DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 28, 2025

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

RE: CCN: 245189
Cycle Start Date: March 27, 2025

Dear Administrator:

On April 25, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

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Electronically delivered

April 28, 2025

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

Re: Reinspection Results
Event ID: UWWJ12

Dear Administrator:

On April 25, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 27, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 10, 2025

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

RE: CCN: 245189
Cycle Start Date: March 27, 2025

Dear Administrator:

On March 27, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);

- Civil money penalty (42 CFR 488.430 through 488.444).

- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by June 27, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 27, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections

488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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Electronically delivered
April 10, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: UWWJ11

Dear Administrator:

The above facility was surveyed on March 26, 2025 through March 27, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245189	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/26/25 through 3/27/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H51892060C (MN00111738) AND The following complaints were reviewed: H51891940C (MN00111663) with a deficiency cited at F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		4/22/25

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

Electronically Signed | 04/14/2025

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 880	Continued From page 1 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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SOUTHVIEW ACRES HEALTHCARE CENTER	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

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F 880	Continued From page 2 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure proper enhanced barrier precautions (EBP), glove use, and hand hygiene was performed during incontinence care for 1 of 3 (R1) residents reviewed for incontinence care. Findings include: R1's quarterly Minimum Data Set (MDS) dated 1/1/25, indicated R1 needed extensive assistance with personal hygiene and had a suprapubic catheter (tube inserted into the bladder through an incision in the lower abdomen). R1's EBP signage undated, indicated staff needed to wear gloves and gown when providing high-contact resident care activities such as	F 880	R1 clinical chart was reviewed from survey exit until present and R1 did not experience any ill effects from this deficient practice. NA-A and NA-B were removed from the floor and in-service education was provided. R1 ADL care plan was reviewed and updated as needed. Current residents who are in EBP and require assistance with peri-care, their charts and care plans were reviewed and updated as needed. Future residents who admit to the facility will have peri-care and EBP procedures followed by facility policy. Facility nurses and nurse aides will be in-serviced on the Handwashing/Hand Hygiene policy with emphasis on completing hand hygiene before and after	

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	245189	A. BUILDING _____ B. WING _____	C 03/27/2025

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

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F 880	Continued From page 3 changing linens, providing hygiene, or changing brief. During an observation on 3/26/25 at 10:43 a.m., nursing assistant (NA)-A and NA-B were observed sanitizing hands and placing on gloves prior to going into R1's room. R1 had a sign indicating he was on EBPs and a bin of personal protective equipment (PPE) was outside the entrance of his door. NA-A and NA-B entered R1's room to assist him with personal hygiene without gowns on. NA-A open R1's soiled incontinent brief and cleansed R1's peri-area, then placed the bowel filled wipes in-between R1's thighs. NA-A grabbed clean towel and wash clothes with her soiled gloves on and went to R1's shared bathroom and got the wash clothes wet. R1 was assisted to his left side, NA-A cleansed R1's buttocks with wash clothes which had bowel on them and rolled the bowel filled wash clothes and brief under R1's body. NA-A removed her gloves, did not perform hand hygiene and removed R1's linen for the right side of his bed pushing the linen under R1. NA-A adjusted R1's pillow under his head, applied a clean fitted sheet to the right side of the bed, and placed a clean brief under R1's buttocks. NA-A assisted R1 to his right side. NA-B cleansed R1's left side near his buttock as there was bowel present, then removed the soiled brief and soiled linen from under R1. NA-B did not remove her soiled gloves and applied the clean fitted sheet to the left side of R1's bed. R1 was then placed on his back. NA-A removed soiled wipes with bowel from R1's groin area without gloves on stating, "I shouldn't be doing this", and placed the bowel soiled wipes in the trash. NA-A grabbed a clean towel and started wiping the remaining bowel off of R1's genital area with no gloves on. NA-A and NA-B	F 880	care, body fluids and removing gloves, the Enhanced Barrier Precaution policy with emphasis on gowns and gloves are to be worn during care, changing linens and changing briefs and the Perineal Care policy with focus on item #8 cleansing process for male and female residents. Infection Preventionist and/or designee is responsible for compliance. Audits on EBP signage, proper PPE worn during care and hand hygiene before and after care will begin 2x week for 3 weeks, weekly x2 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 4/22/2025	

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	245189	A. BUILDING _____ B. WING _____	C 03/27/2025

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SOUTHVIEW ACRES HEALTHCARE CENTER	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

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F 880	Continued From page 4 strapped R1's clean brief together and adjusted his gown. NA-B removed her gloves and did not sanitize her hands. NA-A raised R1's head and leg with the bed remote, adjusted R1's pillow under his head, applied his blanket. NA-B applied new gloves without sanitizing hands and NA-A turned R1 to his right side as NA-B placed a pillow behind R1's back. NA-A left R1's room without sanitizing her hands. During an interview on 3/26/25 at 11:35 a.m., NA-B stated she did not notice R1's EBP sign on his door and that is why she did not wear a gown into his room. Further, NA-B stated she did not remove her gloves after providing personal hygiene to R1 or sanitize her hands after removing her gloves. On 3/26/25 at 12:20 p.m., NA-A stated it slipped her mind that R1 was on EBPs and that is why she did not wear a gown when assisting R1 with personal hygiene. NA-A stated she forgot to remove her gloves after providing personal hygiene to R1. NA-A stated she did not sanitize her hands after removing her soiled gloves. NA-A stated she grabbed soiled wipes from between R1's legs without gloves on because she felt rushed and she did not sanitize her hands before leaving the room. On 3/27/25 at 9:52 a.m., infection preventionist (IP)-A stated if when a resident was on EBPs and staff provided personal care they needed to wear a gown and gloves and follow what the signage and policy stated. IP-A stated staff were expected to remove gloves after cleaning the soiled areas, sanitize their hands, apply new gloves, and not touch soiled products without gloves on. Staff should remove all PPE prior to leaving the	F 880		

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F 880	Continued From page 5 residents room and sanitize their hands. On 3/27/25 at 10:09 a.m., the director of nursing (DON) stated when staff entered a room with a resident on EBP they were expected to do hand hygiene, apply gown, and gloves before providing personal cares. They were expected to follow the policy on hand hygiene. Handwashing/ Hand hygiene policy reviewed 8/25/21, indicated staff would complete hand hygiene before and after direct contact with residents, before moving from a contaminated body site to a clean body site during resident care, after contact with bodily fluids, and after removing gloves. Enhanced Barrier precautions (EBPs) policy reviewed 10/18/22, indicated gown and gloves would be used during high contact resident care activities such as providing hygiene, changing linens, and changing briefs.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 03/27/2025

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/26/25 through 3/27/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 03/27/2025

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

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H51892060C (MN00111738) AND The following complaints were reviewed. H51891940C (MN00111663) with a licensing order issued at 4658.0800 Subp 1. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 2 electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure proper enhanced barrier precautions (EBP), glove use, and hand hygiene was performed during incontinence care for 1 of 3 (R1) residents reviewed for incontinence care. Findings include: R1's quarterly Minimum Data Set (MDS) dated 1/1/25, indicated R1 needed extensive assistance with personal hygiene and had a suprapubic catheter (tube inserted into the bladder through an incision in the lower abdomen).	21375	Corrected 04/22/2025	4/22/25

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21375	Continued From page 3 R1's EBP signage undated, indicated staff needed to wear gloves and gown when providing high-contact resident care activities such as changing linens, providing hygiene, or changing brief. During an observation on 3/26/25 at 10:43 a.m., nursing assistant (NA)-A and NA-B were observed sanitizing hands and placing on gloves prior to going into R1's room. R1 had a sign indicating he was on EBPs and a bin of personal protective equipment (PPE) was outside the entrance of his door. NA-A and NA-B entered R1's room to assist him with personal hygiene without gowns on. NA-A open R1's soiled incontinent brief and cleansed R1's peri-area, then placed the bowel filled wipes in-between R1's thighs. NA-A grabbed clean towel and wash clothes with her soiled gloves on and went to R1's shared bathroom and got the wash clothes wet. R1 was assisted to his left side, NA-A cleansed R1's buttocks with wash clothes which had bowel on them and rolled the bowel filled wash clothes and brief under R1's body. NA-A removed her gloves, did not perform hand hygiene and removed R1's linen for the right side of his bed pushing the linen under R1. NA-A adjusted R1's pillow under his head, applied a clean fitted sheet to the right side of the bed, and placed a clean brief under R1's buttocks. NA-A assisted R1 to his right side. NA-B cleansed R1's left side near his buttock as there was bowel present, then removed the soiled brief and soiled linen from under R1. NA-B did not remove her soiled gloves and applied the clean fitted sheet to the left side of R1's bed. R1 was then placed on his back. NA-A removed soiled wipes with bowel from R1's groin area without gloves on stating, "I shouldn't be doing this", and placed the bowel soiled wipes	21375		

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21375	Continued From page 4 in the trash. NA-A grabbed a clean towel and started wiping the remaining bowel off of R1's genital area with no gloves on. NA-A and NA-B strapped R1's clean brief together and adjusted his gown. NA-B removed her gloves and did not sanitize her hands. NA-A raised R1's head and leg with the bed remote, adjusted R1's pillow under his head, applied his blanket. NA-B applied new gloves without sanitizing hands and NA-A turned R1 to his right side as NA-B placed a pillow behind R1's back. NA-A left R1's room without sanitizing her hands. During an interview on 3/26/25 at 11:35 a.m., NA-B stated she did not notice R1's EBP sign on his door and that is why she did not wear a gown into his room. Further, NA-B stated she did not remove her gloves after providing personal hygiene to R1 or sanitize her hands after removing her gloves. On 3/26/25 at 12:20 p.m., NA-A stated it slipped her mind that R1 was on EBPs and that is why she did not wear a gown when assisting R1 with personal hygiene. NA-A stated she forgot to remove her gloves after providing personal hygiene to R1. NA-A stated she did not sanitize her hands after removing her soiled gloves. NA-A stated she grabbed soiled wipes from between R1's legs without gloves on because she felt rushed and she did not sanitize her hands before leaving the room. On 3/27/25 at 9:52 a.m., infection preventionist (IP)-A stated if when a resident was on EBPs and staff provided personal care they needed to wear a gown and gloves and follow what the signage and policy stated. IP-A stated staff were expected to remove gloves after cleaning the soiled areas, sanitize their hands, apply new gloves, and not	21375		

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21375	Continued From page 5 touch soiled products without gloves on. Staff should remove all PPE prior to leaving the residents room and sanitize their hands. On 3/27/25 at 10:09 a.m., the director of nursing (DON) stated when staff entered a room with a resident on EBP they were expected to do hand hygiene, apply gown, and gloves before providing personal cares. They were expected to follow the policy on hand hygiene. Handwashing/ Hand hygiene policy reviewed 8/25/21, indicated staff would complete hand hygiene before and after direct contact with residents, before moving from a contaminated body site to a clean body site during resident care, after contact with bodily fluids, and after removing gloves. Enhanced Barrier precautions (EBPs) policy reviewed 10/18/22, indicated gown and gloves would be used during high contact resident care activities such as providing hygiene, changing linens, and changing briefs. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review infection control policies and procedures, and provide education to staff basic infection control principles, including hand hygiene and EBPs. The facility could conduct periodic audits of staff completing hand hygiene and applying PPE. The Quality Assurance Performance Improvement (QAPI) committee could monitor ongoing compliance. TIME FOR CORRECTION: Twenty-one (21) days.	21375		

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F 000	INITIAL COMMENTS On 3/26/25 through 3/27/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H51892060C (MN00111738) AND The following complaints were reviewed: H51891940C (MN00111663) with a deficiency cited at F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		4/22/25

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

Electronically Signed | 04/14/2025

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 880	Continued From page 1 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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F 880	Continued From page 2 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure proper enhanced barrier precautions (EBP), glove use, and hand hygiene was performed during incontinence care for 1 of 3 (R1) residents reviewed for incontinence care. Findings include: R1's quarterly Minimum Data Set (MDS) dated 1/1/25, indicated R1 needed extensive assistance with personal hygiene and had a suprapubic catheter (tube inserted into the bladder through an incision in the lower abdomen). R1's EBP signage undated, indicated staff needed to wear gloves and gown when providing high-contact resident care activities such as	F 880	R1 clinical chart was reviewed from survey exit until present and R1 did not experience any ill effects from this deficient practice. NA-A and NA-B were removed from the floor and in-service education was provided. R1 ADL care plan was reviewed and updated as needed. Current residents who are in EBP and require assistance with peri-care, their charts and care plans were reviewed and updated as needed. Future residents who admit to the facility will have peri-care and EBP procedures followed by facility policy. Facility nurses and nurse aides will be in-serviced on the Handwashing/Hand Hygiene policy with emphasis on completing hand hygiene before and after	

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F 880	Continued From page 3 changing linens, providing hygiene, or changing brief. During an observation on 3/26/25 at 10:43 a.m., nursing assistant (NA)-A and NA-B were observed sanitizing hands and placing on gloves prior to going into R1's room. R1 had a sign indicating he was on EBPs and a bin of personal protective equipment (PPE) was outside the entrance of his door. NA-A and NA-B entered R1's room to assist him with personal hygiene without gowns on. NA-A open R1's soiled incontinent brief and cleansed R1's peri-area, then placed the bowel filled wipes in-between R1's thighs. NA-A grabbed clean towel and wash clothes with her soiled gloves on and went to R1's shared bathroom and got the wash clothes wet. R1 was assisted to his left side, NA-A cleansed R1's buttocks with wash clothes which had bowel on them and rolled the bowel filled wash clothes and brief under R1's body. NA-A removed her gloves, did not perform hand hygiene and removed R1's linen for the right side of his bed pushing the linen under R1. NA-A adjusted R1's pillow under his head, applied a clean fitted sheet to the right side of the bed, and placed a clean brief under R1's buttocks. NA-A assisted R1 to his right side. NA-B cleansed R1's left side near his buttock as there was bowel present, then removed the soiled brief and soiled linen from under R1. NA-B did not remove her soiled gloves and applied the clean fitted sheet to the left side of R1's bed. R1 was then placed on his back. NA-A removed soiled wipes with bowel from R1's groin area without gloves on stating, "I shouldn't be doing this", and placed the bowel soiled wipes in the trash. NA-A grabbed a clean towel and started wiping the remaining bowel off of R1's genital area with no gloves on. NA-A and NA-B	F 880	care, body fluids and removing gloves, the Enhanced Barrier Precaution policy with emphasis on gowns and gloves are to be worn during care, changing linens and changing briefs and the Perineal Care policy with focus on item #8 cleansing process for male and female residents. Infection Preventionist and/or designee is responsible for compliance. Audits on EBP signage, proper PPE worn during care and hand hygiene before and after care will begin 2x week for 3 weeks, weekly x2 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 4/22/2025	

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F 880	Continued From page 4 strapped R1's clean brief together and adjusted his gown. NA-B removed her gloves and did not sanitize her hands. NA-A raised R1's head and leg with the bed remote, adjusted R1's pillow under his head, applied his blanket. NA-B applied new gloves without sanitizing hands and NA-A turned R1 to his right side as NA-B placed a pillow behind R1's back. NA-A left R1's room without sanitizing her hands. During an interview on 3/26/25 at 11:35 a.m., NA-B stated she did not notice R1's EBP sign on his door and that is why she did not wear a gown into his room. Further, NA-B stated she did not remove her gloves after providing personal hygiene to R1 or sanitize her hands after removing her gloves. On 3/26/25 at 12:20 p.m., NA-A stated it slipped her mind that R1 was on EBPs and that is why she did not wear a gown when assisting R1 with personal hygiene. NA-A stated she forgot to remove her gloves after providing personal hygiene to R1. NA-A stated she did not sanitize her hands after removing her soiled gloves. NA-A stated she grabbed soiled wipes from between R1's legs without gloves on because she felt rushed and she did not sanitize her hands before leaving the room. On 3/27/25 at 9:52 a.m., infection preventionist (IP)-A stated if when a resident was on EBPs and staff provided personal care they needed to wear a gown and gloves and follow what the signage and policy stated. IP-A stated staff were expected to remove gloves after cleaning the soiled areas, sanitize their hands, apply new gloves, and not touch soiled products without gloves on. Staff should remove all PPE prior to leaving the	F 880		

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F 880	Continued From page 5 residents room and sanitize their hands. On 3/27/25 at 10:09 a.m., the director of nursing (DON) stated when staff entered a room with a resident on EBP they were expected to do hand hygiene, apply gown, and gloves before providing personal cares. They were expected to follow the policy on hand hygiene. Handwashing/ Hand hygiene policy reviewed 8/25/21, indicated staff would complete hand hygiene before and after direct contact with residents, before moving from a contaminated body site to a clean body site during resident care, after contact with bodily fluids, and after removing gloves. Enhanced Barrier precautions (EBPs) policy reviewed 10/18/22, indicated gown and gloves would be used during high contact resident care activities such as providing hygiene, changing linens, and changing briefs.	F 880		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/26/25 through 3/27/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H51892060C (MN00111738) AND The following complaints were reviewed. H51891940C (MN00111663) with a licensing order issued at 4658.0800 Subp 1. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure proper enhanced barrier precautions (EBP), glove use, and hand hygiene was performed during incontinence care for 1 of 3 (R1) residents reviewed for incontinence care. Findings include: R1's quarterly Minimum Data Set (MDS) dated 1/1/25, indicated R1 needed extensive assistance with personal hygiene and had a suprapubic catheter (tube inserted into the bladder through an incision in the lower abdomen).	21375	Corrected 04/22/2025	4/22/25

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21375	Continued From page 3 R1's EBP signage undated, indicated staff needed to wear gloves and gown when providing high-contact resident care activities such as changing linens, providing hygiene, or changing brief. During an observation on 3/26/25 at 10:43 a.m., nursing assistant (NA)-A and NA-B were observed sanitizing hands and placing on gloves prior to going into R1's room. R1 had a sign indicating he was on EBPs and a bin of personal protective equipment (PPE) was outside the entrance of his door. NA-A and NA-B entered R1's room to assist him with personal hygiene without gowns on. NA-A open R1's soiled incontinent brief and cleansed R1's peri-area, then placed the bowel filled wipes in-between R1's thighs. NA-A grabbed clean towel and wash clothes with her soiled gloves on and went to R1's shared bathroom and got the wash clothes wet. R1 was assisted to his left side, NA-A cleansed R1's buttocks with wash clothes which had bowel on them and rolled the bowel filled wash clothes and brief under R1's body. NA-A removed her gloves, did not perform hand hygiene and removed R1's linen for the right side of his bed pushing the linen under R1. NA-A adjusted R1's pillow under his head, applied a clean fitted sheet to the right side of the bed, and placed a clean brief under R1's buttocks. NA-A assisted R1 to his right side. NA-B cleansed R1's left side near his buttock as there was bowel present, then removed the soiled brief and soiled linen from under R1. NA-B did not remove her soiled gloves and applied the clean fitted sheet to the left side of R1's bed. R1 was then placed on his back. NA-A removed soiled wipes with bowel from R1's groin area without gloves on stating, "I shouldn't be doing this", and placed the bowel soiled wipes	21375		

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21375	Continued From page 4 in the trash. NA-A grabbed a clean towel and started wiping the remaining bowel off of R1's genital area with no gloves on. NA-A and NA-B strapped R1's clean brief together and adjusted his gown. NA-B removed her gloves and did not sanitize her hands. NA-A raised R1's head and leg with the bed remote, adjusted R1's pillow under his head, applied his blanket. NA-B applied new gloves without sanitizing hands and NA-A turned R1 to his right side as NA-B placed a pillow behind R1's back. NA-A left R1's room without sanitizing her hands. During an interview on 3/26/25 at 11:35 a.m., NA-B stated she did not notice R1's EBP sign on his door and that is why she did not wear a gown into his room. Further, NA-B stated she did not remove her gloves after providing personal hygiene to R1 or sanitize her hands after removing her gloves. On 3/26/25 at 12:20 p.m., NA-A stated it slipped her mind that R1 was on EBPs and that is why she did not wear a gown when assisting R1 with personal hygiene. NA-A stated she forgot to remove her gloves after providing personal hygiene to R1. NA-A stated she did not sanitize her hands after removing her soiled gloves. NA-A stated she grabbed soiled wipes from between R1's legs without gloves on because she felt rushed and she did not sanitize her hands before leaving the room. On 3/27/25 at 9:52 a.m., infection preventionist (IP)-A stated if when a resident was on EBPs and staff provided personal care they needed to wear a gown and gloves and follow what the signage and policy stated. IP-A stated staff were expected to remove gloves after cleaning the soiled areas, sanitize their hands, apply new gloves, and not	21375		

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21375	Continued From page 5 touch soiled products without gloves on. Staff should remove all PPE prior to leaving the residents room and sanitize their hands. On 3/27/25 at 10:09 a.m., the director of nursing (DON) stated when staff entered a room with a resident on EBP they were expected to do hand hygiene, apply gown, and gloves before providing personal cares. They were expected to follow the policy on hand hygiene. Handwashing/ Hand hygiene policy reviewed 8/25/21, indicated staff would complete hand hygiene before and after direct contact with residents, before moving from a contaminated body site to a clean body site during resident care, after contact with bodily fluids, and after removing gloves. Enhanced Barrier precautions (EBPs) policy reviewed 10/18/22, indicated gown and gloves would be used during high contact resident care activities such as providing hygiene, changing linens, and changing briefs. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review infection control policies and procedures, and provide education to staff basic infection control principles, including hand hygiene and EBPs. The facility could conduct periodic audits of staff completing hand hygiene and applying PPE. The Quality Assurance Performance Improvement (QAPI) committee could monitor ongoing compliance. TIME FOR CORRECTION: Twenty-one (21) days.	21375		