritz, Administrator
Southview Acres Health Care Center Inc.
2000 Oakdale Avenue
West Saint Paul, Minnesota 55118

Dear Mr. Goeritz:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 14, 2014 the above facility is certified for:

241 Skilled Nursing Facility/Nursing Facility Beds

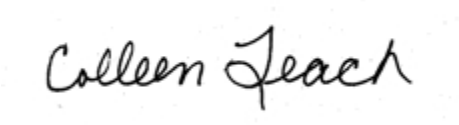
Your facility's Medicare approved area consists of all 241 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,



Colleen B. Leach, Program Specialist
Program Assurance Unit
Licensing and Certification Program

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 28, 2014

Mr. Thomas Goeritz, Administrator
Southview Acres Health Care Center Inc
2000 Oakdale Avenue
West Saint Paul, Minnesota 55118

RE: Project Number S5189024 and Complaint Number H5189074

Dear Mr. Goeritz:

On January 13, 2014, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 14, 2014. (42 CFR 488.417 (b))

Also, we notified you in our letter of January 13, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 14, 2014.

This was based on the deficiencies cited by this Department for an abbreviated survey completed on November 14, 2013, and a standard survey completed on December 12, 2013 The most serious deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 31, 2014, the Minnesota Department of Health, Licensing and Certification Program completed a Post Certification Revisit (PCR) by review of your plan of correction, and on January 14, 2014, the Minnesota Department of Health, Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on November 14, 2013 and a standard survey completed December 12, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 21, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on November 14, 2013, and our standard survey completed December 12, 2013, as of January 21, 2014.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our

letter of January 13, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 14, 2014, is rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective February 14, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective February 14, 2014, is to be rescinded.

In our letter of January 13, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 14, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 21, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245189	A. Building B. Wing	1/31/2014

Name of Facility	Street Address, City, State, Zip Code
SOUTHVIEW ACRES HEALTH CARE CENTER INC	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0314** Reg. # **483.25(c)** LSC	**01/21/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**01/21/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	**01/21/2014**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	02/28/2014	16022	01/31/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
12/12/2013	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6CCD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00102

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245189**

2.STATE VENDOR OR MEDICAID NO.
(L2) **798240200**

3. NAME AND ADDRESS OF FACILITY
(L3) **SOUTHVIEW ACRES HEALTH CARE CENTER**
(L4) **INC 2000 OAKDALE AVENUE**
(L5) **WEST SAINT PAUL, MN** (L6) **55118**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	4. CHOW
5. Validation	6. Complaint
7. On-Site Visit	9. Other
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/12/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **241** (L18)

13.Total Certified Beds **241** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	241			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Sheryl Reed, HFE NE II — 01/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 01/27/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
04/15/1974
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN-245189

At the time of the standard survey completed December 12, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required as evidenced by the attached CMS-2567. Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. CMS Region V has concurred in the imposition of:

-Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 14, 2014. (42 CFR 488.417 (b))

Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3896

January 13, 2014

Mr. Thomas Goeritz, Administrator
Southview Acres Health Care Center Inc
2000 Oakdale Avenue
West Saint Paul, Minnesota 55118

RE: Project Number S5189024, H5189074

Dear Mr. Goeritz:

On December 12, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on November 14, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On December 12, 2013, the Minnesota Departments of Health and Public Safety completd a standard survey to determine if your facility was in compliance with Federal participation requirements for skillede nursing facilities participating in the Medicare and/or Medicaide programs. The survey found the most serious deficiences 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). A copy of the statement of deficiencies (CMS 2567) is enclsosed.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 14, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective February 14, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 14, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Southview Acres Health Care Center Inc is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 14, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0900

Phone: (651) 201-3793 Fax: (651) 201-3790

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

If an acceptable PoC 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 February 14, 2014 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 14, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
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Enclosure

cc: Licensing and Certification File 5189s14lc.rtf

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245189	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTH CARE CENTER INC	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 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
F 000	INITIAL COMMENTS The facility's plan of correction (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 verifcation of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		~~1/27/14~~ 1/21/14
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess, and adequately monitor pressure ulcers for 4 of 4 residents (R120, R294, R354, & R290) in the sample who were reviewed with pressure ulcers. Findings include: R120 developed a pressure ulcer after admission that was not assessed in a timely manner, and risk factors for skin breakdown were not	F 314	1/23/14 SER	~~1/27/14~~ 1/21/14

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

1-17-14

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

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F 314	Continued From page 1 assessed after the development of the pressure ulcer. Record review revealed a Skin Condition Report, dated 11/11/13, describing a wound discovered that date as a small open area on the coccyx (tail bone) area. No measurement or staging of this wound on that date could be located in the record. A Skin Condition Report, dated 11/14/13, described the wound as unable to accurately stage due to presence of slough or eschar (scab), and measuring 1.4 centimeters (cm) by 1 cm. This entry also read, "This wound was not present on admission...pressure reducing or relieving device(s) in place, turning and repositioning program being implemented." From that date forward, Skin Condition Report forms were completed weekly with measurements and wound descriptions, showing that the wound was getting smaller and remained covered with slough or eschar. A reassessment of skin risk factors for developing a pressure ulcer could not be located in the medical record. The most recent Braden Scale for Predicting Pressure Sore Risk form in the record, dated 10/24/13, scored R120 at 12 (high risk). The most recent Tissue Tolerance Observation form in the record, dated 11/16/12, showed the resident had no skin integrity concerns after positioned in the same lying or sitting position for two hours. The most recent Care Area Assessment listed risk of pressure ulcer as a problem for this resident and read, "Resident is at risk for pressure ulcers d/t [due to] needing assist with mobility and transfers, incontinent of bowel and bladder, use of incontinent pads, and communication defecit [sic]. Resident is nonverbal r/t (related to) late stage alzheimer's	F 314	Regarding resident 120, licensed nurse was re- educated during the survey on 12/13/13 regarding skin policy and procedure and wound measurement Comprehensive re-assessment was completed on 1/16/14 by the clinical manager. The final inservices for staff regarding POC for all deficiencies will be completed 1/23 + 1/24, 2014, per phone call = DON.	

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F 314	Continued From page 2 [sic]. Staff to anticipate her needs and meet them. Braden score is 12. Staff to complete pericares with each incontinent episode, observe skin with cares and with weekly baths and turn/reposition per tissue tolerance. Staff to observe for increased risk for pressure ulcers." When interviewed on 12/12/13, at 12:45 p.m. registered nurse (RN)-C, unit manager, was asked why there was a delay in measuring and staging of the wound when discovered. She responded that the nursing staff knows that they should measure and stage a new pressure ulcer at the time it is discovered and she does not know why that was not done. She was asked if an assessment of this resident's risk for developing a pressure sore was completed after the wound was discovered and she replied that an assessment was not done at that time because the resident had already been assessed as high risk. She was then asked if any new interventions were implemented after the resident developed this pressure ulcer and she stated that new interventions were implemented at that time and they were the addition of a Magic Cup (dietary supplement), air mattress on the resident's bed, ongoing assessment by the facility wound team, turning side to side more often, and more restrictive limitation on the amount of time the resident is up in her chair--now up in her chair for meals and right back to bed. She went on to explain that before the development of this wound, the resident had a perimeter mattress (a mattress with elevated ridges on the perimeter) on her bed due to family request and because of that the resident tended to roll onto her back more often.	F 314		

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F 314	Continued From page 3 Closed record review indicated R294 was admitted to the facility on 5/28/13 with no skin breakdown and developed a pressure ulcer on the left lower heal. R294 was admitted to a hospice program on 6/14/13 with Lewy body dementia. R294 expired 7/03/13. The significant change minimum data set (MDS) dated 6/19/13 indicated R294 was cognitively impaired, needed extensive assist with bed mobility and had a pressure reduction mattress on his bed and a cushion in his wheelchair. Diagnoses included dementia and chronic airway obstruction. R294 was at risk for a pressure ulcer. The Braden score, completed on 5/28/13 was a 19 low risk, and on 6/22/13 the Braden score was 15, low risk. The Care Area Assessment (CAA)for pressure ulcers, dated 6/24/13, indicated the resident's skin was intact and score was indicative of the resident being at low risk for the development of a pressure ulcer. Mobility was impaired due to the diagnoses of spinal stenosis, neuropathy, osteoarthritis and degenerative joint disease. Record review of the Skin Condition Report with Images revealed the following: ...On 5/29/13 9:01 p.m. skin tear/laceration on right forehead. ...On 6/21/13 left heel pressure ulcer present L=2.5 cm (centimeters) W=2 cm, skin blanchable, no odor apparent, no drainage is apparent. Surrounding tissue was reddened, skin tissue temperature was cool to touch, margins irregular. There was no further documentation of the left heel pressure ulcer on Skin condition Reports. Additional record review indicated lack of reassessment of the skin risk factors after the heel ulcer was identified on 6/21/13.	F 314	Resident 294 was a closed record and nothing could be changed. The assessment reference date that the CAA was based on was prior to the 6/21/13 pressure ulcer. The clinical manager did fax this information to MDH after the survey.	

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F 314	Continued From page 4 The registered nurses (RN-E and RN-F)unit managers were interviewed on 12/12/13 at approximately 2:20 p.m. RN-E verified the resident had break down on the left heel on 6/21/13 and the CAA , dated 6/24/13, indicated the resident was a low risk and skin was intact. Both RN-E and RN-F verified the CAA was incorrect and there was no reassessment of the casual factors of how the resident 's heel broke down. Resident 354, admitted to the facility on 6/14/13, identified as not being at risk for developing pressure sores, R354 developed a blister on the left fourth toe. During Stage 1 interviews, on 12/10/13 at approximately 10:00 a.m., licensed practical nurse, LPN-A, unit coordinator, indicated R352 did not have any pressure sores. However, during record review, it was noted R354 had a blister on the top of the left 4th toe. The initial minimum data set (MDS), dated 6/25/13. identified the resident as cognitively intact and not at risk for pressure ulcers. The CAA note, dated 6/25/13, indicated resident was at some risk for skin breakdown due to decline in mobility. Diagnoses included left extremity edema and needed limited assist with activities of daily living. A Braden score, completed 9/16/13, of 19 (Scale for predicting pressure Sore Risk) indicated not at risk. The skin review/report with images review revealed the following: A Skin Condition Report, dated 11/11/13, indicated the resident reported to the staff registered nurse of a small blister on the top of the left 4th toe. A Band-Aid was applied and the nurse practitioner was to be updated. The report indicated the resident stated it was caused by	F 314	Resident 354 was re-assessed by clinical coordinator on 12/12/13 during the survey. The area was an abrasion caused by a bunion that rubbed off according to the resident who is a reliable reporter. Licensed nurse was re-educated on skin protocols on 12/12/13.	

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F 314	Continued From page 5 shoes. Skin Condition Report, dated 11/26/13, indicated a blister was noted on the top left 4th toe. Skin color appeared slightly red, blister was closed and no drainage noted. Skin condition report dated 12/5/13 nursing note indicated blister present on top of left 4th toe, skin appeared slightly red, blister not open, no drainage and no change in condition. The medical record lacked any further documentation regarding the 4th digit with a blister. Although R354 reported the cause was from shoes, the medical record lacked any information regarding if shoes were still being worn or if they had been removed from use. The record lacked additional documentation regarding the monitoring of the blister such as measurements, color, temperature of surrounding skin etc. On 12/12/13 at 9:40 a.m., LPN-A and registered nurse (RN-B), unit manager were interviewed. LPN-A confirmed she was not aware of the blister noted on the 4th digit and verified additional wound information, including measurements, should have been documented each week. The LPN-A confirmed R354 received new shoes but was not aware of what shoes caused the blister or if the shoes were still in use. RN-B verified when a pressure ulcer is noticed, staff should inform the coordinator or herself so a reassessment can be completed and the care plan with interventions can be revised. RN-B confirmed this had not been completed. Resident 290 was identified as a risk for pressure ulcers and developed a deep tissue injury (DTI -purple or maroon of discolored intact skin due to damage of underlying soft tissue) on the top of the right thumb and the facility failed to	F 314		

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F 314	Continued From page 6	F 314		

adequately comprehensively assess, and adequately monitor the injury.
During Stage 1 interview, on 12/10/13 at approxiamately 10:15 a.m., the licensed practical nurse (LPN-A) unit coordinator, indicated R280 was free of pressure ulcers. Record review indicated on 11/29/13, a closed blood blister on inside of right thumb was found. Wound measurements were 1 centimeter (cm) x 1 centimeter with wound base pink, the area was thin and shiny, margins regular, mucous membranes are dry.

During observations on 12/11/13 at 8:00 a.m., R290 was in the shower room when RN -A entered to do a skin assessment. RN-A indicated R290 had a the black like blister on the left thumb area and the moon shaped area on the left thumb that was reddened and purplish. There was no dressing on the blister. RN-A indicated he would call the nurse practitioner regarding a possible treatment because the markings were caused by the hand splints. RN-A reported R290 used to wear hand splints at night, however, was stopped due to the blister. On 12/11/13 at 8:40 a.m., RN-A located the hand splint in the room, but indicated staff was not using them during the night until blister was healed.

A review of the medical record was conducted. The annual minimum data set was completed 10/30/13. At that time the resident did not have any pressure ulcers or deep tissue injuries. The Care Area Assessment, dated 10/31/13 indicated the resident was at risk for pressure ulcers related to needing assistance with mobility and transfers. R290 had a severe cognitive deficit and was unable to communicate his needs. A Braden was completed 12/07/13 and indicated a score of

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F 314	Continued From page 7 15, a low risk. The nursing progress note, dated 11/29/13, indicated the resident wife brought to writer's attention the resident had a blood blister on the inside of the right thumb. A band aid was applied and a message was left for the nurse practitioner. The nurse ordered not to use the hand splints until healed. A physician order dated 11/29/13 indicated to apply Band-Aid daily and prn {as needed} to r (right) thumb for protection of blister. Do not apply hand splints at hs (hour sleep) until (r)right thumb blister healed. The Skin Condition Report dated 11/29/13 indicated a blister was present on the right thumb. A raised closed blood blister on inside of right thumb approximately 1 centimeter (cm) by 1 cm, wound base was visible with pink wound base A Skin Condition Report, dated 12/8/13, indicated the right top thumb has a blister, improvement noted; no recent changes were made to the treatment orders. A Skin Condition Report, dated 12/12/13, was made during survey. Note indicated the wound bed had 100% dried exudate present, wound edges intact, length 1.3 cm x 1 cm. Licensed practical nurse (LPN-A) unit coordinator and registered nurse (RN-B) nurse manager were interviewed on 12/12/13 at 9:30 a.m. LPN-A verified she was unaware of the blister when interviewed during stage one. RN-B agreed there had been no formal reassessment to review	F 314	Resident 290 was re-assessed by the clinical coordinator on 12/12/13 during the survey. Resident was also assessed by the Occupational Therapist on 12/12/13. The OT felt that the blister was not caused by the splint.	

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F 314	Continued From page 8 what might have caused the injury, however, the hand split was not being used. RN-B verified occupational therapy had not been asked to review the use of the splint of how it was being applied. When asked if the registered nurse completed a skin assessment on 12/11/13, RN-B indicated a skin assessment should have been completed and progress notes made. RN-B indicated the splint had stopped being used, however, the hand splint remained in the resident's room. The facility's Skin Care policy, last revised 1/13 was reviewed. The policy indicated "Assessments will be performed on admission and as needed. Appropriate interventions will be initiated and revised based upon these assessments." Procedure: step 1 indicated "The Nurse Manager will assess each resident using the Braden Scale for predicting pressure sore risk. Admission nurse will do inspection of the skin." and "If resident assessed at risk, or already has skin breakdown, the clinical Manager and Dietician/Diet Tech will be notified." 3. If the resident is at risk for impaired skin integrity, the nurse will develop interventions needed for pressure relief.	F 314	All licensed nurses and clinical managers have been in serviced on updated facility protocols related to assessment, treatments, and documentation regarding skin integrity and pressure ulcers. Random audits will be completed by clinical managers and coordinators, admission nurse. and building supervisors. Results of random audits will be forwarded to the DON and QA committee for follow up. Clinical managers and clinical coordinators will be responsible to monitor.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329		

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F 329	Continued From page 9 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not identify specific target behaviors and did not document effectiveness of non-pharmacological interventions for 1 of 5 residents (R302) reviewed for unnecessary medications. Findings include: Record review revealed a physician's order, dated 12/9/13, for Haldol (an antipsychotic) solution 0.5 milligram (mg.) sublingual two times daily for agitation. The Informed Consent form for this medication listed the indications for use as agitation and anxiety, however, no documentation could be found in the record defining specific target behaviors. The record also contained an order for, as needed, haloperidol concentrate, dated 9/22/13, 0.5 mg.	F 329	Pharmacy recommendations for Resident 302 were followed up on and implemented during the survey. Care plan was updated to include non pharmacological interventions. This medication was discontinued on 1/17/14.	~~1/27/14~~ 1/21/14

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F 329	Continued From page 10 every four hours, for agitation. The Medication Documentation record showed that only the twice daily dose was administered in the previous seven days. The resident's current care plan, dated 9/19/13, contained a problem that read, "Resident has hx [history] of behaviors which may affect how she interects [sic] with others." The approaches listed for this problem were generic interventions such as assess/identify health care needs prn (as needed), encourage participation in activities of interest prn, and encourage and support interactions prn. No documentation could be found in the record listing individualized, non-pharmacological interventions for this resident's behavior problem and the effectiveness of those interventions. A Consultant Pharmacist Communication to Nursing form, dated 10/28/13, read "[R302] has orders for medication including 0.5mg haloperidol every 4 hours as needed for "aggitation" [sic], which has been documented as used x 3 in October. To help comply with CMS [Centers for Medicare and Medicaid Services] guidelines for medication management, please be sure to document an assessment of reason for use, effectiveness of non-drug interventions attempted..." When interviewed on 12/12/13, at 9:30 a.m., registered nurse (RN)-D, unit manager, was asked if there was any place in record with specific target behaviors listed and she replied, "Not at this time." On 12/12/13, at 12:25 p.m., RN-D, unit manager, was asked her if there was any place in the	F 329	All residents with orders for anti-psychotic medications have had their care plans reviewed for target behaviors and non-pharmocological interventions as appropriate by IDT. Clinical managers will follow up on all consultant pharmacist recommendations to assure compliance. If necessary, medical director may assist with provider follow up as well. Licensed nurses, Nursing assistants,social workers, and IDT members have been re-in serviced on facility protocols related to evaluating and implementing non - pharmacological interventions and the use of antipsychotic medications. The clinical management team has been re-in serviced on tracking pharmacy consultant recommendations. Random audits will be completed by IDT, clinical managers and coordinators and consulting pharmacist.	

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F 329	Continued From page 11 record that contained individualized non-pharmacological interventions and the effectiveness of those interventions for this resident. She replied that there was not and went on to explain that she has had her managerial position only a couple months and will put this information into the plan of care in the future.	F 329	Results of random audits will be forwarded to the DON and QA committee for follow up. Clinical managers and coordinators will be responsible for monitoring.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain clean and sanitary food preparation and storage areas and sanitize dishes at appropriate temperatures. This had the potential to impact all residents residing in the facility,who ate food from the kitchen. Findings include: The facility failed to maintain clean and sanitary food preparation and storage areas. During initial kitchen tour on 12/9/13 between 12:00 noon and 1:00 p.m., dietary assistant-A,	F 371		~~1/27/14~~ 1/21/14

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTH CARE CENTER INC	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 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
F 371	Continued From page 12 (DA)-A, was observed putting her purse on the counter to get a stick of gum while other dietary staff were preparing food on the same counter. The counter was not sanitized immediately after her purse was on it, although food preparation continued. During the second kitchen tour on 12/12/13 at 1:00 p.m., DA-C, was observed placing her winter coat and purse on a metal table near the walk in cooler and freezer. The dietary manager, (DM), reported the table was used to place pans of food. DM-A reported that the table should be sanitized prior to placing pans of food on it. DM added that coats and purses should not be in the food preparation area. During the second kitchen tour on 12/12/13 at 1:00 p.m. winter coats and scarves were observed on a large box of potato chips and the dry storage shelves with food on it. DM reported coats and winter wear should be hung on the hooks. The undated policy, Storage of Personal Belongings, directed staff, "Employee coats and jackets may only be in the store room where the coat hangers are and may NOT be in the kitchen area. Purses are only allowed in lockers or the store room." The facility failed to maintain rinse water temperatures for the dishwasher at a level to sanitize the dishes. During kitchen tour on 12/9/13, a rack of serving tins, a rack of metal serving bowls and a rack with a large metal bowl on it were observed to run through the dishwasher. The rinse water cycle temperature gauge was observed at 170 F (degrees Fahrenheit) for all three racks of dishes.	F 371	(DA)-A was re- in serviced on dietary dietary sanitation and personal belongings during the survey on 12/9/13 by the dietary manager. (DA)-C was re- in serviced on dietary sanitation and personal belongings during the survey on 12/12/13 by the dietary manager. Dietary Manager updated Personal Items Policy as of 12/17/2013. All dietary staff have been re-in serviced on the updated policy. A thermostat was changed out in the dish machine on 12/17/13. The Mechanical Dish Washing Policy was updated on 12/17/13. All dietary staff have been re-in serviced regarding policy revisions regarding the dish machine and assuring appropriate temperatures. Continued on next page:	

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	245189	A. BUILDING _____ B. WING _____	12/12/2013

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SOUTHVIEW ACRES HEALTH CARE CENTER INC	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

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F 371	Continued From page 13 The temperature gauge then rose to, and was able to maintain 180 F. DA-B reported the dishes were clean and did not need to be rewashed because there were no spots on them. DM reported rinse water temperatures were normally between 180 F and 200 F immediately upon starting the dishwasher. Review of the Dish Machine Temperature Log, December 2013, revealed recorded temperatures were below 180 F for 3 out of 10 recorded days for washing of dinner dishes. Temperatures were not recorded for one day of dinner dish washing. Temperatures were below 180 F for 4 out of 10 recorded days for washing of brunch dishes. Temperatures were not recorded for 2 days of brunch dish washing. The Mechanical Dishwashing Procedure policy, undated, directed staff: "Fill dishwasher with water by releasing the hot water valve. Check temperatures to insure (sic) wash water is 150-160 degrees F and rinse water is 180 degrees F. Record temperature. Proceed to wash dishes."	F 371	Random audits will be completed by dietary manager, diet tech, and licensed dieticians. Random audits will be forwarded to the DON and QA committee for follow up. Dietary manager will be responsible for monitoring.	~~1/27/14~~ 1/21/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245189	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/12/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTH CARE CENTER	**2000 OAKDALE AVENUE** **WEST SAINT PAUL, MN 55118**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Southview Acres Health Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 241 beds and had a census of 227 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245189	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/12/2013**

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K 000	Continued From page 1 MET. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 000		

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3896

January 13, 2014

Mr. Thomas Goeritz, Administrator
Southview Acres Health Care Center Inc
2000 Oakdale Avenue
West Saint Paul, MN 55118

Re: Enclosed State Nursing Home Licensing Orders - Project Number S51980924

Dear Mr. Goeritz:

The above facility was surveyed on December 9, 2013 through December 12, 2013 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, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, PO Box 64900 St Paul Minnesota 55164-0900. 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 Susanne Reuss at (651) 201-3793.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File