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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: XR1R

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

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

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

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/28/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **231** (L18)

13.Total Certified Beds **231** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	231			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Cynthia Wentkiewicz, HFE NE II — 03/28/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/10/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 05/16/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/20/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245189
May 10, 2017

Ms. Shelly Weiss, Administrator
Southview Acres Health Care Center, Inc.
2000 Oakdale Avenue
West Saint Paul, MN 55118

Dear Ms. Weiss:

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

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

Effective March 8, 2017 the above facility is certified for or recommended for:

231 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 231 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 10, 2017

Ms. Shelly Weiss, Administrator
Southview Acres Health Care Center, Inc.
2000 Oakdale Avenue
West Saint Paul, MN 55118

RE: Project Number S5189027, H5189078, H5189079, H5189080

Dear Ms. Weiss:

On February 10, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective February 15, 2017. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for an extended survey completed on January 27, 2017 that included an investigation of complaint numbers H5189078, H5189079, & H5189080. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On March 28, 2017, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on January 27, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 8, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on January 27, 2017, as of March 8, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 8, 2017.

However, as we notified you in our letter of February 10, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 27, 2017.

In addition, this Department recommended to the CMS Region V Office the following remedy:

- Civil money penalty for the deficiency at F323 remain in effect (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245189 Y1	A. Building B. Wing Y2	3/28/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTH CARE CENTER INC	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0242	Correction	ID Prefix F0282	Correction	ID Prefix F0323	Correction
Reg. # 483.10(f)(1)-(3)	Completed	Reg. # 483.21(b)(3)(ii)	Completed	Reg. # 483.25(d)(1)(2)(n)(1)-(3)	Completed
LSC	03/08/2017	LSC	03/08/2017	LSC	03/08/2017
ID Prefix F0371	Correction	ID Prefix F0431	Correction	ID Prefix F0441	Correction
Reg. # 483.60(i)(1)-(3)	Completed	Reg. # 483.45(b)(2)(3)(g)(h)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	03/08/2017	LSC	03/08/2017	LSC	03/08/2017
ID Prefix F0494	Correction	ID Prefix F0496	Correction	ID Prefix	Correction
Reg. # 483.35(d)(1)(2)	Completed	Reg. # 483.35(d)(4)-(6)	Completed	Reg. #	Completed
LSC	03/08/2017	LSC	03/08/2017	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 05/10/2017	SIGNATURE OF SURVEYOR 34986	DATE 03/28/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
1/27/2017

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245189 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/3/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTH CARE CENTER INC	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0324	02/24/2017	LSC	K0341	02/17/2017	LSC	K0363	01/27/2017
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0923	01/27/2017	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 05/10/2017	SIGNATURE OF SURVEYOR 37008	DATE 03/03/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/25/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: XR1R

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

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/27/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **231** (L18)

13.Total Certified Beds **231** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	231			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Cynthia Wentkiewicz, HFE NE II 02/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 03/17/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/20/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Submitted
February 10, 2017

Ms. Shelly Weiss, Administrator
Southview Acres Health Care Center, Inc.
2000 Oakdale Avenue
West Saint Paul, MN 55118

RE: Project Number S5189027, H5189078, H5189079 & H5189080

Dear Ms. Weiss:

On January 27, 2017, an extended survey was completed at your facility by the Minnesota Department 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. In addition, at the time of the January 27, 2017 extended survey the Minnesota Department of Health completed an investigation of complaint numbers H5189078 & H5189079.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered. In addition, at the time of the January 27, 2017 extended survey the Minnesota Department of Health completed an investigation of complaint number H5189080 that was found to be unsubstantiated.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;
>
> No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);
>
> Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15,

quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on January 27, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective February 15, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Southview Acres Health Care Center Inc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 27, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 April 27, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 27, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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 01/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A survey was conducted by the Minnesota Department of Health from 1/23/17 through 1/27/17. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failed response to follow care plan interventions for safe transfers which resulted in the high potential for harm or death. The facility was notified of the IJ on 1/26/17 at 4:22 p.m. and notified that it was removed on 1/27/17 at 3:28 p.m. An extended survey was conducted by the Minnesota Department of Health on 1/26/17 through 1/27/17. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. At the time of the recertification survey, the following complaint investigations were conducted: H5189078 was substantiated and a deficiency was issued at F323. H5189079 was subtantiated and a deficiency was issued at F441. H5189080 was not substantiated.	F 000		
F 242	483.10(f)(1)-(3) SELF-DETERMINATION -	F 242		3/8/17

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

Electronically Signed | 02/17/2017

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

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F 242 SS=D	Continued From page 1 RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to assess and provide bathing preferences for 1 of 3 residents (R76) reviewed. Findings include: Review of the most recent quarterly minimum data set (MDS), dated 11/9/16, revealed R76 was cognitively intact and required the physical assistance of one staff in part of bathing. On 1/24/17, at 11:56 a.m., R76 reported R76 would prefer 2-3 tub baths each week. R76 reported the facility provided only one tub bath each week. R76 reported the facility had never asked how many tub baths R76 wanted and R76 was not aware residents could ask for more. On 1/26/17, at 9:48 a.m. R76 confirmed R76 wanted more than one tub bath a week and that was not offered or provided by the facility.	F 242	R76 was interviewed regarding his bathing preferences. His preferences are noted and integrated into his plan of care. Facility has modified the "Welcome Guide" that is given to each resident to include the statement " Southview Acres respects and honors a resident's right to choose their bathing preference including bath or shower, time of day the bath or shower will occur and how many times per week the resident will receive a bath or shower. The facility also modified the Care Conference Review document to include verbally asking and documenting whether a shower or a bath is preferred, the time they prefer the shower or bath and the number of times per week the prefer a shower or a bath, so that any changes in preferences are noted. Resident Council agenda will also include	

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F 242	Continued From page 2 On 1/26/17, at 3:20 p.m., the registered nurse manager (RN)-H and unit social worker (SW)-A reported the facility offered one shower or bath each week, based on a rotation, unless family or the resident requested more than one. RN-H and SW-A explained they did not have a process for asking how many times a resident preferred to bathe each week. R76 was provided one tub bath each week on an assigned day. The second floor group sheets, undated, revealed R76 was scheduled for one tub bath each week. The bathing report by resident, dated 11/26/16 to 1/26/17 revealed R76 received 17 sponge/bed baths, 2 showers and bathed in a "not specified" type 14 times. The report revealed no tub baths provided to R76.	F 242	reminder of the right to choose bathing preference. Audits of the Care Conference Review document will be ongoing to ensure residents know they are able to exercise their bathing choices. Audits will be brought to QA committee for review and further recommendations as needed.	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on document review, observation, and interview, the facility failed to ensure 2 of 2 residents (R105, R406) observed during transfer with full body mechanical lifts were transferred in accordance with the care plan.	F 282	R105 has slings according to her plan of care. R406 no longer resides in the facility. Education was provided to those staff members responsible for using the lifts to ensure the appropriate sling is present	3/8/17

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F 282	Continued From page 3 Findings include: Review of R105's care plan for mobility revealed R105 had a self care deficit in mobility related to transfer. Dated 1/16/17, R105 required the assistance of two staff, a mechanical lift, and a purple full body sling for all transfers. The nursing assistant care guide, dated 1/26/17, indicated staff were to utilize a "PURPLE FULL BODY SLING ONLY" when transferring R105 with the mechanical lift. This intervention to use the purple full body sling was typed in bold capital letters on the care guide, and was dated 1/16/17. During observation on 1/26/17, at 8:31 a.m. nursing assistant (NA)-B prepared to transfer R105 from the bed to wheelchair using an Invacare Reliant 450 mechanical lift. R105 laid on the bed, on top of a sling that appeared blue in color. Printed on the top of the sling, above R105's head, was another resident's name. NA-B brought NA-A into the room to assist. NA-A adjusted the sling under the resident. The sling had four straps with different loops that attached to the mechanical lift, and the staff discussed which loops to use to attach the sling to the lift. "This is too long," NA-A said about the sling as staff hooked the loops to the lift. Using the lift, staff raised R105 into the air above the bed inside the sling. As the sling lifted off the bed, R105 began to tilt to the right, with more weight shifting onto the resident's right hip inside the sling. Staff paused the lift, and as R105 was in the air over the bed, NA-A grabbed the right side of the sling with both hands, and quickly tugged the fabric upwards to re-center R105's hips in the sling. Staff resumed the lift, and positioned the wheelchair. There was confusion between the	F 282	and used, according to the residents care guide. House wide audit of the facility reveals that every resident that uses the mechanical lift has the appropriate sling readily available for use. Audits of the presence and use of the appropriate sling according to the care guides will occur until it is determined that all staff are utilizing the sling according to the care guide. Audits will be presented to QA Committee for review and further recommendation if indicated.	

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F 282	Continued From page 4 NA-A and NA-B about which direction the wheelchair should face. NA-A operated the lift while NA-B placed the wheelchair. NA-A asked NA-B to move the wheels of the wheelchair different directions, and NA-B asked "Oh, are we going to do this sideways?" The wheelchair seat faced perpendicular to the legs of the lift. They lowered R105 into the sideways wheelchair, over the right armrest of the wheelchair. NA-A said, "This is too long, the sling" after R105 was seated in the wheelchair. During an interview on 1/26/17, at 9:06 a.m. NA-B checked the label on the blue sling used in the transfer. The label said it was a size extra large (XL), blue sling. NA-B said the color of the binding on the sling indicated the particular size. NA-B said the blue sling was already in R105's chair when staff came into the room to perform morning cares. When asked how NA-B knew about special care instructions, NA-B said the facility usually had instructions on the nursing assistant care guide. NA-B looked on the guide and read out loud that R105 was supposed to use a "purple full body sling only." NA-B thought the purple sling was size medium, and said "I did not use the purple full body sling." NA-B said that the expectation was to follow what was written in the nursing assistant care guide. During an interview on 1/26/17, at 9:53 a.m. NA-A was asked if the size of the sling was checked before the transfer. NA-A said no, the sling was not checked because it was already on R105's chair, so that was why staff used it. Review of R406's care plan for mobility revealed R406 had a self care deficit in mobility related to transfer. Dated 12/18/16, R406 required the	F 282		

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F 282	Continued From page 5 assistance of two staff and a mechanical lift for all transfers. The nursing assistant care guide, dated 1/26/17, required staff to use the "green sling" when transferring R406 with the mechanical lift. The requirement to use the green sling was typed in bold on the care guide. During observation on 1/26/17, at 10:04 a.m. NA-A asked registered nurse (RN)-G to help transfer R406 to the wheelchair. R406 laid on the bed, on top of a purple sling. NA-A and RN-G hooked the sling up to the lift. They began to raise R406 in the air above the bed. At this time surveyors asked staff to stop the lift, and check that the correct sling was used. NA-A said this sling was on R406's chair. RN-G thought this sling was the one staff had used in previous transfers. When told that the nursing assistant care guide required staff to use a green sling, RN-G explained never even seeing a green sling around. In an interview on 1/26/17, at 10:18 a.m., RN-G checked the label on the purple sling that had been used for R406, and confirmed it was a size medium, purple sling. According to the size chart on the manufacturer label, the green sling was size large. When asked if the both staff should verify that the correct sling is used before starting a transfer, RN-G said, "I thought [NA-A] had it all set up, and that was a bad assumption on my part." Review of the Mechanical Lift Transfer Policy, last revised January 2017, revealed step four of the procedure required staff to get the appropriate sized sling, according to the care guide.	F 282		

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F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff implemented approaches identified as necessary for safe transfer using a mechanical lift for 1 of 8 residents (R105) on the first floor who required assistance with transfer utilizing a mechanical lift. This resulted in an immediate jeopardy (IJ) situation for R105. In addition to the resident in immediate jeopardy, the facility failed to ensure staff followed the care plan to reduce the risk of	F 323	R105 has slings according to her care guide. R406 no longer resides at the facility. EZ Way representative was present in the building to provide education and demonstration of mechanical lift use on 1.24.17 and 2.3.17. This training is ongoing with Staff Development for new hires and veteran staff until all are complete. Audits of staff performing mechanical lifts are being	3/8/17

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F 323	Continued From page 7 falls for 1 of the other 8 residents (R406) on the first floor who also required transfer with the mechanical lift. The IJ began on 1/16/17, when staff failed to implement appropriate interventions for a safe transfer using a mechanical lift for R105. The resident fell out of a sling that had not been attached properly to the mechanical lift, causing R105 to slide through an opening, hit her head and sustain a head laceration. On 1/26/17, staff were observed to transfer R105 with the mechanical lift using a sling other than what had been identified as the appropriate intervention on R105's care plan as a result of the 1/16/17, fall. The administrator and director of nursing (DON) were notified of the IJ at 4:22 p.m. on 1/26/17. The IJ was removed on 1/27/17, but noncompliance remained at the lower scope and severity level of D-isolated, which indicated no actual harm with potential for more than minimal harm that is not an IJ. Findings include: R105 was observed on 1/26/17, at 8:31 a.m. to be a petite woman who was unable to physically participate in her care. Review of R105's medical record Face Sheet, dated 1/27/16, revealed R105 was 99 years old with current diagnoses including: Alzheimer's disease, dementia, difficulty in walking, and generalized muscle weakness. In addition, the care plan printed 1/26/17, indicated R105 was currently receiving hospice care related to Alzheimer's dementia with a functional medical decline. Review of a Minimum Data Set (MDS) resident assessment dated 5/4/16, revealed R105 was totally dependent on staff to transfer between surfaces	F 323	completed to ensure proper technique and sling size according to the care guide. Education will be provided on the spot as needed. These audits will be ongoing until it is determined that all staff are utilizing the correct lift technique with the appropriate sling. New residents are assessed for appropriate transfer technique and appropriate sling size when a mechanical lift is indicated. New residents are added to ongoing audits. Audits will be reviewed by QA committee for further recommendations as indicated. Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance.	

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including from bed to wheelchair, and required two people to physically assist with the transfer.

The facility completed a Fall Risk Assessment dated 11/11/16, which identified R105 as at risk for falls.

Review of an Incident Details report completed 1/20/17, revealed R105 had fallen during a transfer from the bed to a Broda chair (special type of wheelchair) on 1/16/17. Details of the incident were documented in the report indicating R105 was being transferred with a mechanical lift via a sling and had slid out of the sling when it was raised in the air. The report indicated R105 had struck her head on a two-drawer night stand, and had hit her back on the feet of the lift. R105 had sustained a laceration described as 1.5-2 centimeters, on the back center of her head under the hair. Corrective action details indicated R105 had been referred to the clinical manager for further assessment of the mechanical sling appropriateness.

During interview with the director of nursing (DON) and registered nurse (RN) manager-F on 1/26/17, at 12:04 p.m. the DON provided additional explanation as to what had happened during the 1/16/16 incident. The DON said staff had followed the nursing assistant (NA) care guide to use a "purple sling." The DON said one NA was running the mechanical lift, and another NA was guiding R105's legs. The "purple sling" used was a divided leg sling, that crossed at the thighs and attached at four points above the resident on the mechanical lift device. The DON explained the two NAs noticed R105's bottom was slipping down and through an opening in the bottom of the sling, and the NA guiding R105's

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legs couldn't get around the resident in time to grab R105 before she fell through the opening. The DON said staff had reviewed the manufacturer's recommendations and determined they had been using an appropriately sized sling. She also stated the clinical manager determines the sling size required for use for individual residents, based on manufacturer recommendations. The DON then explained when they looked on top of the lift, the two attachment points at the top of the sling, up by the shoulders, had not been connected evenly on both sides. The DON described each attachment point as having multiple loops to choose from to attach the sling to the lift. The DON said at the time when the fall occurred, the staff had connected one attachment point to the lift using the third loop, and the other using the second loop, causing the sling to be "kitty-wompus." RN-F explained the loops were also color coded, and added that the right side shoulder hook had been hooked on black, and the left side had been hooked on purple, which would have tilted one side of the sling a little higher, which was how R105 had likely slid through the opening created in the bottom where the sling crossed over. When asked whether this was equipment malfunction or human error the DON said, "I interpret this as a mistake, as a human error." After the fall, the DON said the facility decided to implement a full body sling for transferring R105. RN-F added that given the fact R105 could not contribute to transfers in any way, they had decided the full body sling was the correct sling to use.

Review of R105's current care plan for mobility revealed R105 had a self care deficit in mobility related to transfers. Interventions dated 1/16/17, indicated R105 required the assistance of two

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

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staff, a mechanical lift, and a purple full body sling for all transfers.

The nursing assistant care guide dated 1/26/17, indicated staff were to use: "PURPLE FULL BODY SLING ONLY" when transferring R105 with the mechanical lift. The special instruction to use the purple full body sling was typed in bold capital letters on the care guide, and was dated as having been initiated 1/16/17, signifying it had been added to R105's care guide after the fall.

During observation on 1/26/17, at 8:31 a.m. nursing assistant (NA)-B prepared to transfer R105 from the bed to wheelchair using an Invacare Reliant 450 mechanical lift. R105 laid on the bed, on top of a sling that appeared blue in color. Printed on the top of the sling, above R105's head, was another resident's name. NA-A also came into the room to assist. NA-A adjusted the sling under the resident. The sling had four straps with different loops that attached to the mechanical lift, and from both sides of the bed, the staff discussed which loops to use to attach the sling to the lift. NA-A was heard to state, "this is too long," as they hooked the loops to the lift. Using the mechanical lift, NA-A raised R105 above the bed while R105 was positioned in the sling. As the sling lifted off the bed, R105 began to tilt to the right, with more weight shifting onto the resident's right hip inside the sling. NA-A paused the lift, and while R105 was still up over the bed, NA-A grabbed the right side of the sling with both hands, and quickly tugged the fabric upwards to re-center R105's hips in the sling. NA-A went back to operate the lift controls. While R105 was raised in the sling, NA-A stood at the lift controls and motioned with her hands, asking NA-B to move the wheels of the wheelchair

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different directions. At this time, nobody was on either side of the sling. NA-B had both hands on the wheelchair near the foot of the bed and moved it from side to side, trying to interpret and follow NA-A's instructions to position the wheelchair. NA-B was over heard asking, "Oh, are we going to do this sideways?" The wheelchair seat faced perpendicular to the legs of the lift as NA-A used the lift controls to lower R105 into the wheelchair sideways, while NA-B guided R105's bottom over the right armrest of the wheelchair. NA-A repeated again, "This is too long, the sling" after R105 was seated in the wheelchair.

During interview at 8:46 a.m., following R105's transfer on 1/26/17, NA-A said the sling was too long because it went up past R105's head too much, and down too far on R105's legs. NA-A then said she thought the nurses decided which sling each resident should use, but was not sure what size sling had just been used to transfer R105. NA-A said there were different sling sizes, and picked up a purple sling from another resident's room to show the surveyor. When asked what size the purple sling was, NA-A was not sure if the size was written anywhere on the sling. When asked to look at the manufacturer label on the sling, although the size was indicated on the label, NA-A stated being unable to determine the size of the sling by looking at the label. Surveyor review of the manufacturer label identified the purple sling to be size medium. NA-A also described being present when R105 had fallen during the transfer on 1/16/17. NA-A said R105 had been using a divided leg sling at that time that crossed at the legs, and that R105 had slipped out the opening in the middle at the bottom of the sling. NA-A said now they used the

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long slings for full body lifts. NA-A also stated there had been staff training for appropriate use of the lifts/slings on Tuesday (1/24/17) which she had attended.

During an interview on 1/26/17, at 9:06 a.m. NA-B checked the label on the blue sling they had just used to transfer R105. The label indicated it was a size extra large (XL), blue sling. NA-B said there was another sling in R105's closet that had a purple binding, and explained how the color of the binding on the sling indicated the particular size. When NA-B took the sling out of R105's closet, it was observed to be a purple divided leg sling which was the style R105 had fallen out of on 1/16/17. Although the manufacturer's size label had been torn off the purple sling available in R105's closet, NA-B confirmed the slings were color coordinated for size. NA-B said the facility usually included size instructions on the nursing assistant care guide. NA-B then looked at the guide for R105 and read out loud that R105 was supposed to use a "purple full body sling only." NA-B confirmed having made an error in the size of the sling that morning. NA-B stated the care guides were updated almost every day, and said the expectation was to follow the care guide, then added, "I kind of went with the sling that was already in [R105's] chair, but I shouldn't have." NA-B further stated, "I did not use the purple full body sling." NA-B then said she had to look at the manufacturer's size chart to know for sure, but thought the purple full body sling would be a size medium. The purple divided leg sling available in R105's closet had been labeled with R105's name. During the interview, NA-B confirmed that the blue XL sling she and NA-A had just used to transfer R105 was labeled with another resident's name. NA-B said she had noticed the sling might

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be too big for R105 that morning, when putting R105 in the sling before transfer. NA-B said "I just used the sling that was in the chair" confirming the blue XL sling was already in R105's chair that morning prior to R105's transfer. NA-B explained that staff provide R105 with a new sling on bath day, because the sling gets wet from the bath. NA-B continued, every Thursday morning R105 got a bath from facility staff, and every Monday R105 got a bath from hospice staff, so R105 would get new slings after bathing on those days. NA-B said that today, Thursday, was bath day, but R105 had not had a bath yet. NA-B said R105 would get a new sling after the bath later that day. When asked how NAs would know about any resident specific special sling, NA-B said the color correlated to the size. When asked if there were any potential outcomes for not using the correct sling, NA-B said that a resident might sit uncomfortably, or they might not go up in the sling the right way. NA-B then stated being unaware of R105's recent fall involving the mechanical lift however, acknowledged having attended a mechanical lift training on Tuesday this week (1/24/17). When asked why there had been confusion during the transfer about the wheelchair placement in relation to the lift, NA-B explained preferring the wheelchair to be closer to the lift during transfer.

During a follow-up interview on 1/26/17, at 9:53 a.m. NA-A confirmed the blue sling had already been on R105's chair, and that staff would normally use what was on the chair. NA-A also stated that sometimes a sling was hung up in the closet to use. NA-A explained that when NA-B came to ask for help with the transfer, NA-B was worried about using the right sling. NA-A was then asked whether the size of the sling was checked

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before the transfer, and NA-A said no, the sling was not checked because it was already on R105's chair, therefore staff just used it.

The facility provided the survey staff with the Invacare Lift manufacturer guidelines. The guidelines revealed recommendations for sling sizes based on user weight. According to the guidelines, for full body sling styles: the purple (medium) sling was recommended for users between 100-175 pounds; the green (large) sling was recommended for users between 150-275 pounds; and the blue (extra large) sling was recommended for users between 200-400 pounds. Weight documentation provided by facility staff revealed R105 weighed 100.2 pounds on 1/27/17.

Review of the Invacare Reliant 450 user's manual revealed a warning on page 9 under the section titled, Lifting the Patient. The warning included: "Adjustments for safety and comfort should be made before moving the patient."

R406's Face Sheet dated 1/27/17, revealed diagnoses including: cancer of the bone, nervous system, and prostate; unspecified cord compression; and paraplegia.

Review of the MDS resident assessment dated 12/22/16, revealed R406 was totally dependent on staff to transfer between surfaces (example: moving from bed to wheelchair), and required two people to physically assist with transfers. The comments section on the MDS form, Review of Indicators of Fall Risk, revealed a falls' risk assessment indicated R406 was at risk for falls, and required use of a mechanical lift for all transfers.

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Review of R406's care plan for mobility, revealed R406 had a self care deficit in mobility related to transfer. Interventions dated 12/18/16, included R406 required assistance of two staff and a mechanical lift for all transfers.

The nursing assistant care guide dated 1/26/17, indicated staff were to use a "green sling" when transferring R406 with the mechanical lift. The intervention for use of the green sling was typed in bold on the care guide.

During interview at 9:53 a.m. on 1/26/17, NA-A said R406 was waiting to be transferred from the bed to the chair. After being asked how staff know which sling to use when transferring R406, NA-A unfolded the NA care guide that was kept in a pocket. While looking at the care guide, NA-A said "it does not say what kind of sling." When asked to look again at the care guide, and pointing to where the guide designated "green sling", NA-A said that R406 used a blue sling now, but that it was the same style as the green sling.

During observation on 1/26/17, at 10:04 a.m. NA-A asked RN-G to help transfer R406 to the wheelchair. R406 laid on the bed, on top of a purple divided leg sling. Standing on each side of the bed, NA-A and RN-G discussed which color loop to use as they attached the sling up to the lift. They began to raise R406 in the air above the bed. The purple sling did not cover R406's shoulders. At that time, surveyors asked staff to stop the lift, and check that the correct sling was used. NA-A said the purple sling had been on R406's chair, and RN-G stated he thought the sling was the one staff had used in previous

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transfers. When asked how nursing staff were to ensure the correct sling was used, RN-G said it was a tough task, and expected NAs to find a nurse if they worried about the size or fit of a sling. RN-G said the correct sling should be listed on the care guides. When RN-G was informed by the surveyor that the nursing assistant care guide required staff to use a green sling, RN-G responded by stating he had never even seen a green sling around.

In an interview on 1/26/17, at 10:16 a.m. R406 was asked how the purple sling was working. R406 stated the sling hurts "my crotch." R406 was not sure how long the purple sling had been used for transfers.

During interview on 1/26/17, at 10:18 a.m., RN-G checked the label on the purple sling that had been used for R406, and confirmed it was a size medium, purple sling. According to the size chart on the manufacturer label, the green sling was a size large. When asked if both staff involved in a two person transfer should verify that the correct sling is used before starting a transfer, RN-G said, "I thought [NA-A] had it all set up, and that was a bad assumption on my part." RN-G acknowledged there had been mechanical lift training earlier that week, but stated he had not been able to attend. RN-G stated he planned to re-schedule the training with the nurse educator. RN-G verified having received previous training for mechanical lifts last year.

In an interview at 1/26/17, at 12:04 p.m. the DON explained that the clinical manager determined the sling sizes for residents based on manufacturer recommendations. The DON said R406 actually fit both the medium and large sling

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based on weight, but they chose the large green sling because R406 had cancer, and transferring could be difficult for R406. RN-F said that slings should be assessed before transfer. The DON added that if something was noticed during transfer, she would expect staff to stop the transfer, lower the patient to safety, and tell a clinical manager. The DON further stated the nursing assistant assigned to the patient was responsible for ensuring use of the appropriate equipment. RN-F updated the care guides as needed, and said the sling color was designated in the care guides. RN-F said the NA assigned to the resident should check the care guide.

Review of the facility provided Invacare manufacturer guidelines revealed recommendations for sling sizes based on user weight. For divided leg sling styles: the purple medium sling was recommended for users between 100-175 pounds; the green large sling was recommended for users between 150-275 pounds; and the blue extra large sling was recommended for users between 200-400 pounds. Weight documentation provided by facility staff revealed R406 weighed 156.7 pounds on 1/14/17.

Review of the Mechanical Lift Transfer Policy, last revised January 2017, revealed step four of the procedure required staff to get the appropriate sized sling, according to the care guide.

A Patient Lifts Safety Guide found at the FDA (Food and Drug Administration) web page, indicated persons using mechanical devices are supposed to ensure they have the correct lift and sling prior to using the lift. The guidance indicated that "Choosing the correct sling is critical for safe

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F 323	Continued From page 18 patient transfer." In addition, the guidance indicates that if a sling is too large there is an increased risk for a resident to slip out. The guidance further included: "Using the wrong sling or attaching the sling incorrectly may cause an accident that can result in serious injury or death." Surveyors requested a list of residents currently residing in the facility who use full body mechanical lifts. On 1/26/17, the DON provided a list of 24 residents in the entire facility who needed full body mechanical lifts for transfer. The immediate jeopardy that began on 1/16/17, was removed on 1/27/17, when the facility had educated staff about the importance of appropriate mechanical lift use, the importance of following care guide sheets, audited care plans and care guides to ensure residents were assigned appropriate slings, had initiated audits for staff using mechanical lifts, and had audited residents to ensure appropriate slings were available in resident rooms. During a follow up conversation with the provider on 1/30/17, at 3:00 p.m., the administrator and DON stated their Invacare product representative had told them the size of the sling did not matter if the sling was larger than what the resident required, indicating there were no minimum weight requirements for the slings identified in any of the materials. Following that conversation, MDH staff contacted the manufacturer at 3:30 p.m. (also on 1/30/17) and were informed the size of the sling was important to ensure appropriate support and posture of the resident during transfer.	F 323		
F 371	483.60(i)(1)-(3) FOOD PROCURE,	F 371		3/8/17

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F 371 SS=F	Continued From page 19 STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to minimize the potential for foodborne outbreaks by proper cleaning of food trays, and failed to ensure the 2nd floor transitional care unit kitchenette was clean, with the potential to affect all 206 residents who resided in the facility. Findings include: During observation of dishwashing on 1/23/16, at	F 371	All tape was removed from all food trays used for service. The procedure for labeling trays has been updated and no adhesives are used to label trays. Kitchenettes will be cleaned by the dietary staff at the completion of each meal served. This cleaning includes the steam tables and the refrigerator and freezer. All dietary staff will be educated on the new procedures. Audits of the food trays and kitchenettes will be completed by the	

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F 371	Continued From page 20 12:13 p.m. trays were observed on the dirty side of the dishwashing machine with white tape over the lips of the trays. Written on the tape were different floor numbers. On the clean side of the dishwashing machine, where dishes and trays dry after being washed, there were two stacks of trays that had been washed, but still had pieces of tape over the lip of each tray that were labeled in pen with different floor numbers. During an interview on 1/23/17, at 12:13 p.m. the dietary director (DD) explained that staff labeled the tape with the floor that each tray was usually used during meals. The DD estimated that one stack of washed trays included over 30 trays that still had tape on them from previous meals, and estimated another stack included around 70 trays that had been washed with the tape still affixed to the trays. The DD expected staff to remove the tape labels before washing the trays, and if a label was missed, expected staff to remove the label and re-wash the tray. The DD said this was important to remove bacteria, and confirmed that the stacks of trays that staff washed with the tape labels still affixed were not considered clean and sanitary. The DD explained that staff needed to remove the tape and re-wash all the trays before use. After requesting a policy for dishwashing, a policy titled Labeling Items in Kitchen with Scotch Tape was received on 1/27/17. The policy was last revised on 1/27/17, and required staff to remove the tape after the labeled tray was placed on a cart for the assigned unit. The policy required staff washing dishes to check for leftover tape and remove any prior to washing. If staff found any tape on the clean side of the dishwashing machine, the policy required them to discard the	F 371	Dietary Services Director or designee. Audit results will be brought to QA for review and ongoing plan to ensure proper cleaning of food trays and clean kitchenettes.	

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F 371	Continued From page 21 tape and re-wash the tray. On 1/23/17, at 12:40 p.m., the 2nd floor transitional care unit kitchenette was toured. The freezer and refrigerator had multiple color spots, both dried and wet throughout the entire inside surface. The freezer and refrigerator had a sticky film residue, dust and crumbs. The refrigerator and freezer contained ice cream, dairy nectar thick drink, pudding, milk and juice. In addition there was a large amount of dust buildup on the bottom rack of the hot food serving cart. The dietary technician (DT)-A confirmed findings. DT-A reported the kitchenette had been cleaned earlier that day, but should have been cleaned better. The Cleaning Kitchenette Refrigerators and Freezers policy, revised 1/27/17, [4 days after the observation], directed staff, "When dietary staff is completing their daily cleaning of unit refrigerator or freezer they must:..wipe shelves and drawers while moving items as needed, store food in a manner to avoid leaks and spills, frequently check refrigerators and freezers for spills and leaks, clean leaks and spills as they occur." The policy further directed staff, "When dietary staff is deep cleaning a unit refrigerator or freezer they must...remove shelves and drawers, wash interior of refrigerator and shelves with hot soapy water."	F 371		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 431		3/8/17

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(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 431	Continued From page 22 law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of	F 431		

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	245189	A. BUILDING _____ B. WING _____	C 01/27/2017

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F 431	Continued From page 23 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored and labeled properly for 2 of 26 residents (R220 and R241) whose medications were observed for medication storage. In addition, the facility did not ensure that expired stock medications were removed from medication storage, which had the potential to affect residents residing on the transition care unit (TCU) second floor, of the 206 residents who resided in the facility. Findings include: During observations of multiple medication storage areas throughout the facility, medications for R220, R241 and R417, which included liquid medications, insulin vial, lacked dates to indicate when they were opened, or when the medications expired. During the medication storage tour on 1/23/17, at 12:23 p.m., with license practical nurse (LPN)-B, in the TCU medication room, multiple opened, used, undated and expired medication bottles were observed to be stored. During the tour, the following concerns were identified: - R220's hydromorphone (for pain; shortness of breath) liquid bottle was opened, used and undated with expired date 1/12/17 placed in	F 431	Medications for R220 and R241 are labeled correctly. All medication carts are audited for correctly labeled multi-dose medications and expired medications. All medication rooms are audited for expired medications and correctly labeled multi-dose medications and expired medications. All units are supplied with Sharpie's and Date Opened Stickers and the Pharmacy Guide to confirm when a medication expires. Education will be provided to nurses and TMA's on policy for removing expired medications, for labeling multi-dose medications, and nurses who stick the medication room will be educated on rotating stock medications and removing them prior to expiration. Audits of the med carts and the med rooms will be completed by the Clinical Managers. Pharmacy Services will continue to audit med carts and med rooms with reports sent to Clinical Manager, DON and to QA Committee. QA Committee will review the audits and make recommendations if necessary.	

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F 431	Continued From page 24 plastic cup with syringe. - On 1/24/17, at 11:20 a.m. with LPN-A, R241's Lantus insulin (diabetes II) vial was opened, used and was undated. At 11:39 a.m. LPN-A verified medications needed to be stored properly, dated when opened and stated, insulin vials should be dated when taken out of refrigerator, opened and should be dated at the same time. - On 1/25/17, at 1:27 p.m. with registered nurse (RN)-B, observed two bottles of Docusate sodium stool softner with expired date of 12/16 in the second floor TCU medication room. RN-B verified medications needed to be stored properly and discarded when expired and stated, the expired medication bottles will be placed in the waste bin. In addition, RN-B, explained the expectation was that expired medications are pulled from the medication cabinet and placed in the waste bin. - On 1/25/17, at 2:52 p.m. the director of nursing (DON) indicated staff was supposed to date insulin medication when opened, check for expired medications, remove expired medications from supply areas. DON further stated staff should follow policies and recommendations and if beyond the recommendation date, medications should be destroyed per policy and procedure. Medication storage and expiration guidelines undated, directed, "Insulin 10ml vials Opened - Room Temp, 28 days After 1st Use, date when open yes." Policy and procedure titled, MEDICATION STORAGE IN THE FACILITY, undated, read, "10. Outdated, contaminated, or deteriorated medications and those in containers that are	F 431		

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F 431	Continued From page 25 cracked, soiled, unlabeled, or without secure closures are immediately removed from stock, disposed of according to facility procedures for medication destruction, and reordered from the pharmacy if a current order exists."	F 431		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 441		3/8/17

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F 441	Continued From page 26 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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 review, the facility failed to ensure proper handwashing to prevent the spread of infection, which had the potential to affect 4 of 4 residents (R84, R85, R246, R343) observed for	F 441	All Staff will be educated on the need to wash hands for at least 20 seconds, according to the facility policy. The facility posted MDH hand washing signs above each sink, indicating the procedure and	

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F 441	Continued From page 27 handwashing. Findings include: During an observation on 1/24/17, at 9:50 a.m. registered nurse (RN)-C administered an insulin injection to R85 in the bedroom. RN-C removed the gloves, turned on the faucet to wash hands, and proceeded to wash hands for 5 seconds. During an observation on 1/24/17, at 10:21 a.m. RN-C administered an insulin injection to R246 in the bedroom and then proceeded to the sink to wash hands. RN-C ran the water and washed hands for 5 seconds. When interviewed on 1/24/17, at 10:30 a.m. RN-C thought the facility policy was to wash hands for 15 to 20 seconds but was not sure what the policy was for handwashing. During an observation on 1/26/17, at 9:50 a.m., RN-D administered oral medication to R84 and assisted to drink water while seated in the bedroom. RN-D assisted R84 to sit up in the chair and to adjust clothing. RN-D washed hands under running water for 5 seconds. When interviewed on 1/26/17, at 10:15 a.m. RN-D thought handwashing was for 15-20 seconds but was not aware of the amount of time RN-D performed handwashing. Document review of the facility policy titled; Handwashing, dated Rev. (revision) 4/14 directed to rub hands briskly for minimally 20-25 seconds, pay special attention to area between fingers. During an interview on 1/26/17, at 2:54 p.m. the	F 441	duration of hand washing is 20 seconds. Staff education will include counting out loud to 20 seconds to ensure each staff member is washing for 20 seconds. New associates will also be taught and encouraged to wash hands for at least 20 seconds.Audits of hand washing will occur until the audits reveal all staff is washing for 20 seconds. Audits will be brought to the QA committee for review for further recommendation.	

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F 441	Continued From page 28 director of nursing, verified the facility expectation was to wash hands briskly for minimally 20-25 seconds according to the facility policy and procedure. During observation on 1/25/17, at 12:23 p.m. licensed practical nurse (LPN)-D provided wound care to R343. After completing wound care, LPN-D removed gloves and washed hands with soap and water for approximately nine seconds. LPN-D removed a bag of waste from R343's room and disposed of it in a garbage bin in the hallway. After disposing of the waste, LPN-D washed hands with soap and water for approximately 10 seconds. During an interview on 1/25/17, at 12:41 p.m. LPN-D said hand washing should occur for "at least 15 seconds."	F 441		
F 494 SS=E	483.35(d)(1)(2) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY (d)(1) General rule A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless-- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or	F 494		3/8/17

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F 494	Continued From page 29 determined competent as provided in §483.150(a) and (b). (d)(2) Non-permanent employees A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure training and performance reviews were completed for 2 of 6 nursing assistants (NA-C, NA-D) in the past 12 months. This had the potential to affect residents cared for by NA-C and NA-D. Findings include: A review of six employee files indicated nursing assistants (NA)-C and NA-D did not receive training or have a performance review completed in the past 12 months. During an interview on 1/27/17, at 3:45 p.m. the human resources director (HRD) verified NA-C and NA-D had received no training or performance reviews. NA-C's last work day was 1/20/17, and NA-D's last work day was 12/1/16. A policy and procedure for performance reviews was not provided.	F 494	Two NAR's had no training documented in Relias System and no Performance Evaluation. NA-C Personnel file will be updated to show the education that was completed during the previous 12 months. NA-D Personnel file will be updated to show the education that was completed during the previous 12 months. Any incomplete education will be completed by 3.8.17. NA-C will have Performance Evaluation completed by 3.8.17. NA-D will have Performance Evaluation completed by 3.8.17.Facility will review all staff for completion of annual training and performance reviews. Training and Performance Evaluations will be completed, giving priority to nursing staff until all are completed by 3.31.17. Review of the annual training process resulted in a change to add 2 classroom sessions where veteran staff can complete required training in addition to the online learning that is available. HR and Staff Development will perform monthly audits for compliance of performance evaluations and required training. Audits will be brought to QA committee for review and recommendations if needed.	

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F 496 SS=E	483.35(d)(4)-(6) NURSE AIDE REGISTRY VERIFICATION, RETRAINING d)(4) Registry verification Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. (d)(5) Multi-State registry verification Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. (d)(6) Required retraining If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced	F 496		3/8/17

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F 496	Continued From page 31 by: Based on record review and interview, the facility failed to ensure a nursing assistant (NA)-E was on the nursing assistant registry, which had the potential to impact 8 of 8 residents on NA-E's assigned group. Findings include: The Minnesota nursing assistant registry verification of registration, dated 1/27/17, revealed a nursing assistant (NA)-E had an expired registration as of 4/28/16. The report had the word "EXPIRED" written on the top. On 1/27/17, at 3:10 p.m., the director of nursing (DON) explained that NA-E was not current on the nursing assistant registry and was scheduled for a 0.8 day shift position. A daily staffing sheet, dated 1/27/17, revealed NA-E was scheduled to work as a nursing assistant for the day shift. After survey exit, an email sent by the facility, dated 1/31/17, revealed a Minnesota nursing assistant registry verification of registration, dated 1/31/17, identifying that NA-E was now current on the registry.	F 496	NA-E was not on the Minnesota Registry on 1.27.17. Information was submitted and the registry revealed NA-E was active on the registry on 1.31.17. Audit of all NAR's indicate that every other NAR was active on the registry. NAR's will be added to the tickler file used for licensed nurses on a monthly basis. If an NAR is set to expire in the coming 2 months, HR will print the form for updating the registry and provide a reminder to the NAR. HR will do monthly audits to ensure compliance. Audit results will be brought to QA committee for review for any further recommendations.	

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K 000	INITIAL COMMENTS Aspen with Deficiencies 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Name of facility) 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/17/2017

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

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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

(The Southview Acres Health Care Center) is a 4-story building. The building was constructed at (3) different times. The original building was constructed in 1961 and was determined to be of Type II(222) construction. In 1973 & 2009, addition was constructed to the (West wing) that was determined to be of Type II(222) construction. Because the original building and the (2) addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 231 beds and had a census of 208 at the time of the survey.

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=F	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small	K 324	BIDS have been obtained from Paul's Plumbing, Southside Electric and Summit companies. All aspects of extinguishing system are expected to be installed on 2-22-17. Once installation is complete and approved by fire marshall the	2/24/17

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	245189	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/25/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 3 appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 1/25/2017, based on observation and interview revealed that the following include: That there was no range hood fire extinguishing system located at the cooking equipment in the kitchen. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 324	extinguishing system will be added to the preventative maintenance schedule for cleaning and testing as recommended by the manufacturer. Maintenance Engineers will be responsible for ongoing monitoring of the system	
K 341 SS=D	NFPA 101 Fire Alarm System - Installation 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,	K 341		2/17/17

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K 341	Continued From page 4 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 STANDARD is not met as evidenced by: 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 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 1/25/2017, based on observation and interview revealed that the following include: The fire alarm system was in trouble mode. Stated a dirty smoke detector on 2nd floor.	K 341	On 1-26-17 Summit Companies was on site for cleaning of smoke detector on 2nd floor and reset system. Electrowatchman was provided direct dial number to the maintenance department to prevent future miscommunication related to the system being in trouble mode. Preventative maintenance for annual sensitivity testing will be ongoing. Random audits will be completed by maintenance department to ensure compliance. Maintenance engineers will be responsible to monitor	

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K 341	Continued From page 5 This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 341		
K 363 SS=F	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483,	K 363		1/27/17

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K 363	Continued From page 6 and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363	on 1-26-17 maintenance department tightened all hinges of affected doors and ensured proper closure of door when tested. Monthly preventative maintenance testing of fire doors will be ongoing as well as full annual inspection of same. Random audits will be done by maintenance department to ensure compliance. Maintenance Engineers are responsible to monitor.	

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K 363	Continued From page 7 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 1/25/2017, based on observation and interview revealed that the following include: The fire rated doors did not close and latch when tested at S114, E339, E342, by room E323, and S320. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 363		
K 923 SS=D	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient	K 923		1/27/17

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K 923	Continued From page 8 care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be	K 923	Northwest Respiratory came to facility on 1-26-17 and added a separate storage rack to keep full and empty tanks separate and on opposite sides of the room. Clearly labeled signage was also posted to differentiate the use of the separate racks. ADON or designee will perform random audits for compliance. ADON is responsible to monitor ongoing.	

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K 923	Continued From page 9 stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Findings Include: On facility tour between 09:00 AM and 01:00 PM on 1/25/2017, based on observation and interview revealed that the following include: Both the full and empty O2 cylinders are mixed together in store racks. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923		