Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 13, 2023

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

RE: CCN: 245189
Cycle Start Date: November 30, 2023

Dear Administrator:

On November 30, 2023, 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:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: Peter.Cole@state.mn.us
Office/Mobile: (651) 249-1724

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 March 1, 2024 (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 May 30, 2024 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

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

Feel free to contact me if you have questions.

Sincerely,

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

Electronically delivered
December 13, 2023

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

Re: State Nursing Home Licensing Orders
Event ID: NQS411

Dear Administrator:

The above facility was surveyed on November 27, 2023 through November 30, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: Peter.Cole@state.mn.us
Office/Mobile: (651) 249-1724

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

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 _____	**11/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	**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
K 000	INITIAL COMMENTS The Minnesota Department of Public Safety, State Fire Marshal Division conducted an annual Life Safety recertification survey on November 30th, 2023. At the time of this survey, Southview Acres Health Care Center 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	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/22/2023

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.

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 _____	**11/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	**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
K 000	Continued From page 1 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us 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	K 000		

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 _____	**11/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	**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
K 000	Continued From page 2 building. The facility has a capacity of 220 beds and had a census of 157 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location	K 222		3/1/24

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 _____	**11/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	**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
K 222	Continued From page 3 within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility needed to maintain the Egress Doors per NFPA 101 (2012 edition), Life Safety Code, section(s) 7.2.1.5.6 and 7.2.1.5.10.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 11/30/2023 between 9-1 PM, it was revealed	K 222	1. Facility has had said area of deficiency inspected and reviewed on 3 dates (12.13.2023, 12.20.2023, and 12.22.2023) by licensed professionals, is in receipt of quotes from vendors, and will schedule install of rim exit device (i.e. panic bar) to meet NRPA 101 (2012) Life Safety Code at soonest availability.	

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 _____	**11/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	**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
K 222	Continued From page 4 by observation that the exit door located on the 1st floor (old Entry) needs to have the correct exit hardware found on the door. An interview with the maintenance director verified these or these deficient findings at the time of discovery.	K 222	2. Installation of rim exit device. Once complete, deficiency will no longer exist. 3. Code alert checks will be done daily on the specified egress door and will continue as regularly planned. Monthly monitoring will also occur during regularly scheduled fire drills and exit evaluations. 4. Maintenance Director or designee will ensure compliance is monitored and ongoing. 5. Completion date: Waiver Submitted with completion date of 3/1/24	
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain Discharge from Exits per NFPA 101 (2012 edition), Life Safety Code section 19.2.7. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 11/30/2023 between 9-1 PM, it was revealed by observation that the retainer wall located on the 1st-floor level North side of the building is showing signs of felling away and could abstract the means of discharge from the building to the public way.	K 271	1. Facility has sought licensed professional inspection from landscape/contractors on dates 12.14.2023 and 12.18.2023 to assess repair, provide quote and timeframe, and will set date of completion weather permitting. 2. Retaining wall will be properly secured and reinforced, the deficiency will seize to persist once complete. 3. Maintenance Director and EVS Director or designee will continue with regularly facility rounding of external	11/29/24

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 _____	**11/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	**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
K 271	Continued From page 5 An interview with the Director of Maintenance verified this or these deficient findings at the time of discovery.	K 271	property to ensure free from trash, debris, or in need of repair. As indicated, notification will be given to landscape and lawn care providers to ensure no disruption. 4. Maintenance Director and EVS Director or designee will ensure compliance is monitored and ongoing. 5. Completion date: Waiver Submitted with compliance date of 11/29/24	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain the Fire Alarm System - Installation per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.8.1, and NFPA 72-2010 section 29.3.3. This deficient finding has	K 341	1. Facility has received quotes from licensed professionals (Summit Fire and Johnson Controls) on 12.22.2023 who will install smoke detection devices, in said area of 4th floor, installed per NFPA 101	5/1/24

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 _____	**11/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	**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
K 341	Continued From page 6 a patterned impact on the residents within the facility. Findings include: On 11/30/2023 between 9-1 PM, it was revealed by observation that the 4th floor is being used as a large storage area and has no smoke detection per the Life Safety code. An interview with the Director of Maintenance verified this finding of deficiency at the time of discovery.	K 341	(2012 edition). 2. Installation will occur at earliest availability of vendor and deficiency will no longer exist. 3. Monthly facility wide fire smoke alarm detection monitoring and testing will continue with addition of 4th floor. 4. Maintenance Director or designee will be responsible for ensuring compliance is monitored and ongoing. 5. Completion date: Waiver Submited with completion date of 5/1/24	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain the Sprinkler System -	K 353	1. Facility has gathered quotes from licensed vendors on 12.22.2023 who will	1/31/24

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 _____	**11/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	**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
K 353	Continued From page 7 Maintenance and Testing per NFPA 101 (2012 edition), Life Safety Code, section(s) 9.7.5, 9.7.7, 9.7.8, and NFPA 25. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/30/2023 between 9-1 PM, it was revealed by observation that the fire sprinkler heads in the kitchen around the dishwashing area showed signs of being hit by something, bent the deflectors of the sprinkler heads, and needed to be replaced. An interview with the maintenance director verified this finding of deficiency at the time of discovery.	K 353	replace said damaged overhead sprinkler heads in kitchen dish area. 2. Once installation of replacement overhead sprinklers occurs, deficiency will no longer exist. 3. Monthly facility wide fire alarm and sprinkler monitoring will continue via TELS life safety management notification system. 4. Maintenance Director and EVS Director or designee will be responsible for ensuring compliance is monitored and ongoing. 5. Completion date: 1/31/24	
K 753 SS=E	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by:	K 753		12/25/23

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 _____	**11/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	**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
K 753	Continued From page 8 Based on observation and staff interviews, the facility failed to maintain combustible decorations per NFPA 101 (2012 edition), Life Safety Code, section 19.7.5.6. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 11/30/2023 between 9-1 PM, it was revealed by observation that combustible decorations were being put on resident room doors and could impede the means of egress. An interview with the Director of Maintenance verified this or these deficient findings at the time of discovery.	K 753	1. All combustible decorations on resident doors were removed. 2. Facility wide education to that will educate staff, residents, and family on the safety risks of having combustible decorations on resident doors. 3. Facility staff will perform regular rounding and monitoring to ensure decorations do not impede means of egress. 4. Department Heads and staff will be responsible for identifying any potential threats and notifying Maintenance Director and Social Services Director with Administrator support. 5. Completion date: 12.25.23	
K 927 SS=E	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to implement Gas Equipment - Transfilling Cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.2.	K 927	1. Facility immediately removed oxygen cylinder from said location and stored in designated Oxygen closet. 2. Direct contact made to Oxygen	12/25/23

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 _____	**11/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	**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
K 927	Continued From page 9 These deficient findings have a patterned impact on the residents within the facility. Findings include: On 11/30/2023 between 9-1 PM, it was revealed by observation that a liquid oxygen cylinder tank was sitting in the hallway on the 2nd floor short-term area. An interview with the Director of Maintenance verified this finding of deficiency at the time of discovery.	K 927	provider on 12.15.2023 and 12.22.2023 to ensure that delivery representatives will comply with proper placement and storage of unattended containers. 3. Facility wide staff education will be offered to all direct care clinical staff and has been updated in facility General Orientation training as of 12.22.2023. 4. Director of Nursing in conjunction with Director of Maintenance and Administrator will regularly monitor. 5. Compliance Date: 12.25.23	

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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
E 000	Initial Comments On 11/27/23 to 11/30/23, a survey for compliance with CMS Appendix Z, the Emergency Preparedness Requirements, was conducted during a standard recertification survey. Southview Acres Healthcare Center was found in compliance with the requirements. 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.	E 000		
F 000	INITIAL COMMENTS On 11/27/23 to 11/30/23, a standard recertification survey was conducted by surveyors from the Minnesota Department of Health (MDH). Multiple complaint investigations were also completed. Southview Acres Health Care Center was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H51897309C (MN90194) H51897310C (MN90681); non-compliance cited at F580. H51897308C (MN91111); non-compliance cited at F580. H51897307C (MN92471) H51897305C (MN96834) H51897304C (MN92472) H51897306C (MN92474) H51897303C (MN96835) H51897302C (MN98052) H51897227C (MN98249)	F 000		

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

Electronically Signed | 12/21/2023

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.

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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	Continued From page 1 H51897396C (MN98662) 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.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/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	F 580		12/27/23

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 580	Continued From page 2 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 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 observation, interview, and document review, the facility failed to ensure resident' responsible parties were notified in a timely manner with abnormal lab values and corresponding medical treatment being implemented for 1 of 2 residents (R173); and with the development of a skin ulcer which required medical care and treatment for 1 of 2 residents (R49) reviewed for notification of change. Findings include:	F 580	F 580 R173 and R49 have both been discharged from the facility. All existing residents from 12/13 to present will have clinical documentation reviewed for notification of change in resident care and appropriate resident/resident representative notification. Future residents who experience a change in resident care, the resident/resident representative will be notified, and documentation initiated. Licensed nurses will be in-serviced on the	

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 580	Continued From page 3 A Vulnerable Adult Maltreatment Report, dated 2/14/23, identified a report had been submitted for R173 which alleged multiple care-related concerns. These included an allegation R173 had a change in condition, with abnormal laboratory values (i.e., elevated potassium, failing kidneys) and new medications (i.e., Lasix; a diuretic) being started to address. However, the allegation outlined R173's family or responsible party was not notified of these until later when R173 had to be hospitalized for continued treatment. R173's significant change in status Minimum Data Set (MDS), dated 1/22/23, identified R173 had both long-term and short-term memory impairment and required extensive assistance for transfers, dressing, and toileting. Further, the MDS outlined R173 had several medical conditions including cancer, anemia, and renal insufficiency. R173's electronic medical record (EMR) Clinical Resident Profile, printed 11/30/23, identified R173 admitted to the nursing home on 8/15/22 and discharged on 2/9/23. A section was present and labeled, "Contacts," which outlined R173's responsible party as family member (FM)-D along with contact information. On 11/30/23 at 9:50 a.m., a telephone interview was attempted with FM-D. However, they were unable to be reached. R173's progress note(s), dated 12/1/22 to 2/9/23, identified the following: On 12/30/22, R173 was identified as being in isolation for an active COVID-19 infection. However, R173 refused to remain in their room	F 580	change in condition policy with focus on items #4-6 that resident, resident representative, and the MD will be notified of a resident change in condition, medication, treatment or change in mental status and documentation indicating that notification was initiated. Director of Nursing and/or designee will be responsible for compliance. Audits on notification of change in resident condition documentation to resident representative and MD will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 12/27/2023	

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 580	Continued From page 4 (on isolation) and had to be re-directed multiple times. On 1/8/23, R173 was removed from isolation precautions. The note identified R173 had received a dosing of Paxlovid (anti-viral medication) and had no fever or cough present. On 1/13/23, a series of notes identified a basic metabolic panel (BMP) and magnesium level were ordered for stage III chronic kidney disease with one note dictation, "Rescheduled for tomorrow [1/14/23]." On 1/14/23, the lab results were obtained and, " ... values out of normal range." The note outlined the on-call physician service was updated. A subsequent note, dated 1/14/23, identified the nursing home had received orders for Lasix 20 milligrams (mg) daily, push fluids, and recheck laboratory work on 1/18/23. The completed note(s) lacked evidence R173's family or responsible party was updated. On 1/18/23, the lab notified the nursing home of " ... critical K [potassium] level of 6.3 ... On call [physician] updated with orders ... Lab form faxed." The completed note lacked evidence R173's family or responsible party was updated. On 1/19/23, an additional lab was drawn and dictation present, " ... call received from M Health Fairview ... critical Potassium level of 6.1 ... call made out to on call MD ... Awaiting call back." A subsequent note, dated 1/19/23, identified the physician returned the call and would update R173's primary physician with the information. However, again, the completed note(s) lacked evidence R173's family or responsible party was	F 580		

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 580	Continued From page 5 updated. On 1/22/23, an additional note identified the medical provider ordered another BMP for 1/23/23, and the physicians were considering adding a medication regimen for R173. The note concluded, "Daughters updated." On 1/23/23, additional laboratory results were faxed to the medical provider. A subsequent note, dated 1/23/23, identified R173's family called and requested R173 have intravenous (IV) fluids for dehydration. On 1/24/23, a peripheral IV was started and IV solution started in accordance with physician orders. On 1/26/23, the IV was discontinued. However, R173's entire medical record was reviewed and lacked evidence R173's responsible party and/or family members had been updated prior to 1/22/23 with the laboratory testing orders, results, or subsequent medication and treatment changes despite these being ordered and obtained nearly 10 days prior (on 1/13/23). On 11/30/23 at 10:02 a.m., licensed practical nurse (LPN)-B was interviewed. LPN-B explained they typically worked on the unit where R173 had resided, and expressed family should be updated "immediately" with a change of condition or abnormal laboratory values. LPN-B stated such notification should also be recorded in the progress notes of the medical record to demonstrate, "Family was updated." LPN-B stated it was important to ensure such	F 580		

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 580	Continued From page 6 notifications as the information for families was "necessary for them to know what's going one with their loved one." On 11/30/23 at 10:46 a.m., registered nurse unit manager (RN)-A was interviewed and verified they had reviewed R173's medical record. RN-A explained R173's family was "highly involved" with her care at the nursing home and they would be "very surprised" if family had not been updated about the abnormal laboratory values and subsequent medication orders. RN-A stated they had not reached out to the nurses' who authored the various progress notes (dated 1/13/23 to 1/22/23) to question them about it adding herself and the director of nursing (DON) felt they'd be unlikely to accurately recall the information due to the amount of time passed since R173 discharged. However, RN-A acknowledged the lack of any documented evidence in the progress notes or medical record demonstrating FM-D had been notified and expressed such "should be documented." RN-A added timely notification to responsible parties was important to do so family can be involved with the decision making. R49's quarterly Minimal Data Set (MDS) dated 9/18/23, indicated R49 was cognitively intact, had difficulty focusing, had disorganized thinking, and did not refuse personal cares. The MDS indicated R49 had diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), hypertension, heart failure (chronic condition in which the heart doesn't pump blood as well as it should), and dementia. R49's care plan indicated R49 was independent	F 580		

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 580	Continued From page 7 with ambulation, transfers and bed mobility. R49 required set up and assistance to eat and personal hygiene and required assistance with lower extremity dressing. R49's provider orders dated 11/1/23, indicated use of "wound cleanse/Vashe wash, pat dry, apply calcium alginate with collagen powder, cover with foam dressing, change dressing every other day and as needed". The order also indicated to avoid pressure or trauma. R49 had an order dated 11/6/23, for ace wraps to be put on his lower extremities in the morning and removed at bedtime for edema exacerbation. The order directed staff to use tenso stockings, once the edema improved. R49's skin and wound assessment dated 11/28/23, indicated the stasis wound on R49's left lower extremity which was identified on 10/31/23. R49's medical record lacked documentation indicating R49's family (FM)-C was informed about the development of a stasis wound. During an interview with on 11/29/23 at 10:25 a.m., R49's family member (FM)-C stated nobody from the facility had informed her about R49's wound on his left leg. During an interview on 11/30/23 at 9:03 a.m., RN-H was requested to provide documentation about reporting R49's left leg wound to FM-C. RN-H confirmed there was no documentation of notification regarding the wound identified on 10/31/23. RN-H stated, family members needed to be notified with any change in condition, including new skin issues.	F 580		

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 580	Continued From page 8 During an interview on 11/30/23 at 10:30 a.m., the director of nursing (DON) stated when a resident developed a new skin issue, the nurses should notify the family and the provider. Facility policy regarding notification of family or representative about changes in condition was requested but not received.	F 580		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a significant change in status assessment (SCSA) was completed within required timeframe to help facilitate timely person-centered careplanning for 1 of 2 residents (R144) reviewed for Minimum Data Set (MDS) accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI)	F 637	F 637 R144 Significant Change in Status MDS and accompanied progress note was completed on 11/29/2023. All resident MDS scheduled from 12/13/2023 to present was reviewed to ensure all SCSAs are scheduled timely. Future resident significant change in status MDSs will be scheduled and a progress note indicating the purpose for the change will accompany. The IDT team and MDS consultant was	12/27/23

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 637	Continued From page 9 3.0 User's Manual, dated October 2023, indicated a significant change in status assessment (SCSA) was required when various criteria were met. The manual directed the MDS completion date must be no later than 14 days from the assessment reference date (ARD) (ARD + 14 calendar days) and no later than 14 days after the determination the criteria for an SCSA were met. R144's SCSA MDS, dated 9/15/23, identified R144 had intact cognition, required supervision to limited assistance with activities of daily living (ADLs), and had no current pressure injuries. However, R144's electronic medical record (EMR) Minimum Data Set (MDS 3.0) Summary, printed 11/28/23, identified another SCSA had been initiated with an assessment reference date (ARD) listed of 11/07/23. However, the assessment remained unfinished with several areas of the MDS, including sections for bladder and bowel, active diagnoses, skin conditions, and medications, all being left red-colored and uncompleted. The section provided to record any corresponding triggered Care Area Assessments (CAAs) was left yellow-colored with, "In Progress;" and the MDS was unsigned. When interviewed on 11/30/23 at 8:20 a.m., registered nurse (RN)-D explained the entire campus MDS' were completed offsite through a consulting agency. RN-D stated they contacted them asking about R144's SCSA MDS (dated 11/7/23) and provided the e-mails for review. A e-mail from the outside consulting agency, dated 11/3/23, identified R144 had a SCSA opened for new and/or reopened wounds. A subsequent note, dated 11/29/23, identified, "The	F 637	in-serviced on the Resident Assessment Policy item #3 that the SCSA is completed within 14 days when the IDT determines the resident meets the guidelines and item # Director of Nursing and/or designee will be responsible for compliance. Audits on SCSA completion timely and associated documentation will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 12/27/2023	

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 637	Continued From page 10 Significant change is completed." However, there was no rationale provided to explain the delay from 11/3/23 (when the criteria for a SCSA were identified) to 11/29/23 (over 21 days later) despite the MDS being due 14 days after the SCSA was identified. Further, R144's medical record was reviewed and lacked rationale or evidence explaining the delay with the SCSA completion. RN-D explained a potential reason for delay was workload, as the consultant does "all the MDS(s)," however, acknowledged the lack of rationale being provided. RN-D stated the SCSA was completed now, however, verified it had not been completed as of 11/29/23, when the record was initially reviewed. A provided MDS completion and Submission Timeframes policy, dated 12/2021, identified the facility would conduct and submit resident' assessments in accordance with federal and state submission timeframe(s). The policy outlined, "Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual."	F 637		
F 656 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	F 656		12/27/23

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 656	Continued From page 11 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)- (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 and document review, the facility failed to develop a comprehensive care	F 656	F 656 R78 care plan was reviewed, and a mood	

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 656	Continued From page 12 plan, including with resident-specific interventions, to meet the known and identified behavioral expressions and needs for 1 of 1 resident (R78) reviewed with cognitive impairment who, at times, refused personal care. Findings include: R78's admission Minimum Data Set (MDS), dated 10/16/23, identified R78 had intact cognition, demonstrated several indicators of depression (i.e., feeling down, poor appetite or overeating), but demonstrated no rejection of care behaviors. Further, the MDS outlined R78 had traumatic brain dysfunction and it was "somewhat important" for her to be able to choose her bathing method (i.e., shower vs bath). On 11/27/23 at 1:55 p.m., R78 was interviewed, and stated she had been at the nursing home for several weeks and had only received a couple baths which was "really weird." R78 stated they would like to get, at minimum, a sponge bath more regularly but added a full tub bath helps "feel like I actually got cleaned." R78 reiterated she would like a weekly bath or shower, if offered. When interviewed on 11/28/23 at 2:44 p.m., nursing assistant (NA)-A stated they worked for a staffing agency, but had been at the campus several times and worked with R78. NA-A stated R78 was scheduled for a bath that day (11/28/23), however, had refused it when offered which NA-A attributed to her being "really depressed." NA-A stated R78 would, at times, refuse cares like bathing and reiterated it seemed due to depression. NA-A explained they ask R78 if she wants her bath and, if refused, report it to the nurse. NA-A stated they had reported to the nurse	F 656	care plan was initiated on 12/18/2023 along with the resident target behavior and interventions initiated. All other residents existing residents with identified mood focuses care plan triggers and interventions will be reviewed and updated as needed. Future residents who trigger on the CAA for mood or behaviors, the care plan will be initiated and will include target behavior and de-escalation intervention. The IDT team will be in-serviced on the Comprehensive Assessment Care Delivery Process Policy with emphasis on item #3 expanding on triggered CAA□s and adding data to formulate the resident care plan and appropriate interventions related to the focus. Director of Social Services and/or designee will be responsible for compliance. Audits on mood care plan initiation with appropriate interventions initiated will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 12/27/2023	

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 656	Continued From page 13 working, identified as registered nurse (RN)-E, awhile earlier when R78 refused the bath. R78's care plan, revised 11/27/23, identified R78 had self care needs, required assistance to complete bathing, ambulation, and transfers, and consumed antidepressant medication as ordered. The care plan continued and outlined R78 had adjustment issues which were affecting their well-being and directed to encourage ongoing family involvement. However, the care plan lacked any behavioral expressions or concerns, no evidence R78 had a history of refusing cares as identified by NA-A, nor any interventions for staff to attempt or implement when care was refused to help ensure needs were met. When interviewed on 11/28/23 at 2:56 p.m., RN-E stated R78 seemed to, at times, struggle with cares being completed due to her mental status. RN-E stated the nursing assistant, NA-A, had just notified her (immediately prior to visiting with the surveyor) R78 had refused her scheduled bath which was not helpful considering the shift was over and R78 could no longer be re-approached for the cares. RN-E stated if the NA had reported it earlier, when it was initially refused, then some other approach or consulting could have been done adding, "That's not helping me." On 11/28/23 at 3:11 p.m., the registered nurse unit managers (RN)-B and RN-C were interviewed. RN-B explained R78 would likely not initiate her own cares, but rather needed a "we're going to do this now" approach from the staff. RN-B clarified if R78 was asked if she would do a certain task, she would likely say no which was the reason for approaching in the more direct manner. RN-B explained R78 did have cognitive	F 656		

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 656	Continued From page 14 impairment and the NA should have reported the bath refusal "right away" to the nurse to allow a chance to intervene in the moment. RN-B stated they were unsure if the approach (i.e., going to do this now) was outlined on the care plan or not. RN-B reviewed R78's care plan and acknowledged it lacked the interventional approach so, as a result, it was just added. A provided Care Plans, Comprehensive Person-Centered policy, dated 11/2021, identified a comprehensive care plan included measurable objectives to meet resident' physical and mental needs, and such would be developed and implemented for each resident. The policy included, "Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change."	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure routine bathing was offered or provided to promote good hygiene for 1 of 5 residents (R78) reviewed for activities of daily living (ADLs) and who was dependent on staff for their cares. Findings include: R78's admission Minimum Data Set (MDS), dated	F 677	F 677 R78 has documented bathing initiated on 12/5 and 12/12. R78 bathing preference was added to the resident ADL care plan intervention list and the resident bathing task tab was updated. Existing residents bathing care plan was reviewed and/or updated as needed. Future residents upon admission will be assigned bathing per resident preference.	12/27/23

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 677	Continued From page 15 10/16/23, identified R78 had intact cognition, demonstrated no rejection of care behaviors, and required substantial assistance to complete mobility and self-care activities of daily living (ADLs). R78's care plan, dated 11/2/23, identified R78 admitted to the nursing home on 10/10/23, and had several self care needs. The care plan outlined several interventions for R78 including, "BATHING/SHOWERING: The patient requires maximum assistance with dressing," and, "PERSONAL HYGIENE/ORAL CARE: The resident requires maximum assist X 1." However, the care plan lacked any evidence for when or how (i.e., frequency, type) R78's bathing would be completed; nor did the care plan outline any refusal of care behaviors. On 11/27/23 at 1:55 p.m., R78 was interviewed and expressed she felt the "bathing schedule is really weird." R78 explained she had been at the nursing home for nearly two months and had only been given one whirlpool bath and one "sponge bath." R78 stated she enjoyed the tub bath most as she "felt like I actually gotten cleaned." R78 reiterated she would like to get, at least, a weekly bath while at the nursing home. On 11/28/23 at 2:44 p.m., nursing assistant (NA)-A stated they worked for an agency staffing pool, however, had been at the facility several times and worked with R78 multiple times over the past weeks. NA-A explained R78 was scheduled for a bath that day (11/28), however, she hadn't been able to complete it as R78 refused. NA-A stated she reported the refusal to the nurse prior, and explained R78 seemed "really depressed" so she would, at times, refuse	F 677	HUCs, Licensed Nurses and Nurse Aides will be in-serviced on the Resident Self-Determination Policy with focus that residents have the right to choose their daily activities, personal care needs that includes bathing schedules. Director of Nursing and/or designee will be responsible for compliance. Audits on bathing schedules completed in the resident task tab and care plan bathing preferences listed in the ADL interventions will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 12/27/2023	

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 677	Continued From page 16 cares. NA-A stated the facility had a bath list which was kept at the nursing station and provided it for review. Further, NA-A stated any bathing refusals or completions should be recorded in the POC charting or in the nurses' charting. A provided Daily Bathing Schedule, undated, identified the 1st floor transitional care unit (TCU) bathing schedule with each room assigned to a day of the week and corresponding shift (i.e., a.m. or p.m.). This identified R78's room was scheduled for a weekly bath on Tuesday AM. R78's POC (Point of Care) Response History, printed 11/28/23, outlined a series of questions which could be answered via electronic charting to demonstrate bathing completed for R78. The report included a look-back period of 30 days (i.e., 10/28/23 to 11/28/23), however, there was no recorded data or evidence R78 had bathing offered or completed. All data fields were answered, "No Data Found." R78's medical record, including Treatment Administration Record (TAR) and progress notes, were reviewed. There was no evidence R78 had been offered, refused, or provided any bathing episodes within the past several weeks. On 11/28/23 at 2:56 p.m., registered nurse (RN)-E was interviewed. RN-E explained they worked for a staffing agency and "don't exactly know" how bathing was scheduled on the unit; however, felt each resident had a "once a week bath." RN-E stated when a resident has a bath, the NA should call the nurse into the room to complete a skin check and those would be recorded in the medical record. RN-E stated	F 677		

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 677	Continued From page 17 there was also "a sheet" the NA(s) would, at times, bring the nurse to be signed demonstrating the care was completed, however, RN-E stated the sheet was only given to the nurses "sometimes" and not consistently. RN-E stated if a resident refused bathing, then it should be recorded in the medical record. RN-E stated NA-A had just now, immediately prior to the interview with the surveyor, informed them R78 had refused her bath which RN-E expressed concern with as there was no longer time to reproach R78 for the care (see F656 for additional information). RN-E had a white-colored paper in her hand and provided it for review. A provided Bathing/Showering Checklist, dated 11/28/23, identified R78's weight was recorded that day as 184 pounds (lbs) along with several spaces to check off what items with bathing were completed including washing body and hair, lotioning the skin, and changing the bed linens. However, none of these were checked with just written dictation below reading, "She refused." RN-E reiterated these sheets were not always provided to the nurses and, to their understanding, should be. However, RN-E verified if a resident refuses a bath, then it should immediately be reported to the nurses so it can be addressed timely. On 11/28/23 at 3:11 p.m., registered nurse unit managers (RN)-B and RN-C were interviewed, and RN-B explained there was a process in the electronic medical record (EMR) to record bathing, however, they had been "fighting [it] for a little while" now. RN-B stated the facility' policy was for a weekly bath and R78 needed a "we're going to do this now" approach and then, if	F 677		

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 677	Continued From page 18 refused, the nurse should be notified and it should be charted in the medical record. RN-B stated the facility had limited employees of their own hire and with numerous agency staff present, it was sometimes difficult to get all staff on the same page with care delivery and documentation. RN-B explained the unit was supposed to have four NA(s) on the floor for care, however, when short staffed then baths were "a difficult thing" to get done, too. RN-B explained the facility used a white-colored paper bathing sheets which should be filled out by the NA and then signed by the nurse to demonstrated care was attempted or provided. RN-B provided a stack of these for review which, per RN-B, were the past several weeks worth of saved documents. However, upon review of these documents, only one additional bath for R78 was located (dated 11/3/23) which RN-C verified. RN-B verified the medical record lacked evidence bathing was attempted, offered or provided to R78 and stated bathing was important and should be completed adding the lack of routine bathing "comes up in every single care conference" it seems on the unit. A provided Bath, Shower/Tub policy, dated 2/2022, identified the purpose of the procedure was to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident' skin. A step-by-step procedure on bath completion was listed along with a section labeled, "Documentation," which identified the date and time of a shower or bath should be documented in the medical record. This included, "If the resident refused ... the reason(s) why and the intervention taken."	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		12/27/23

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 689	Continued From page 19 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care plan interventions for 2 or 2 residents (R73, R83) reviewed for falls. Findings include: R73's quarterly Minimum Data Set (MDS) dated 9/21/23, documented R73 with intact cognition and required support with setup for bed mobility, transfers, walking in her room and corridor, and all assistance with daily living (ADL's). Also, R73 had no limitations in upper and lower extremity range of motion. In addition, R73 had diagnoses of osteoarthritis and anxiety. In addition, the facility failed to ensure safe management of diabetic testing supplies for R44. R73 R73's Resident Fall Risk Assessment dated 9/22/23, indicated R73 had no falls in previous three months and a normal gait. R73's electronic medical record (EMR) failed to indicate subsequent falls assessments. R73's progress note (PN) dated 11/2/23, indicated R73 had an unwitnessed fall on 11/2/23 with no injury.	F 689	F 689 R73 risk management incidents for 11/2 and 11/16 falls were completed and the fall root cause identified, and interventions initiated. R83 fall incidents for 10/5, 11/8, 11/24 and 12/12, the risk management incidents were completed, fall root cause identified, and interventions initiated. Existing resident fall risk management incidents from 12/13 until present will be reviewed, fall care plan interventions reviewed and updated as needed. Future residents who fall will have a risk management incident created and thoroughly investigated for root cause and new intervention added to the care plan per the facility policy. Licensed Nurses will be in-serviced on the Falls and Fall Risk Management Policy with emphasis on identifying possible interventions and adding these interventions to the resident care plan so that the care team is knowledgeable of implemented interventions. Director of Nursing and/or designee will be responsible for compliance. Audits on risk management completion and indication of identified intervention	

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 689	Continued From page 20 R73's PN dated 11/16/23, indicated R73 had an unwitnessed fall resulting in left wrist injury. A splint was placed per provider order and an x-ray was ordered showing a fracture. R73's PN dated 11/17/23, indicated the x-ray showed a nondisplaced fracture to radius (lower arm bone) and the ulnar styloid (wrist). The NP (nurse practitioner) applied a different splint and ordered the resident to be non-weight bearing to the right wrist. During interview PN stated therapy worked with resident and the resident voiced moderate pain and weakness. This PN referred to the right wrist as having the fracture instead of the left wrist. R73's PN dated 11/22/23, indicated R73 had an orthopedic appointment resulting in application of a hard cast to hand and wrist. R73's physician orders (PO) dated 11/17/23, indicated R73 with, "Coffee-cup weight bearing of left hand and wrist" and an order for a splint to left hand and forearm. R73's PO did not indicate a new diagnosis of a fracture and casting of hand on 11/22/23. R73's care plan (CP) printed 11/28/23, with revision date of 11/27/23, indicated no mention of R73's fall on 11/2/23. The CP stated "The resident is at risk for falls r/t dementia, incontinence. Recent fall with fracture of the thumb-left. Currently splinted". R73's CP failed to indicate pain monitoring or changes to ADL's as a result of the fracture. R73's kardex dated and printed 11/29/23, failed to indicate any change or update regarding falls on	F 689	and fall care plan intervention initiation will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 12/27/2023	

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 689	Continued From page 21 11/2/23 and 11/16/23, including the casting of left hand. The kardex stated R73 was independent with all transfers, mobility, and dressing. R83 R83's significant change in assessment MDS dated 9/6/23, documented R83 with intact cognition and required limited assistance with bed mobility and personal hygiene and required extensive assistance of one staff member for transfers and toileting. R83's diagnoses include dementia, diabetes, and heart disease. R83's Resident Fall Risk Assessment dated 11/20/23, indicated R83 had 1-2 falls in past three months and was chairbound requiring assistance with elimination. R83's physician PN dated 11/21/2,3 indicated R83 suffered falls on the following dates in 2023: 4/30/23 (due to confusion), 5/31/23 (falling backwards and hitting head), two falls on 6/5/23 (due to urinary tract infection), 7/18/23 (fall with injury to face, chest, right hand and knees resuling in multiple rib fractures, right thumb fracture), 11/8/23 (fall with fracture of left hip and pelvis), and 11/18/23 (fall with femoral neck fracture). R83's CP revised on 12/4/22, indicated R83 was, "partially dependent on staff and family for meeting emotional, intellectual, physical, and social needs r/t physical mobility deficits". R83's CP goal with revision on 9/28/23, indicated R83, "will not sustain serious injury through the review date."	F 689		

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 689	Continued From page 22 R83's CP failed to indicate re-assessment of interventions following the falls on 4/30/23, 5/31/23, 11/8/23 and 11/18/23. During interview with registered nurse (RN)-A on 11/29/23 at 9:30 a.m., RN-A stated both R73's and R83's care plan "should be updated with new interventions" following each fall and stated it was not done. RN-A also indicated R73's and R83's kardex's was not updated to provide instructions for nursing assistants to care appropriately for both R73 and R83 including assistance needed for mobility, dressing, and toileting. During interview with director of nursing (DON) on 11/29/23 at 8:31 a.m., DON stated, "following a fall the IDT [interdisciplinary team] meets to determine the root cause and appropriate interventions". The DON stated new interventions and updated kardex's should be implemented following each fall and agreed that this was not done for both R73 and R83. Facility policy titled Falls and Fall Risk, Managing reviewed 10/04/2021 indicate, "staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable." In addition, the policy stated, "If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use	F 758		12/27/23

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 758	Continued From page 23 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 758	Continued From page 24 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure non-pharmacological interventions were care planned, attempted, and recorded before the administration of as-needed (PRN) psychotropic medication to reduce the risk of complication for 1 of 1 residents (R38) reviewed for unnecessary medication use. Findings include: R38's significant change Minimum Data Set (MDS) dated 11/9/23, indicated R38 had severely impaired cognition and was diagnosed with dementia, anxiety, and depression. R38's care plan dated 9/15/23, indicated R38 required extensive assistance with personal hygiene, bed mobility, toilet use, and dressing. R38's care plan indicated that R38 had impaired cognitive function, thought processes, and decision-making. The care plan indicated R38 had a communication problem related to cognitive loss and confusion and staff were to anticipate his needs. The care plan indicated R38 was partially dependent on staff for meeting his emotional, intellectual, and social needs related	F 758	F 758 R38 has since discharged from the facility. Current residents who have PRN psychotropic medications will be reviewed and their medication orders will be updated as needed. Future residents who have PRN psychotropics will have non-pharmalogical interventions attempted and documented before administering PRN psychotropics. Facility licensed nurses and social workers will be in-serviced on the Behavioral Assessment Monitoring policy with emphasis on item #9 that non-pharmalogical interventions will be utilized to the extent possible to avoid or reduce the use of the use of antipsychotic medications to manage behavioral symptoms. Social Service Director and/or designee will be responsible for compliance. Audits on non-pharmalogical intervention attempts prior to PRN administration of psychotropic medication will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the	

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 758	Continued From page 25 to his depression and anxiety and as interventions, R38 can socialize with family and staff during visits and care and included R38's preferred activities. The care plan did not include drinking two cups of coffee, ambulating in the hallway, or assisting R38 to the common area to converse with others as methods to decrease R38's anxiety. The care plan indicated that R38 utilized an anti-anxiety medication, lorazepam, related to his anxiety disorder and accompanying heart palpitations. The care plan indicated nursing staff were to observe for medication side effects and effectiveness but did not indicate non-pharmacological interventions that could have been attempted before administering the lorazepam. R38's order summary report dated 6/16/22, indicated R38 was able to take lorazepam one or two milligrams (mg) by mouth every one hour as needed with a maximum dose of six milligrams in twenty-four hours. R38's administration record dated 11/1/23-11/29/23, indicated R38 received 20 one mg doses and 10 two mg doses of lorazepam during this time frame. The administration record did not document non-pharmacological anxiety methods had been attempted. The record did not indicate non-pharmacologicals had been attempted before administering lorazepam. During an interview on 11/27/23 at 12:56 p.m., family member (FM)-A stated the facility utilized agency staff resulting in his dad having "so many new people" taking care of him who were not aware of his routine. During an observation and interview on 11/27/23	F 758	Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 12/27/2023	

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 758	Continued From page 26 at 12:57 p.m., R38 was observed sitting on the edge of his bed with a green bottle attached to a lanyard around his neck talking with FM-A. Licensed practical nurse (LPN)-E was observed entering R38's room. FM-A stated to LPN-E that R38 had his "heart pill" in the green bottle. LPN-E stated she did not know the lorazepam was kept in the bottle and "sometimes things get missed" when referring to checking his lorazepam bottle. FM-A stated it took too long for staff to answer his call light to administer lorazepam, so it was important, that staff checked his bottle to ensure a pill was in there. FM-A stated he didn't feel like he could relax when he left the facility and clarified that there were a lot of good staff members but also many new staff members who were unaware of R38's routines or needs. During an interview on 11/29/23 at 10:06 a.m., LPN-C stated occasionally things like socializing with other residents and assistance with going to a common area would ease R38's anxiety, but acknowledged this was not in the medical record for staff who are unfamiliar with R38 to find and implement. During an interview on 11/29/23 at 12:58 p.m., the consultant pharmacist (CP) stated R38 was taking lorazepam for the heart palpitations he had related to his anxiety. The CP stated staff should have been providing non-pharmacological interventions to assist with his anxiety. During an interview on 11/30/23 at 9:20 a.m., the director of nursing (DON) stated that R38 came into the facility with significant anxiety and utilized as-needed lorazepam that he kept in the bottle around his neck. The DON stated that R38 liked to ambulate in the hallway and drink two cups of	F 758		

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 758	Continued From page 27 coffee in the morning to assist with his anxiety and she would have expected staff to care plan these interventions so they could have been seen and followed by all staff. A policy regarding non-pharmacological interventions was requested but not received from the facility.	F 758		
F 880 SS=E	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 §483.70(e) and following accepted national standards; §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	F 880		12/27/23

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 880	Continued From page 28 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 880		

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 880	Continued From page 29 review, the facility failed to ensure a community-use available glucometer was properly cleaned and disinfected between patient' use for 1 of 1 resident (R107) observed to have their blood glucose checked with the device. This had potential to affect 12 of 12 residents identified to reside on the 200 East Unit and have diabetes mellitus. In addition, the facility failed to ensure medical supplies with potential for blood-borne cross contamination were appropriately stored away from patient living areas for 1 of 1 resident (R44); and failed to ensure posted transmission-based precautions were consistently implemented to reduce to risk of infectious spread for 1 of 1 resident (R18) identified to be on such precautions. This had potential to affect 25 of 25 residents identified to reside on the same unit. Findings include: An email correspondance from the director of nursing (DON) dated 11/20/23 at 1:11 p.m., indicated 12 residents on the 200 East Unit were diagnosed with diabetes. R107's quarterly Minimum Data Set (MDS) dated 7/28/23, indicated R107 had intact cognition and was diagnosed with diabetes, end-stage kidney disease, and heart failure. R107's care plan dated 8/2/23, indicated R107 required staff set up help for eating and extensive assistance for locomotion and bathing. R44's order summary dated 11/9/23, indicated R107 received blood sugar checks daily. During an observation and interview on 11/28/23	F 880	Glucometer Residents currently residing on the 200 East unit were issued their own glucometer. There were no ill effects noted by any resident due to this deficient practice. R 44 was assessed and there were no ill effects from use of community glucometer machine use. The bucket containing community glucometers and supplies was disposed of. Existing residents were assessed, and those residents identified were provided with a glucometer. Future residents who admit and require glucose monitoring will be issued a glucometer for use throughout their stay as needed. Licensed nurses will be in-serviced on the Obtaining Fingerstick Glucometer policy and procedure with focus on #18 that glucometers must be cleaned between use per manufacturer instructions. Licensed nurses will also be in-serviced on the Storage of Meds Policy that all biologicals must be maintained in the medication cart. Director of Nursing and/or designee will be responsible for compliance. Audits on issuing glucometers upon admission and maintaining unused lancets on the medication carts will begin 2x a week for 2 weeks, weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 12/27/2023 Hand Hygiene/Glove Usage	

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 880	Continued From page 30 at 8:38 a.m., licensed practical nurse (LPN)-C was observed obtaining a blood sample from R107 and using a glucometer to measure the result, then discarded the test strip from the glucometer and immediately placed the glucometer into a basket on top of loose needle stick devices without disinfecting the device. LPN-C exited the room and placed the basket with the glucometer back on top of the 200-east medication cart. LPN-C stated the glucometer was available for use for all residents on the 200-east wing as a backup or in case of emergency. LPN-C stated he did not think any other residents used the floor-stocked glucometer regularly and therefore had not cleaned it. On 11/29/23 at 1:55 p.m., registered nurse infection preventionist (RN)-F and the DON were interviewed. RN-F explained a community-use glucometer should be cleaned using "purple top" wipes between patient' uses and allowed to dry. RN-F stated the facility tried to have each patient with their own device, to reduce the risk of cross contamination, however, the staff would make "buckets" up with various supplies and a community-based glucometer at times still. RN-F verified there was clean, community-use glucometers present in the medication room(s) which staff could use and reiterated the device' should be cleaned and disinfected between patient' use to prevent blood-borne pathogen cross contamination. R44's quarterly Minimum Data Set (MDS) dated 11/7/23, indicated R44 had severely impaired cognition. R44's Order Summary Report dated 8/4/23,	F 880	R 18 isolation precautions were discontinued on 12/1/2023. R 18 did not experience any ill effects from this deficient practice. Current and future residents who are on isolation will always have supplies available for use and that staff will don the appropriate PPE before entering the room. Facility staff will be in-serviced on the Use of PPE policy with emphasis on wearing gloves, gown and a mask when entering a resident room who is on isolation. Infection Preventionist and/or designee will be responsible for compliance. Audits on donning and doffing of PPE will begin 2x week for 2 weeks, weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 12/27/2023	

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 880	Continued From page 31 indicated R44 received blood sugar monitoring four times a day. R44's face sheet dated 8/4/23, indicated R44 was diagnosed with diabetes, heart failure, and chronic obstructive pulmonary disease (COPD-incurable lung disease causing breathlessness, frequent coughing, and chest tightness). R44's care plan dated 10/18/23, indicated R44 was independent with ambulation and bed mobility but required verbal cues and set-up assistance for personal hygiene and eating. During an observation on 11/27/23 at 3:26 p.m., a cardboard box was observed on R44's bedside table containing a glucometer, glucometer test strips, and multiple needle stick devices. The cardboard box had a patient label with identifying information that did not match R44. During an observation on 11/27/23 at 5:57 p.m., a cardboard box was observed on R44's bedside table containing a glucometer, glucometer test strips, and multiple needle stick devices. The cardboard box had a patient label with identifying information that did not match R44. During an observation on 11/29/23 at 9:30 a.m., R44's bedside table was observed directly to the right of his bed with a cardboard box on its surface containing a glucometer, glucometer test strips, and multiple lancets with a patient label not matching R44. A one-centimeter round brownish-red stain was observed under the patient label inside of the box. During an interview on 11/29/23 at 9:45 a.m.,	F 880		

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 880	Continued From page 32 licensed practical nurse (LPN)-A stated this box containing multiple needle stick devices, a glucometer, and glucose testing strips was refilled by nursing staff every Friday and contained items they used to assess R44's blood glucose. LPN-A stated the brownish-red stain appeared to have been blood and he was unsure how a different resident's supplies got into R44's room. LPN-A stated a different resident's box should not have been in R44's room but they had been using this box for an undetermined amount of time. During an interview on 11/29/23 at 12:11 p.m., nurse manager (RN)-A stated the box containing the glucometer and supplies should have been discarded and never placed in R44's room. RN-A stated she would have been worried about the risk of infection because the box had belonged to a previous resident and contained blood. On 11/29/23 at 1:55 p.m., registered nurse infection preventionist (RN)-F and the director of nursing (DON) were interviewed. DON stated she was aware of the lancet's being found in R44's room and was not sure how they had been left there on top of the table. RN-F stated while housing supplies like lancets in the room was not disallowed, they should have been inside the dresser drawer or someplace not out in the open adding they don't want them "strung around the room." RN-F stated there was some residents on the same unit with R44 who wander the hallways and better storage, such as in the drawer, would help prevent someone from accidentaly poking themselves with the devices. During observation on 11/28/23 at 8:35 a.m., PPE was outside the door of R18 room. Signage on R18's door indicated Isolation Room, respiratory	F 880		

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 880	Continued From page 33 precautions and instructed all staff who enter the room to wear PPE gown, N95 mask, goggles/faceshield, and gloves. Signage on R18's door indicated how to properly remove PPE. The PPE bin was a three-drawer bin white and clear in color. The top drawer contained N95 masks, the middle drawer contained goggles and the bottom drawer contained washable gowns. On top of the bin was a container of super Sani-cloths disinfectant wipes. The handrail located directly behind the PPE bin held three boxes of procedure masks, one box of procedure mask with attached face shield and one bottle of hand sanitizer. However, the PPE bin and handrail lacked any gloves. During interview on 11/28/23 at 8:35 a.m., registered nurse (RN)-G, verified no gloves were in or around the PPE storage. They indicated that there are gloves on the medication cart. They also verified that the medication cart is not stationed by R18's room. During observation on 11/28/23 at 9:10 a.m., housekeeper(HK)-A pushed a clean linen cart outside of R18's room. Housekeeper-A was observed using hand sanitizer, putting on gown, removing procedure and donning a N95 mask. HK-A grabbed the laundry off the laundry cart, knocked on R18's and entered. R18 did not have gloves or goggles/face shield on. During interview with HK-A on 11/28/23 at 9:20 a.m., after exiting from R18's room, they indicated the proper use of PPE. They indicated it is important to use proper PPE to stop the spread of diseases. HK-A confirmed that she did not wear gloves into the room as there were no gloves by the door or in the PPE bin. Housekeeper-A did	F 880		

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 880	Continued From page 34 not acknowledge that they did not wear goggles/face shield in R18's room. During observation on 11/28/23 at 12:17 p.m., it was noted that no gloves had been placed inside or around the PPE bin outside of R18's room. During interview on 11/29/23 at 1:55 p.m., with director of nursing (DON) and registered nurse (RN)-F, they verified the facility had "quite the outbreak unfortunately" lately regarding residents having COVID. They indicated they have been working and had done "whole house" education with all staff members from all departments regarding proper use of PPE. They indicated that audits for donning and doffing have been completed and they had a "annual skills fair" this past September during which transmission based precautions were reviewed. They indicated PPE carts are stocked nightly by night nurses and again by the evening charge nurse. They verified all staff, including laundry, should have full PPE when entering the room and "that should not happen" [entering without gloves or eye protection]. They indicated that proper PPE is important as it ensure themselves and other residents are protected. A facility policy on cleaning and use of a community glucometer was requested, however, none was received. A policy was requested regarding proper usage of PPE and transmission based precuations, however, none was recieved.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		12/27/23

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 883	Continued From page 35 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 883		

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 883	Continued From page 36 already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure recommended pneumococcal vaccinations, as outlined by the Centers for Disease Control (CDC), were offered and provided in a timely manner for 2 of 5 residents (R18, R140) reviewed for immunizations. Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 65 years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer PCV20 who had received PCV13 at any age and PPSV23 at or after 65 years old. R18's quarterly Minimum Data Set (MDS), dated 9/15/23, identified R18 had severe cognitive impairment and several medical conditions	F 883	F883 R 140 received their pneumococcal vaccine on 11/29/2023 and R 18 will receive the pneumococcal vaccine on 12/17/2023. All current residents were reviewed for pneumococcal vaccine and the vaccine was ordered and administered if needed. Existing residents who have not received the pneumococcal vaccine will be screened upon admission and will be administered per resident consent. Licensed nurses will be in-serviced on the Vaccination of Residents Policy and Procedure with emphasis on offering the vaccine to the resident upon admission (unless contraindicated), that refusals must be documented and orders for this vaccine will follow the physician standing order procedure. Infection Preventionist and/or designee will be responsible for compliance. Audits on residents being offered	

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 883	Continued From page 37 including heart failure, dementia, and malnutrition. Further, under Section O - Special Treatments and Programs, the MDS outlined R18's pneumococcal vaccinations were up to date. R18's most recent Immunization Consent or Declination, dated 9/20/23, identified R18's family member (FM)-A had consented for "all series" of pneumococcal vaccinations when offered. When interviewed on 11/29/23 at 9:56 a.m., FM-A explained they recalled being asked about giving R18 the updated pneumococcal vaccination during their vaccine clinic a few months prior. FM-D stated they told the facility to "check with the doctor" about it and, if they were in agreement, to administer the vaccine. FM-A stated they believed it had been given but added, "You assume they [nursing home] follow through." R18's facility' electronic medical record (EMR) was reviewed. A section labeled, "Clinical - Immunizations," identified R18's completed vaccinations. This identified R18 received the Pneumovax 23 (PPSV23) on 11/30/00, and the Prevnar 13 (PCV13) on 10/20/2014. However, the record lacked evidence R18 had received the PCV20 despite the consent for it being obtained months prior. R140's quarterly MDS, dated 8/18/23, identified R140 had severe cognitive impairment and several medical conditions including renal insufficiency and dementia. Further, under Section O - Special Treatments and Programs, the MDS outlined R140's pneumococcal vaccination was not up to date as it had been, "Offered and declined."	F 883	pneumococcal vaccine upon admission, vaccine refusal or acceptance and the recording the results into the immunization tab will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 12/27/2023	

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 883	Continued From page 38 However, R140's most recent Immunization Consent or Declination, dated 10/3/23, identified R140's FM-B had verbally consented for all vaccinations, including the pneumococcal series, when offered. When interviewed on 11/29/23 at 9:47 a.m., FM-B explained they were the primary relative who helped make care decisions for R140 due to his cognition. FM-B stated they had, to their recall, never been asked about giving R140 a pneumococcal vaccine series since he admitted to the nursing home in January 2023, however, voiced R140 could have "whatever he needs to be safe." R140's facility' EMR was reviewed. A section labeled, "Clinical - Immunizations," identified R140's completed vaccinations. This identified R140 received the influenza vaccination on 10/4/23, however, lacked any evidence R140 had been offered or received any of the pneumococcal vaccinations, including PPSV23 or PCV13, despite the consent for the series given nearly two months prior. On 11/30/23 at 8:27 a.m., registered nurse infection preventionist (RN)-F was interviewed. RN-F explained immunizations were reviewed upon admission and with annual vaccine clinics thereafter. RN-F verified they had reviewed R18's medical record and the PCV20 had not been provided yet despite the consent being obtained months prior. RN-F stated R18 was currently on transmission-based precautions for an active COVID-19 infection and they would administer it as timely as able when the infection had resolved. RN-F verified they had reviewed R140's medical	F 883		

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 _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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 883	Continued From page 39 record and it lacked evidence any of the pneumococcal immunizations had been given so, as a result, R140 had just been given the PCV20 last evening (after discussion about it with the surveyor). RN-F acknowledged the delay in administrations of the vaccines and expressed "part of it" was likely due to the COVID-19 outbreak in the nursing home, however, acknowledged vaccinations should be administered in a timely manner. A provided Pneumococcal Vaccine policy, dated 1/2022, identified all residents would be offered the vaccines to aid in preventing pneumonia-related infections. The policy outlined residents would be assessed for eligibility prior to or upon admission and, when indicated, would be offered the vaccination within 30 days of admission to the nursing home. The policy outlined several aspects of the administration, including the date of vaccination and lot number for the vaccine, would be documented in the medical record.	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 000	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 11/27/23 to 11/30/23, a 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 Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaints were found to be substantiated with licensing orders issued H51897310C (MN90681) H51897308C (MN91111) The following complaints were found to be unsubstantiated: H51897309C (MN90194) H51897307C (MN92471) H51897305C (MN96834) H51897304C (MN92472) H51897306C (MN92474) H51897303C (MN96835) H51897302C (MN98052) H51897227C (MN98249) H51897396C (MN98662) 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 surveyors 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 https://www.health.state.mn.us/facilities/regulatio	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 000	Continued From page 2 n/infobulletins/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 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.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status 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	2 265		12/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 265	Continued From page 3 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident' responsible parties were notified in a timely manner with abnormal lab values and corresponding medical treatment being implemented for 1 of 2 residents (R173); and with the development of a skin ulcer which required medical care and treatment for 1 of 2 residents (R49) reviewed for notification of change. Findings include: A Vulnerable Adult Maltreatment Report, dated 2/14/23, identified a report had been submitted for R173 which alleged multiple care-related concerns. These included an allegation R173 had a change in condition, with abnormal laboratory values (i.e., elevated potassium, failing kidneys) and new medications (i.e., Lasix; a diuretic) being	2 265	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 265	Continued From page 4 started to address. However, the allegation outlined R173's family or responsible party was not notified of these until later when R173 had to be hospitalized for continued treatment. R173's significant change in status Minimum Data Set (MDS), dated 1/22/23, identified R173 had both long-term and short-term memory impairment and required extensive assistance for transfers, dressing, and toileting. Further, the MDS outlined R173 had several medical conditions including cancer, anemia, and renal insufficiency. R173's electronic medical record (EMR) Clinical Resident Profile, printed 11/30/23, identified R173 admitted to the nursing home on 8/15/22 and discharged on 2/9/23. A section was present and labeled, "Contacts," which outlined R173's responsible party as family member (FM)-D along with contact information. On 11/30/23 at 9:50 a.m., a telephone interview was attempted with FM-D. However, they were unable to be reached. R173's progress note(s), dated 12/1/22 to 2/9/23, identified the following: On 12/30/22, R173 was identified as being in isolation for an active COVID-19 infection. However, R173 refused to remain in their room (on isolation) and had to be re-directed multiple times. On 1/8/23, R173 was removed from isolation precautions. The note identified R173 had received a dosing of Paxlovid (anti-viral medication) and had no fever or cough present.	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 265	Continued From page 5 On 1/13/23, a series of notes identified a basic metabolic panel (BMP) and magnesium level were ordered for stage III chronic kidney disease with one note dictation, "Rescheduled for tomorrow [1/14/23]." On 1/14/23, the lab results were obtained and, " ... values out of normal range." The note outlined the on-call physician service was updated. A subsequent note, dated 1/14/23, identified the nursing home had received orders for Lasix 20 milligrams (mg) daily, push fluids, and recheck laboratory work on 1/18/23. The completed note(s) lacked evidence R173's family or responsible party was updated. On 1/18/23, the lab notified the nursing home of " ... critical K [potassium] level of 6.3 ... On call [physician] updated with orders ... Lab form faxed." The completed note lacked evidence R173's family or responsible party was updated. On 1/19/23, an additional lab was drawn and dictation present, " ... call received from M Health Fairview ... critical Potassium level of 6.1 ... call made out to on call MD ... Awaiting call back." A subsequent note, dated 1/19/23, identified the physician returned the call and would update R173's primary physician with the information. However, again, the completed note(s) lacked evidence R173's family or responsible party was updated. On 1/22/23, an additional note identified the medical provider ordered another BMP for 1/23/23, and the physicians were considering adding a medication regimen for R173. The note concluded, "Daughters updated." On 1/23/23, additional laboratory results were	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 265	Continued From page 6 faxed to the medical provider. A subsequent note, dated 1/23/23, identified R173's family called and requested R173 have intravenous (IV) fluids for dehydration. On 1/24/23, a peripheral IV was started and IV solution started in accordance with physician orders. On 1/26/23, the IV was discontinued. However, R173's entire medical record was reviewed and lacked evidence R173's responsible party and/or family members had been updated prior to 1/22/23 with the laboratory testing orders, results, or subsequent medication and treatment changes despite these being ordered and obtained nearly 10 days prior (on 1/13/23). On 11/30/23 at 10:02 a.m., licensed practical nurse (LPN)-B was interviewed. LPN-B explained they typically worked on the unit where R173 had resided, and expressed family should be updated "immediately" with a change of condition or abnormal laboratory values. LPN-B stated such notification should also be recorded in the progress notes of the medical record to demonstrate, "Family was updated." LPN-B stated it was important to ensure such notifications as the information for families was "necessary for them to know what's going one with their loved one." On 11/30/23 at 10:46 a.m., registered nurse unit manager (RN)-A was interviewed and verified they had reviewed R173's medical record. RN-A explained R173's family was "highly involved" with her care at the nursing home and they would be "very surprised" if family had not been updated	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 265	Continued From page 7 about the abnormal laboratory values and subsequent medication orders. RN-A stated they had not reached out to the nurses' who authored the various progress notes (dated 1/13/23 to 1/22/23) to question them about it adding herself and the director of nursing (DON) felt they'd be unlikely to accurately recall the information due to the amount of time passed since R173 discharged. However, RN-A acknowledged the lack of any documented evidence in the progress notes or medical record demonstrating FM-D had been notified and expressed such "should be documented." RN-A added timely notification to responsible parties was important to do so family can be involved with the decision making. R49's quarterly Minimal Data Set (MDS) dated 9/18/23, indicated R49 was cognitively intact, had difficulty focusing, had disorganized thinking, and did not refuse personal cares. The MDS indicated R49 had diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), hypertension, heart failure (chronic condition in which the heart doesn't pump blood as well as it should), and dementia. R49's care plan indicated R49 was independent with ambulation, transfers and bed mobility. R49 required set up and assistance to eat and personal hygiene and required assistance with lower extremity dressing. R49's provider orders dated 11/1/23, indicated use of "wound cleanse/Vashe wash, pat dry, apply calcium alginate with collagen powder, cover with foam dressing, change dressing every other day and as needed". The order also indicated to avoid pressure or trauma. R49 had an order dated 11/6/23, for ace wraps to be put on his lower extremities in the morning and	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 265	Continued From page 8 removed at bedtime for edema exacerbation. The order directed staff to use tenso stockings, once the edema improved. R49's skin and wound assessment dated 11/28/23, indicated the stasis wound on R49's left lower extremity which was identified on 10/31/23. R49's medical record lacked documentation indicating R49's family (FM)-C was informed about the development of a stasis wound. During an interview with on 11/29/23 at 10:25 a.m., R49's family member (FM)-C stated nobody from the facility had informed her about R49's wound on his left leg. During an interview on 11/30/23 at 9:03 a.m., RN-H was requested to provide documentation about reporting R49's left leg wound to FM-C. RN-H confirmed there was no documentation of notification regarding the wound identified on 10/31/23. RN-H stated, family members needed to be notified with any change in condition, including new skin issues. During an interview on 11/30/23 at 10:30 a.m., the director of nursing (DON) stated when a resident developed a new skin issue, the nurses should notify the family and the provider. Requested facility's policy to notify family or representative about changes in condition was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 265	Continued From page 9 review applicable policies and procedures to ensure accuracy, educate floor staff on timely notification to family with a change in condition or abnormal laboratory results, and then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days	2 265		
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a significant change in status assessment (SCSA) was completed within required timeframe to help facilitate timely person-centered careplanning for 1 of 2 residents (R144) reviewed for Minimum Data Set (MDS) accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) 3.0 User's Manual, dated October 2023, indicated a significant change in status assessment (SCSA) was required when various criteria were met. The manual directed the MDS completion date must be no later than 14 days from the assessment reference date (ARD) (ARD + 14	2 545	Corrected	12/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 545	Continued From page 10 calendar days) and no later than 14 days after the determination the criteria for an SCSA were met. R144's SCSA MDS, dated 9/15/23, identified R144 had intact cognition, required supervision to limited assistance with activities of daily living (ADLs), and had no current pressure injuries. However, R144's electronic medical record (EMR) Minimum Data Set (MDS 3.0) Summary, printed 11/28/23, identified another SCSA had been initiated with an assessment reference date (ARD) listed of 11/07/23. However, the assessment remained unfinished with several areas of the MDS, including sections for bladder and bowel, active diagnoses, skin conditions, and medications, all being left red-colored and uncompleted. The section provided to record any corresponding triggered Care Area Assessments (CAAs) was left yellow-colored with, "In Progress;" and the MDS was unsigned. When interviewed on 11/30/23 at 8:20 a.m., registered nurse (RN)-D explained the entire campus MDS' were completed offsite through a consulting agency. RN-D stated they contacted them asking about R144's SCSA MDS (dated 11/7/23) and provided the e-mails for review. A e-mail from the outside consulting agency, dated 11/3/23, identified R144 had a SCSA opened for new and/or reopened wounds. A subsequent note, dated 11/29/23, identified, "The Significant change is completed." However, there was no rationale provided to explain the delay from 11/3/23 (when the criteria for a SCSA were identified) to 11/29/23 (over 21 days later) despite the MDS being due 14 days after the SCSA was identified. Further, R144's medical record was reviewed and lacked rationale or evidence	2 545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 545	Continued From page 11 explaining the delay with the SCSA completion. RN-D explained a potential reason for delay was workload, as the consultant does "all the MDS(s)," however, acknowledged the lack of rationale being provided. RN-D stated the SCSA was completed now, however, verified it had not been completed as of 11/29/23, when the record was initially reviewed. A provided MDS completion and Submission Timeframes policy, dated 12/2021, identified the facility would conduct and submit resident' assessments in accordance with federal and state submission timeframe(s). The policy outlined, "Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure accuracy, educate floor staff and/or consulting staff on expectations for the timely completion of the MDS, and then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days	2 545		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and	2 830		12/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 830	Continued From page 12 plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care plan interventions for 2 or 2 residents (R73, R83) reviewed for falls. Findings include: R73's quarterly Minimum Data Set (MDS) dated 9/21/23, documented R73 with intact cognition and required support with setup for bed mobility, transfers, walking in her room and corridor, and all assistance with daily living (ADL's). Also, R73 had no limitations in upper and lower extremity range of motion. In addition, R73 had diagnoses of osteoarthritis and anxiety. In addition, the facility failed to ensure safe management of diabetic testing supplies for R44. R73 R73's Resident Fall Risk Assessment dated 9/22/23, indicated R73 had no falls in previous three months and a normal gait. R73's electronic medical record (EMR) failed to indicate subsequent falls assessments. R73's progress note (PN) dated 11/2/23, indicated R73 had an unwitnessed fall on 11/2/23 with no injury.	2 830	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 830	Continued From page 13 R73's PN dated 11/16/23, indicated R73 had an unwitnessed fall resulting in left wrist injury. A splint was placed per provider order and an x-ray was ordered showing a fracture. R73's PN dated 11/17/23, indicated the x-ray showed a nondisplaced fracture to radius (lower arm bone) and the ulnar styloid (wrist). The NP (nurse practitioner) applied a different splint and ordered the resident to be non-weight bearing to the right wrist. During interview PN stated therapy worked with resident and the resident voiced moderate pain and weakness. This PN referred to the right wrist as having the fracture instead of the left wrist. R73's PN dated 11/22/23, indicated R73 had an orthopedic appointment resulting in application of a hard cast to hand and wrist. R73's physician orders (PO) dated 11/17/23, indicated R73 with, "Coffee-cup weight bearing of left hand and wrist" and an order for a splint to left hand and forearm. R73's PO did not indicate a new diagnosis of a fracture and casting of hand on 11/22/23. R73's care plan (CP) printed 11/28/23, with revision date of 11/27/23, indicated no mention of R73's fall on 11/2/23. The CP stated "The resident is at risk for falls r/t dementia, incontinence. Recent fall with fracture of the thumb-left. Currently splinted". R73's CP failed to indicate pain monitoring or changes to ADL's as a result of the fracture. R73's kardex dated and printed 11/29/23, failed to indicate any change or update regarding falls on 11/2/23 and 11/16/23, including the casting of left	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 830	Continued From page 14 hand. The kardex stated R73 was independent with all transfers, mobility, and dressing. R83 R83's significant change in assessment MDS dated 9/6/23, documented R83 with intact cognition and required limited assistance with bed mobility and personal hygiene and required extensive assistance of one staff member for transfers and toileting. R83's diagnoses include dementia, diabetes, and heart disease. R83's Resident Fall Risk Assessment dated 11/20/23, indicated R83 had 1-2 falls in past three months and was chairbound requiring assistance with elimination. R83's physician PN dated 11/21/2,3 indicated R83 suffered falls on the following dates in 2023: 4/30/23 (due to confusion), 5/31/23 (falling backwards and hitting head), two falls on 6/5/23 (due to urinary tract infection), 7/18/23 (fall with injury to face, chest, right hand and knees resuling in multiple rib fractures, right thumb fracture), 11/8/23 (fall with fracture of left hip and pelvis), and 11/18/23 (fall with femoral neck fracture). R83's CP revised on 12/4/22, indicated R83 was, "partially dependent on staff and family for meeting emotional, intellectual, physical, and social needs r/t physical mobility deficits". R83's CP goal with revision on 9/28/23, indicated R83, "will not sustain serious injury through the review date." R83's CP failed to indicate re-assessment of	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 830	Continued From page 15 interventions following the falls on 4/30/23, 5/31/23, 11/8/23 and 11/18/23. During interview with registered nurse (RN)-A on 11/29/23 at 9:30 a.m., RN-A stated both R73's and R83's care plan "should be updated with new interventions" following each fall and stated it was not done. RN-A also indicated R73's and R83's kardex's was not updated to provide instructions for nursing assistants to care appropriately for both R73 and R83 including assistance needed for mobility, dressing, and toileting. During interview with director of nursing (DON) on 11/29/23 at 8:31 a.m., DON stated, "following a fall the IDT [interdisciplinary team] meets to determine the root cause and appropriate interventions". The DON stated new interventions and updated kardex's should be implemented following each fall and agreed that this was not done for both R73 and R83. Facility policy titled Falls and Fall Risk, Managing reviewed 10/04/2021 indicate, "staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable." In addition, the policy stated, "If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 830	Continued From page 16 ensure accuracy, educate floor staff on expectations in accordance with those policies for the various care areas identified, and then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure routine bathing was offered or provided to promote good hygiene for 1 of 5 residents (R78) reviewed for activities of daily living (ADLs) and who was dependent on staff for their cares. Findings include: R78's admission Minimum Data Set (MDS), dated 10/16/23, identified R78 had intact cognition, demonstrated no rejection of care behaviors, and required substantial assistance to complete mobility and self-care activities of daily living (ADLs). R78's care plan, dated 11/2/23, identified R78 admitted to the nursing home on 10/10/23, and had several self care needs. The care plan	2 920	Corrected	12/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 920	Continued From page 17 outlined several interventions for R78 including, "BATHING/SHOWERING: The patient requires maximum assistance with dressing," and, "PERSONAL HYGIENE/ORAL CARE: The resident requires maximum assist X 1." However, the care plan lacked any evidence for when or how (i.e., frequency, type) R78's bathing would be completed; nor did the care plan outline any refusal of care behaviors. On 11/27/23 at 1:55 p.m., R78 was interviewed and expressed she felt the "bathing schedule is really weird." R78 explained she had been at the nursing home for nearly two months and had only been given one whirlpool bath and one "sponge bath." R78 stated she enjoyed the tub bath most as she "felt like I actually gotten cleaned." R78 reiterated she would like to get, at least, a weekly bath while at the nursing home. On 11/28/23 at 2:44 p.m., nursing assistant (NA)-A stated they worked for an agency staffing pool, however, had been at the facility several times and worked with R78 multiple times over the past weeks. NA-A explained R78 was scheduled for a bath that day (11/28), however, she hadn't been able to complete it as R78 refused. NA-A stated she reported the refusal to the nurse prior, and explained R78 seemed "really depressed" so she would, at times, refuse cares. NA-A stated the facility had a bath list which was kept at the nursing station and provided it for review. Further, NA-A stated any bathing refusals or completions should be recorded in the POC charting or in the nurses' charting. A provided Daily Bathing Schedule, undated, identified the 1st floor transitional care unit (TCU) bathing schedule with each room assigned to a	2 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 920	Continued From page 18 day of the week and corresponding shift (i.e., a.m. or p.m.). This identified R78's room was scheduled for a weekly bath on Tuesday AM. R78's POC (Point of Care) Response History, printed 11/28/23, outlined a series of questions which could be answered via electronic charting to demonstrate bathing completed for R78. The report included a look-back period of 30 days (i.e., 10/28/23 to 11/28/23), however, there was no recorded data or evidence R78 had bathing offered or completed. All data fields were answered, "No Data Found." R78's medical record, including Treatment Administration Record (TAR) and progress notes, were reviewed. There was no evidence R78 had been offered, refused, or provided any bathing episodes within the past several weeks. On 11/28/23 at 2:56 p.m., registered nurse (RN)-E was interviewed. RN-E explained they worked for a staffing agency and "don't exactly know" how bathing was scheduled on the unit; however, felt each resident had a "once a week bath." RN-E stated when a resident has a bath, the NA should call the nurse into the room to complete a skin check and those would be recorded in the medical record. RN-E stated there was also "a sheet" the NA(s) would, at times, bring the nurse to be signed demonstrating the care was completed, however, RN-E stated the sheet was only given to the nurses "sometimes" and not consistently. RN-E stated if a resident refused bathing, then it should be recorded in the medical record. RN-E stated NA-A had just now, immediately prior to the interview with the surveyor, informed them R78 had refused her bath which RN-E expressed concern with as there was no longer time to	2 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 920	Continued From page 19 reproach R78 for the care (see F656 for additional information). RN-E had a white-colored paper in her hand and provided it for review. A provided Bathing/Showering Checklist, dated 11/28/23, identified R78's weight was recorded that day as 184 pounds (lbs) along with several spaces to check off what items with bathing were completed including washing body and hair, lotioning the skin, and changing the bed linens. However, none of these were checked with just written dictation below reading, "She refused." RN-E reiterated these sheets were not always provided to the nurses and, to their understanding, should be. However, RN-E verified if a resident refuses a bath, then it should immediately be reported to the nurses so it can be addressed timely. On 11/28/23 at 3:11 p.m., registered nurse unit managers (RN)-B and RN-C were interviewed, and RN-B explained there was a process in the electronic medical record (EMR) to record bathing, however, they had been "fighting [it] for a little while" now. RN-B stated the facility' policy was for a weekly bath and R78 needed a "we're going to do this now" approach and then, if refused, the nurse should be notified and it should be charted in the medical record. RN-B stated the facility had limited employees of their own hire and with numerous agency staff present, it was sometimes difficult to get all staff on the same page with care delivery and documentation. RN-B explained the unit was supposed to have four NA(s) on the floor for care, however, when short staffed then baths were "a difficult thing" to get done, too. RN-B explained the facility used a white-colored paper bathing sheets which should be filled out by the NA and then signed by the	2 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
2 920	Continued From page 20 nurse to demonstrated care was attempted or provided. RN-B provided a stack of these for review which, per RN-B, were the past several weeks worth of saved documents. However, upon review of these documents, only one additional bath for R78 was located (dated 11/3/23) which RN-C verified. RN-B verified the medical record lacked evidence bathing was attempted, offered or provided to R78 and stated bathing was important and should be completed adding the lack of routine bathing "comes up in every single care conference" it seems on the unit. A provided Bath, Shower/Tub policy, dated 2/2022, identified the purpose of the procedure was to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident' skin. A step-by-step procedure on bath completion was listed along with a section labeled, "Documentation," which identified the date and time of a shower or bath should be documented in the medical record. This included, "If the resident refused ... the reason(s) why and the intervention taken." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure accuracy, educate floor staff on bathing completion and documentation, and then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing	21375		12/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
21375	Continued From page 21 home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a community-use available glucometer was properly cleaned and disinfected between patient' use for 1 of 1 resident (R107) observed to have their blood glucose checked with the device. This had potential to affect 12 of 12 residents identified to reside on the 200 East Unit and have diabetes mellitus. In addition, the facility failed to ensure medical supplies with potential for blood-borne cross contamination were appropriately stored away from patient living areas for 1 of 1 resident (R44); and failed to ensure posted transmission-based precautions were consistently implemented to reduce to risk of infectious spread for 1 of 1 resident (R18) identified to be on such precautions. This had potential to affect 25 of 25 residents identified to reside on the same unit. Findings include: An email correspondance from the director of nursing (DON) dated 11/20/23 at 1:11 p.m., indicated 12 residents on the 200 East Unit were diagnosed with diabetes. R107's quarterly Minimum Data Set (MDS) dated 7/28/23, indicated R107 had intact cognition and was diagnosed with diabetes, end-stage kidney disease, and heart failure. R107's care plan dated 8/2/23, indicated R107	21375	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
21375	Continued From page 22 required staff set up help for eating and extensive assistance for locomotion and bathing. R44's order summary dated 11/9/23, indicated R107 received blood sugar checks daily. During an observation and interview on 11/28/23 at 8:38 a.m., licensed practical nurse (LPN)-C was observed obtaining a blood sample from R107 and using a glucometer to measure the result, then discarded the test strip from the glucometer and immediately placed the glucometer into a basket on top of loose needle stick devices without disinfecting the device. LPN-C exited the room and placed the basket with the glucometer back on top of the 200-east medication cart. LPN-C stated the glucometer was available for use for all residents on the 200-east wing as a backup or in case of emergency. LPN-C stated he did not think any other residents used the floor-stocked glucometer regularly and therefore had not cleaned it. On 11/29/23 at 1:55 p.m., registered nurse infection preventionist (RN)-F and the DON were interviewed. RN-F explained a community-use glucometer should be cleaned using "purple top" wipes between patient' uses and allowed to dry. RN-F stated the facility tried to have each patient with their own device, to reduce the risk of cross contamination, however, the staff would make "buckets" up with various supplies and a community-based glucometer at times still. RN-F verified there was clean, community-use glucometers present in the medication room(s) which staff could use and reiterated the device' should be cleaned and disinfected between patient' use to prevent blood-borne pathogen cross contamination.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
21375	Continued From page 23 R44's quarterly Minimum Data Set (MDS) dated 11/7/23, indicated R44 had severely impaired cognition. R44's Order Summary Report dated 8/4/23, indicated R44 received blood sugar monitoring four times a day. R44's face sheet dated 8/4/23, indicated R44 was diagnosed with diabetes, heart failure, and chronic obstructive pulmonary disease (COPD-incurable lung disease causing breathlessness, frequent coughing, and chest tightness). R44's care plan dated 10/18/23, indicated R44 was independent with ambulation and bed mobility but required verbal cues and set-up assistance for personal hygiene and eating. During an observation on 11/27/23 at 3:26 p.m., a cardboard box was observed on R44's bedside table containing a glucometer, glucometer test strips, and multiple needle stick devices. The cardboard box had a patient label with identifying information that did not match R44. During an observation on 11/27/23 at 5:57 p.m., a cardboard box was observed on R44's bedside table containing a glucometer, glucometer test strips, and multiple needle stick devices. The cardboard box had a patient label with identifying information that did not match R44. During an observation on 11/29/23 at 9:30 a.m., R44's bedside table was observed directly to the right of his bed with a cardboard box on its surface containing a glucometer, glucometer test strips, and multiple lancets with a patient label not matching R44. A one-centimeter round	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
21375	Continued From page 24 brownish-red stain was observed under the patient label inside of the box. During an interview on 11/29/23 at 9:45 a.m., licensed practical nurse (LPN)-A stated this box containing multiple needle stick devices, a glucometer, and glucose testing strips was refilled by nursing staff every Friday and contained items they used to assess R44's blood glucose. LPN-A stated the brownish-red stain appeared to have been blood and he was unsure how a different resident's supplies got into R44's room. LPN-A stated a different resident's box should not have been in R44's room but they had been using this box for an undetermined amount of time. During an interview on 11/29/23 at 12:11 p.m., nurse manager (RN)-A stated the box containing the glucometer and supplies should have been discarded and never placed in R44's room. RN-A stated she would have been worried about the risk of infection because the box had belonged to a previous resident and contained blood. On 11/29/23 at 1:55 p.m., registered nurse infection preventionist (RN)-F and the director of nursing (DON) were interviewed. DON stated she was aware of the lancet's being found in R44's room and was not sure how they had been left there on top of the table. RN-F stated while housing supplies like lancets in the room was not disallowed, they should have been inside the dresser drawer or someplace not out in the open adding they don't want them "strung around the room." RN-F stated there was some residents on the same unit with R44 who wander the hallways and better storage, such as in the drawer, would help prevent someone from accidentaly poking themselves with the devices.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
21375	Continued From page 25 During observation on 11/28/23 at 8:35 a.m., PPE was outside the door of R18 room. Signage on R18's door indicated Isolation Room, respiratory precautions and instructed all staff who enter the room to wear PPE gown, N95 mask, goggles/faceshield, and gloves. Signage on R18's door indicated how to properly remove PPE. The PPE bin was a three-drawer bin white and clear in color. The top drawer contained N95 masks, the middle drawer contained goggles and the bottom drawer contained washable gowns. On top of the bin was a container of super Sani-cloths disinfectant wipes. The handrail located directly behind the PPE bin held three boxes of procedure masks, one box of procedure mask with attached face shield and one bottle of hand sanitizer. However, the PPE bin and handrail lacked any gloves. During interview on 11/28/23 at 8:35 a.m., registered nurse (RN)-G, verified no gloves were in or around the PPE storage. They indicated that there are gloves on the medication cart. They also verified that the medication cart is not stationed by R18's room. During observation on 11/28/23 at 9:10 a.m., housekeeper(HK)-A pushed a clean linen cart outside of R18's room. Housekeeper-A was observed using hand sanitizer, putting on gown, removing procedure and donning a N95 mask. HK-A grabbed the laundry off the laundry cart, knocked on R18's and entered. R18 did not have gloves or goggles/face shield on. During interview with HK-A on 11/28/23 at 9:20 a.m., after exiting from R18's room, they indicated the proper use of PPE. They indicated it is important to use proper PPE to stop the spread of	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
21375	Continued From page 26 diseases. HK-A confirmed that she did not wear gloves into the room as there were no gloves by the door or in the PPE bin. Housekeeper-A did not acknowledge that they did not wear goggles/face shield in R18's room. During observation on 11/28/23 at 12:17 p.m., it was noted that no gloves had been placed inside or around the PPE bin outside of R18's room. During interview on 11/29/23 at 1:55 p.m., with director of nursing (DON) and registered nurse (RN)-F, they verified the facility had "quite the outbreak unfortunately" lately regarding residents having COVID. They indicated they have been working and had done "whole house" education with all staff members from all departments regarding proper use of PPE. They indicated that audits for donning and doffing have been completed and they had a "annual skills fair" this past September during which transmission based precautions were reviewed. They indicated PPE carts are stocked nightly by night nurses and again by the evening charge nurse. They verified all staff, including laundry, should have full PPE when entering the room and "that should not happen" [entering without gloves or eye protection]. They indicated that proper PPE is important as it ensure themselves and other residents are protected. A facility policy on cleaning and use of a community glucometer was requested, however, none was received. A policy was requested regarding proper usage of PPE and transmission based precuations, however, none was recieved.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	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) COMPLETE DATE
21375	Continued From page 27 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure accuracy, educate floor staff on glucometer cleaning and transmission-based precautions, and then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days	21375		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2024

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

RE: CCN: 245189
Cycle Start Date: November 30, 2023

Dear Administrator:

On January 26, 2024, we notified you a remedy was imposed. On February 27, 2024, 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 February 9, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 10, 2024, did not go into effect. (42 CFR 488.417 (b))

In our letter of January 26, 2024, 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 13, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 9, 2024, 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.

Correction of the Life Safety Code deficiency(ies) cited under K222, K271, K341 at the time of the November 30, 2023 standard survey, has not yet been verified. Your plan of correction for this deficiency / these deficiencies, including your request for a temporary waiver with a date of completion of November 29, 2024, has been approved. Failure to come into substantial compliance with this deficiency / these deficiencies by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 7, 2024

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

Re: Reinspection Results
Event ID: NQS412

Dear Administrator:

On January 4, 2024, 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 survey completed on November 30, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us