Electronically delivered

December 30, 2021

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

RE: CCN: 245189
Cycle Start Date: December 1, 2021

Dear Administrator:

On December 13, 2021, we informed you that we may impose enforcement remedies.

On December 16, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 1, 2022

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 1, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 1, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of

payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 1, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Southview Acres Healthcare Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 1, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 - Health Regulation Division 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 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 June 1, 2022 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
December 30, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: GFTJ11

Dear Administrator:

The above facility was surveyed on December 10, 2021 through December 16, 2021 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/10/21 to 12/16/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	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 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5189231C (MN70118), H5189232C (MN69465), H5189238C (MN66419), H5189239C (MN63355), and H5189248C (MN74435) however, NO licensing orders were issued. The following complaints were found to be SUBSTANTIATED: H5189242C (MN63093) with a deficiency cited at 830. The following complaints were found to be UNSUBSTANTIATED: H5189219C(MN77540), H189220C (MN76689), H5189221C (MN75265), , H5189222C (MN74942), H5189223C (MN74810), H5189225C (MN71020), H5189226C(MN74286), H5199227C (MN73090), H5189228C (MN72473), H5189229C (MN72226), H5189230C (MN70733), H5189233C (MN69358), H5189234C (MN69147), H5189235C (MN68769), H5189236C (MN68294), H5189237C (MN66600), H5189240C (MN65512), H5189241C (MN63195), H5189243C (MN62912), H5189244C (MN62879), H5189245C (MN56587), H5189246C (MN57121), H5189247C (MN77042), and H5189249C (MN58824). The following complaints were also UNSUBSTANTIATED: H5189224C (MN74951), however a licensing order was issued at 1100. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To	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 12/16/2021

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 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 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in	2 830		1/18/22

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 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R30) was appropriately supervised to prevent falls. R30's admission, Minimum Data Set (MDS) dated 10/14/21, indicated R30 had moderate cognitive deficits. R30 required total assistance of 2 staff for bed mobility, transfers, and toileting, and extensive assistance of 1 staff for dressing, eating, and personal hygiene. R30 was on hospice. R30 had a history of displaced fracture of the right shoulder, dementia, anxiety, bilateral osteoarthritis of the knees, and low back pain. R30's Care Area Assessment (CAA) indicated R30 triggered for falls related to balance problems. R30 was unsteady when moving from a seated to standing position, while turning around, while walking, during surface-to-surface transfers, and while sitting. R30 was a high risk for falls related to dementia, incontinence, limited mobility, and psychotropic and opioid medication use. R30 was on hospice and was expected to decline in his overall status. R30 was forgetful and his needs should have been anticipated. R30's 10/8/21, Fall Risk assessment dated	2 830	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 4 indicated R30 was a high risk for falls due to intermittent confusion, an inability to stand without support, and taking medications known to increase the risk for falls. Review of R30's 12/13/21, video surveillance tape of the fall events with the director of nursing (DON) identified although the video surveillance times were inaccurate and not set to current time, the events were recorded as follows. At: 1) 10:32 a.m. R30 was wheeled in his Broda chair into the second-floor day room by trained medical assistant (TMA)-B. R30 was left by TMA-B to sit approximately 2 feet away from a table with the back of his chair towards the nurse's station. R30 was on camera facing out the window where his front was easily seen on video. 2) 10:52 a.m. R30 began to move around, looking from side to side and reaching out for the table. 3) 11:04 a.m. R30 sat forward in his chair and attempted to reach for the table. 4) 11:12 a.m. R30 stood up on his Broda chair foot-stand and reached for the table, became unstable and sat back down. 5) 11:21 a.m. R30 reached for the table and attempted unsuccessfully to stand. 6) 11:29 a.m. R30 attempted to stand up twice then sat back down. 7) 11:34 a.m. R30 attempted to stand up then sat back down. 8) 11:37 a.m. R30 stood up on his Broda chair foot-stand, reached for the table, took a cross-step to the right and fell onto the ground next to his chair. At no time during any of the above-mentioned video surveillance were staff seen as to provide appropriate supervision as no staff were seen on camera either walking by the day room or within the immediate vicinity of the day room. R30 had been left unattended for over 1 hour.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 During an observation and interview on 12/13/21, at 12:26 p.m., with R30 and multiple staff immediately after R30's fall identified R30 was lying on his right side on the floor of the day room on the second floor, next to his Broda chair. Activities coordinator (AC)-A stated she found R30 unattended on the floor moments prior and was unsure how "long" he had been there. R30 reported his elbow hurt and he had hit his head "a little bit". Registered nurse (RN)-E stated R30 had told her he "stood up." Nursing assistant (NA)-B stated R30 "always attempted" to climb out of his bed and chair. RN-E noted R30 was a high fall risk because he often tried to get out of his chair. R30 was uninjured from his fall and required no medical care by a physician. R30's progress notes identified on: 1) 12/3/21, at 6:14 p.m. indicated R30 was moving around and trying to get out of his Broda chair (a specific brand of wheelchair with a high back, extra padding, and a full footrest). At 7:00 p.m. R30 was observed removing his socks and brief while in the day room. 2) 12/13/21, at 2:40 p.m. indicated R30 was found on the floor next to his Broda chair in the day room with a skin tear 0.5 cm round on his elbow. R30 was confused and unable to recall events except to say he "stood up." R30's current, undated care plan indicated R30 had a communication deficit related to dementia. Interventions included anticipating R30's needs and being conscious of R30's position in groups, activities, and dining to promote proper communication with others. R30 was a high risk for falls and staff were to anticipate his needs, keep the call light within reach, and answering the resident's request for assistance promptly. There	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6	2 830		

was no mention staff were identified R30 had previous attempts to get out of his chair without staff assistance and would require increased supervision.

During an interview on 12/13/21, at 3:43 p.m. family member (FM)-K stated she was surprised R30 had fallen only once after admission as R30 would turn himself around and often tried to get out of bed without staff assistance.

During an interview on 12/16/21, at 9:33 a.m. HCM-M, who was currently R30's hospice case manager, stated HCM-L notified him of R30's fall the day after it happened. HCM-M stated R30 had multiple falls prior to admission and that was the reason for use of the Broda chair. HCM-M further stated R30 would not be cognizant enough to use a call light if he needed assistance with transferring or toileting, leading R30 to attempt to self-transfer.

During an interview on 12/16/21, at 10:47 a.m. the director of nursing (DON) identified she agreed R30 was a risk for falls. R30 was not to have been left unsupervised or have staff near him when he was not in bed.

Review of the 7/10/12, Hospice Nursing Facility Services Agreement contract identified the facility was to ensure the hospice patient was free from accidents and injury. The facility and hospice group shall communicate regularly and as needed for each hospice patient and the facility shall immediately report any change in condition of the hospice patient and must not make any modifications to the plan of care without first consulting the hospice group. There was no mention the facility could add additional interventions as needed to keep a resident safe

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 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7 while in the care of the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure milk was stored and then served served at a safe temperatures below 41 degrees Fahrenheit. This had the potential to affect the 33 of 139 residents who ate meals in their rooms on the second floor. Findings include: The U.S. Food & Drug Administration (FDA) Food Code dated 2017, indicated improper holding	21100	Corrected	1/18/22

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 12/16/2021

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
21100	Continued From page 8	21100		

temperatures as one of five major risk factors repeatedly identified as contributing to food born illness. The Code also indicated temperature for safety food shall be maintained at 41 degrees Fahrenheit or less. The Code further indicated "bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature 'Danger Zone' of 5 [degrees Celsius] C to 57 degrees C (41 F to 135 F) too long. Up to a point, the rate of growth increases with an increase in temperature within this zone."

During an observation on 12/14/21, at 8:15 a.m. a white plastic tub containing three half gallons of milk, pitchers of apple and orange juices, and a pint of Lactaid milk was sitting on the second-floor kitchen serving counter. The tub had approximately two inches of water with some ice in the bottom. No meal service was occurring and no staff or residents were in the kitchen or dining area.

During an observation and interview on 12/14/21, at 11:10 a.m. two half gallons of milk were sitting in a white plastic tub with approximately two inches of cold water and no ice, in the second-floor kitchen. A third half gallon of milk that was approximately one quarter full, was sitting out on the serving counter with the lid off. Trained medical assistant (TMA)-A and nursing assistant (NA)-A were pouring milk into plastic cups from the open milk container and placing them on trays to be delivered to resident rooms. At 11:17 a.m. chef (CH)-A and dietary manager (DM) noted the temperature of the three milk cartons to be: 56.8 degrees Fahrenheit, 67.3 degrees Fahrenheit, and 70.7 degrees Fahrenheit. A cup of milk from a prepared resident tray was also temp'd at 60.2 degrees

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 12/16/2021

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
21100	Continued From page 9	21100		

Fahrenheit. The DM stated milk temperature should be below 40 degrees Fahrenheit to avoid the residents getting a food born illness. Dietary server (DS)-A stated the white plastic tray of milk and juice being served, was already in the kitchen service area when he started his shift at 9:00 a.m. and at no point had he returned the drinks to the refrigerator prior to lunch service.

During an interview on 12/14/21, at 1:55 p.m. registered dietician (RD)-C stated milk should have been kept below 40 degrees Fahrenheit to avoid causing a food born illness in residents.

During an interview on 12/14/21, at 2:16 p.m. the DM stated DS's were supposed to return unused milk to the main kitchen on the first floor, after breakfast around 9:00 a.m. DS should go back to the main, first floor kitchen just before 10:00 a.m., put the milk and juices in a white tub and cover it with approximately 1.5 to 2 inches of ice. The DM also stated the half gallon cartons of milk should be placed in the white tub with the lid on in between use and not placed on the counter without a lid. The DM further stated the DS did not follow the proper procedure to ensure the milk was kept at safe serving temperatures.

The facility Food Safety and Sanitation policy dated 2017, indicated refrigerated food was to be stored at or below 41 degrees Fahrenheit and perishable items should be refrigerated when they are not being used.

The facility Food Safety-Director of Food and Nutrition Services Responsibility policy dated 2017, indicated the director of food and nutrition services would ensure all refrigerated foods would be stored and handled properly and conduct regular inspections to ensure proper food

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 12/16/2021

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
21100	Continued From page 10 handling. The policy also indicated all Hazard Analysis and Critical Control Point (HACCP) procedures would be followed. SUGGESTED METHOD OF CORRECTION: The director of dietary services or designee could develop, review, and revise policies and procedures to ensure parishable foods were stored and served at safe temperatures to prevent food born illnesses. The director of dietary services or designee could educate staff on the policies and procedures and conduct audits to ensure staff adhere to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21100		

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 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 12/10/21 through 12/16/21, COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was found to be IN compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567	E 000		
F 000	INITIAL COMMENTS On 12/10/21, to 12/16/21, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. In addition, a standard abbreviated survey was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5189231C (MN70118), H5189232C (MN69465), H5189238C (MN66419), H5189239C (MN63355), and H5189248C (MN74435) however, NO deficiencies were cited. The following complaints were found to be SUBSTANTIATED: H5189242C (MN63093) with a deficiency cited at F558 and F689. The following complaints were found to be UNSUBSTANTIATED: H5189219C(MN77540), H189220C (MN76689), H5189221C (MN75265), , H5189222C (MN74942), H5189223C (MN74810), H5189225C (MN71020), H5189226C(MN74286), H5199227C (MN73090), H5189228C (MN72473),	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/06/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245189	A. BUILDING _____ B. WING _____	C 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 H5189229C (MN72226), H5189230C (MN70733), H5189233C (MN69358), H5189234C (MN69147), H5189235C (MN68769), H5189236C (MN68294), H5189237C (MN66600), H5189240C (MN65512), H5189241C (MN63195), H5189243C (MN62912), H5189244C (MN62879), H5189246C (MN57121), H5189247C (MN77042), and H5189249C (MN58824). The following complaints were also UNSUBSTANTIATED: H5189224C (MN74951) however, a related deficiency was cited at F812. 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a call light was	F 558	R24 was provided with the call light. R24 care plan was reviewed and updated to	1/18/22

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 12/16/2021

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 558	Continued From page 2 accessible and within reach for 1 of 1 resident (R24). Findings include: R24's quarterly Minimum Data Set (MDS) dated 9/23/21, indicated R24 was cognitively intact. R24 had a diagnosis of hemiplegia (paralysis of one side of the body). R24's 2/3/20, care plan dated indicated staff were to encourage R24 to use the call light. R24's Fall Risk Assessment dated 7/8/20, indicated a high risk for falls with a history of 1-2 falls in the previous three months. During observation on 12/10/21, at 12:36 p.m. R24 was sitting in a bedside chair with her call light out of reach, attached to the railing of her bed. Observation and interview on 12/10/21, at 12:55 p.m. with registered nurse (RN)-A of R24's room identified R24 was to use her call light to get help. The call light should be closer to R24. When interviewed on 12/10, 21, at 12:56 p.m. nursing assistant (NA-C) indicated R24 used her call light to get assistance. R24 could not reach her call light where it was on the bed and for safety it should be next to R24. Observation and interview on 12/14/21 at 9:54 a.m., of R24 identified she was once more sitting in her bedside chair with her call light out of reach, lying on the floor beside her bed. R24 indicated she was unable to reach the call light and would have to holler out to get help if needed.	F 558	include keeping call light within reach. All other resident care plans were reviewed and updated as needed. Facility staff were in-serviced on the answering call light policy and procedure with focus on keeping the call light within reach of the resident. DON and/or designee will be responsible for compliance Audits on call light placement frequency will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audits will be reviewed by the DON and Administrator or designees, audit results will be brought to QAPI for review and recommendations. Compliance 1/18/2022	

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 12/16/2021

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 558	Continued From page 3 Observation and interview on 12/14/21, at 10:03 a.m., with registered nurse (RN)-F in R24's room identified R24's call light was not within reach. When interviewed on 12/14/21, at 11:02 a.m. family member (FM-F) indicated R24's call light was often looped on the bed rail and not within reach if R24 was in her chair. When interviewed on 12/16/21, at 11:26 a.m. director of nurses (DON) indicated call lights should be within reach. Review of the 8/5/21, Answering Call Light Policy identified when a resident was in bed or seated in the chair the call light should be within reach.	F 558		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R30) was appropriately supervised to prevent falls. R30's admission, Minimum Data Set (MDS) dated 10/14/21, indicated R30 had moderate cognitive deficits. R30 required total assistance of 2 staff	F 689	R30 fall incident was reviewed and the root cause identified. R 30 had a medication adjustment as a result of this review. R 30□s care plan was reviewed and care plan intervention updated. All other resident care plans were reviewed and updated as needed. Facility staff were in-serviced on the fall	1/18/22

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 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4 for bed mobility, transfers, and toileting, and extensive assistance of 1 staff for dressing, eating, and personal hygiene. R30 was on hospice. R30 had a history of displaced fracture of the right shoulder, dementia, anxiety, bilateral osteoarthritis of the knees, and low back pain. R30's Care Area Assessment (CAA) indicated R30 triggered for falls related to balance problems. R30 was unsteady when moving from a seated to standing position, while turning around, while walking, during surface-to-surface transfers, and while sitting. R30 was a high risk for falls related to dementia, incontinence, limited mobility, and psychotropic and opioid medication use. R30 was on hospice and was expected to decline in his overall status. R30 was forgetful and his needs should have been anticipated. R30's 10/8/21, Fall Risk assessment dated indicated R30 was a high risk for falls due to intermittent confusion, an inability to stand without support, and taking medications known to increase the risk for falls. Review of R30's 12/13/21, video surveillance tape of the fall events with the director of nursing (DON) identified although the video surveillance times were inaccurate and not set to current time, the events were recorded as follows. At: 1) 10:32 a.m. R30 was wheeled in his Broda chair into the second-floor day room by trained medical assistant (TMA)-B. R30 was left by TMA-B to sit approximately 2 feet away from a table with the back of his chair towards the nurse's station. R30 was on camera facing out the window where his front was easily seen on video. 2) 10:52 a.m. R30 began to move around, looking from side to side and reaching out for the table. 3) 11:04 a.m. R30 sat forward in his chair and	F 689	and fall risk, managing policy and procedure with focus on resident centered approaches to managing falls and fall risk, and monitoring subsequent falls and fall risk. DON and/or designee will be responsible for compliance Audits on managing falls and fall risk frequency will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audits will be reviewed by the Administrator and audit results will be brought to QAPI for review and recommendations. Compliance 1/18/2022	

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 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5	F 689		

attempted to reach for the table.
4) 11:12 a.m. R30 stood up on his Broda chair foot-stand and reached for the table, became unstable and sat back down.
5) 11:21 a.m. R30 reached for the table and attempted unsuccessfully to stand.
6) 11:29 a.m. R30 attempted to stand up twice then sat back down.
7) 11:34 a.m. R30 attempted to stand up then sat back down.
8) 11:37 a.m. R30 stood up on his Broda chair foot-stand, reached for the table, took a cross-step to the right and fell onto the ground next to his chair.
At no time during any of the above-mentioned video surveillance were staff seen as to provide appropriate supervision as no staff were seen on camera either walking by the day room or within the immediate vicinity of the day room. R30 had been left unattended for over 1 hour.

During an observation and interview on 12/13/21, at 12:26 p.m., with R30 and multiple staff immediately after R30's fall identified R30 was lying on his right side on the floor of the day room on the second floor, next to his Broda chair. Activities coordinator (AC)-A stated she found R30 unattended on the floor moments prior and was unsure how "long" he had been there. R30 reported his elbow hurt and he had hit his head "a little bit". Registered nurse (RN)-E stated R30 had told her he "stood up." Nursing assistant (NA)-B stated R30 "always attempted" to climb out of his bed and chair. RN-E noted R30 was a high fall risk because he often tried to get out of his chair. R30 was uninjured from his fall and required no medical care by a physician.

R30's progress notes identified on:

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 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6	F 689		

1) 12/3/21, at 6:14 p.m. indicated R30 was moving around and trying to get out of his Broda chair (a specific brand of wheelchair with a high back, extra padding, and a full footrest). At 7:00 p.m. R30 was observed removing his socks and brief while in the day room.
2) 12/13/21, at 2:40 p.m. indicated R30 was found on the floor next to his Broda chair in the day room with a skin tear 0.5 cm round on his elbow. R30 was confused and unable to recall events except to say he "stood up."

R30's current, undated care plan indicated R30 had a communication deficit related to dementia. Interventions included anticipating R30's needs and being conscious of R30's position in groups, activities, and dining to promote proper communication with others. R30 was a high risk for falls and staff were to anticipate his needs, keep the call light within reach, and answering the resident's request for assistance promptly. There was no mention staff were identified R30 had previous attempts to get out of his chair without staff assistance and would require increased supervision.

During an interview on 12/13/21, at 3:43 p.m. family member (FM)-K stated she was surprised R30 had fallen only once after admission as R30 would turn himself around and often tried to get out of bed without staff assistance.

During an interview on 12/16/21, at 9:33 a.m. HCM-M, who was currently R30's hospice case manager, stated HCM-L notified him of R30's fall the day after it happened. HCM-M stated R30 had multiple falls prior to admission and that was the reason for use of the Broda chair. HCM-M further stated R30 would not be cognizant enough to use

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 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7 a call light if he needed assistance with transferring or toileting, leading R30 to attempt to self-transfer. During an interview on 12/16/21, at 10:47 a.m. the director of nursing (DON) identified she agreed R30 was a risk for falls. R30 was not to have been left unsupervised or have staff near him when he was not in bed. Review of the 7/10/12, Hospice Nursing Facility Services Agreement contract identified the facility was to ensure the hospice patient was free from accidents and injury. The facility and hospice group shall communicate regularly and as needed for each hospice patient and the facility shall immediately report any change in condition of the hospice patient and must not make any modifications to the plan of care without first consulting the hospice group. There was no mention the facility could add additional interventions as needed to keep a resident safe while in the care of the facility.	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		1/18/22

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 12/16/2021

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 761	Continued From page 8 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of 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 record review, the facility failed to secure medications and/or syringes from unauthorized access on 2 of 2 units (TCU and the quarantined unit) . Findings include: During a continuous observation on 12/13/21, from 9:58 a.m. to 10:18 a.m. on the third floor quarantined unit, a basket containing more than two dozen lancets (an auto-inject needle used for capillary blood sampling) and other finger-sticking supplies, an unopened box of 100 lancets were sitting on top of a treatment cart. Across the hall, approximately four feet away, was an unlocked treatment cart with tuberculin syringes in the top drawer. No staff were present. -From 10:00 a.m. to 10:11 a.m. dietary staff passed through area with food cart four times and speech therapy passed by the area twice. -At 10:10 a.m. to 10:12 a.m. housekeeping parked cleaning cart in front of treatment cart with lancets. -At 10:18 a.m. carts remained unlocked, and	F 761	Medications and syringes were secured. Facility staff were in-serviced on Storage of medication policy and procedure with focus on item #1. DON and/or designee will be responsible for compliance. Audits on securing medications and syringes from unauthorized access frequency will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audits will be reviewed by the Administrator and audit results will be brought to QAPI for review and recommendations. Compliance 1/18/2022	

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 12/16/2021

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 761	Continued From page 9	F 761		

lancets remained on top of cart.

During an observation on 12/13/21, at 10:23 a.m. the treatment cart on the third-floor, transitional care unit (TCU) was found unlocked with an opened, brown cardboard box, nearly full of tuberculin syringes on top. No nursing staff were present. Physical Therapy (PT) was ambulating a resident in the hallway. At 10:29 a.m. housekeeping entered area to clean. At 10:30 a.m. licensed registered nurse (LPN)-B grabbed a handful of syringes from the box and walked down the hall away from the treatment cart and his medication cart.

During an interview on 12/13/21, at 12:15 p.m. registered nurse (RN)-H stated the lancets on the cart in the quarantined unit should have been locked up in the cart or in the medication room and the cart should have been locked so no one could access the syringes.

During an interview on 12/13/21, at 12:21 p.m. LPN-B in TCU stated the syringes should have been locked up in the treatment cart and not left unsecured on top.

During an observation and interview on 12/14/21, at 11:04 a.m. a basket of lancets was on top of the central, third-floor medication cart with no nursing staff present. Housekeeping and an outside vendor carrying a mattress were in the hallway. At 11:05 a.m. RN-A came out of a resident room and stated the supplies were kept on top of the medication cart during med pass. RN-A stated there was no concern for safety or contamination because the lancets were new and had not been used. RN-A further stated they were considered a sharp and were required to be

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 12/16/2021

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 761	Continued From page 10 disposed of in a sharps container after use. During an observation and interview on 12/15/21, at 4:25 p.m. a bucket containing lancets was on top of the second-floor east medication cart and two tuberculin syringes were sitting behind the bucket. No nursing staff was present. Housekeeping was in the hallway with their cleaning cart and a family was heard visiting a resident in a nearby room. LPN-A was at the nurse's station, unaware of the items on top of the cart. LPN-A stated the other LPN, who was in charge of that cart and contents, was on break and LPN-A did not have keys to the cart. LPN-A stated the syringes should have been locked in the medication cart so no one could grab them. LPN-A then walked back to the nurse's station without securing the sharps. LPN-A was asked to secure the sharps and he did so by locking them in his own medication cart. During an observation and interview on 12/14/21, at 10:35 a.m. a bucket of stock medications was on top of the second-floor north medication cart. No nursing staff were present and a resident was in her wheelchair in the hallway and had potential access to the medications. The bucket contained: -Senna (a laxative) -Senna Plus (a laxative plus stool softener) -Gas relief -Vitamin D3 -Aspirin -Magnesium oxide x 2 -Tylenol -Tylenol extended release -Vitamin C -Baby Aspirin -Multi-Vitamin -Ferrous Gluconate x 2 (Iron)	F 761		

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 12/16/2021

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 761	Continued From page 11 -Omeprazole (proton pump inhibitor for acid reflux) Interview on 12/14/21 at 10:46 a.m., with RN-D identified she came out of a resident room and stated the above mentioned medications were "too far away" for the residents to be able to reach them. RN-D stated there was only 1 resident who was "grabby" who lived on the south unit and she "kept an eye out" for him. During an interview on 12/16/21, at 3:13 p.m. the director of nursing (DON) stated medication and medication supplies were to be secured away from unauthorized person access. Stock medications were to be locked in the medication cart in between use. Review of the 12/20/21, Storage of Medications policy identified drugs used in the facility were to be in locked compartments and only staff authorized were to have access. Nursing staff were responsible for maintaining safe medication storage and compartments such as carts and drawers. Those storage areas were to be locked when not in use and unlocked carts were not to be left unattended.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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	F 812		1/18/22

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 12/16/2021

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 812	Continued From page 12 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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure milk was stored and then served served at a safe temperatures below 41 degrees Fahrenheit. This had the potential to affect the 33 of 139 residents who ate meals in their rooms on the second floor. Findings include: The U.S. Food & Drug Administration (FDA) Food Code dated 2017, indicated improper holding temperatures as one of five major risk factors repeatedly identified as contributing to food born illness. The Code also indicated temperature for safety food shall be maintained at 41 degrees Fahrenheit or less. The Code further indicated "bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature 'Danger Zone' of 5 [degrees Celsius] C to 57 degrees C (41 F to 135 F) too long. Up to a point, the rate of growth increases with an increase in temperature within this zone." During an observation on 12/14/21, at 8:15 a.m. a white plastic tub containing three half gallons of	F 812	Milk was disposed of and new beverages were poured for service to residents. Facility staff were in-serviced on food safety and sanitation policy and procedure with focus on item 4, food storage and to discard milk based beverages after each meal. Dining Services Director and/or designee will be responsible for compliance. Audits on food safety and sanitation frequency will begin 2x week for 2 weeks, weekly x 3 weeks then monthly to ensure sustained compliance. Audits will be reviewed by Administrator and audit results will be brought to QAPI for review and recommendations. Compliance 1/18/2022	

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 12/16/2021

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 812	Continued From page 13	F 812		

milk, pitchers of apple and orange juices, and a pint of Lactaid milk was sitting on the second-floor kitchen serving counter. The tub had approximately two inches of water with some ice in the bottom. No meal service was occurring and no staff or residents were in the kitchen or dining area.

During an observation and interview on 12/14/21, at 11:10 a.m. two half gallons of milk were sitting in a white plastic tub with approximately two inches of cold water and no ice, in the second-floor kitchen. A third half gallon of milk that was approximately one quarter full, was sitting out on the serving counter with the lid off. Trained medical assistant (TMA)-A and nursing assistant (NA)-A were pouring milk into plastic cups from the open milk container and placing them on trays to be delivered to resident rooms. At 11:17 a.m. chef (CH)-A and dietary manager (DM) noted the temperature of the three milk cartons to be: 56.8 degrees Fahrenheit, 67.3 degrees Fahrenheit, and 70.7 degrees Fahrenheit. A cup of milk from a prepared resident tray was also temp'd at 60.2 degrees Fahrenheit. The DM stated milk temperature should be below 40 degrees Fahrenheit to avoid the residents getting a food born illness. Dietary server (DS)-A stated the white plastic tray of milk and juice being served, was already in the kitchen service area when he started his shift at 9:00 a.m. and at no point had he returned the drinks to the refrigerator prior to lunch service.

During an interview on 12/14/21, at 1:55 p.m. registered dietician (RD)-C stated milk should have been kept below 40 degrees Fahrenheit to avoid causing a food born illness in residents.

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 12/16/2021

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 812	Continued From page 14 During an interview on 12/14/21, at 2:16 p.m. the DM stated DS's were supposed to return unused milk to the main kitchen on the first floor, after breakfast around 9:00 a.m. DS should go back to the main, first floor kitchen just before 10:00 a.m., put the milk and juices in a white tub and cover it with approximately 1.5 to 2 inches of ice. The DM also stated the half gallon cartons of milk should be placed in the white tub with the lid on in between use and not placed on the counter without a lid. The DM further stated the DS did not follow the proper procedure to ensure the milk was kept at safe serving temperatures. The facility Food Safety and Sanitation policy dated 2017, indicated refrigerated food was to be stored at or below 41 degrees Fahrenheit and perishable items should be refrigerated when they are not being used. The facility Food Safety-Director of Food and Nutrition Services Responsibility policy dated 2017, indicated the director of food and nutrition services would ensure all refrigerated foods would be stored and handled properly and conduct regular inspections to ensure proper food handling. The policy also indicated all Hazard Analysis and Critical Control Point (HACCP) procedures would be followed.	F 812		