



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 27, 2023

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

RE: CCN: 245189
Cycle Start Date: September 28, 2023

Dear Administrator:

On October 23, 2023, 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.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 12, 2023

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

RE: CCN: 245189
Cycle Start Date: September 28, 2023

Dear Administrator:

On September 28, 2023, 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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.

Southview Acres Healthcare Center

October 12, 2023

Page 3

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 December 28, 2023, (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 March 28, 2024, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

Southview Acres Healthcare Center

October 12, 2023

Page 4

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.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads "Lori Hagen". The signature is written in a cursive style with a large initial "L" and "H".

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 12, 2023

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

Re: Event ID: YOPK11

Dear Administrator:

The above facility survey was completed on September 28, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

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

PRINTED: 10/18/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245189	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/28/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>On 9/27/23 through 9/28/23, 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.</p> <p>The following complaints were reviewed. H51895724C(MN96886)</p> <p>The following complaints were reviewed. H51896246C(MN95812). with a deficiency issued at F610.</p> <p>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.</p> <p>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.</p>	F 000		
F 610 SS=D	<p>Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p>	F 610		10/18/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 10/18/2023
--	-------	-----------------------------

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245189	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/28/2023	
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 610	<p>Continued From page 1</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>The facility failed to thoroughly investigate a resident's ability to consent to consensual sexual activities for 2 of 2 residents (R3 and R4) reviewed for an allegation of abuse when the residents had impaired cognition, impaired communication, and required extensive assistance for all their activities of daily living (ADLS.)</p> <p>The findings included:</p> <p>R3's care plan dated 2/24/23 indicated she had an elevated risk for falling.</p> <p>R3's care plan dated 5/30/23, indicated R3 needed assistance from staff to meet all of her "emotional, intellectual, physical, and social needs" related to her mental and physical disabilities.</p> <p>R3's care plan dated 6/22/23, indicated R3 had impaired; cognition, thought process, and the ability to make decisions. Her SLUMS (test to evaluate memory, attention span, orientation, level of awareness and the ability to organize thoughts and regulate emotions) test score was 7 out of 30 indicating she had dementia (loss of ability; to think, remember, reason, or control emotions.) Based on their findings staff would</p>	F 610	<p>F 610</p> <p>A risk management incident was created for R3 and R4. Both risk management incidents were completed and thoroughly investigated. There have been no further incidents from R3 and R4. All other like residents were assessed and there were no reports of consensual sexual activities noted. Future residents will be thoroughly assessed for the capacity to consent, guardians (if necessary) will be informed, and risk vs benefits explained. The IDT team will be in-serviced on the Abuse Reporting and Investigation policy and procedure with emphasis on item #7 that the resident record will be reviewed, the MD/NP response reviewed to thoroughly determine the cognitive status of the resident and to document if resident has the capacity to consent. In addition, the resident involved and/or guardian(s) will complete the Capacity to Consent Form prior to residents engaging in consensual activities. Social Service Director and/or designee is responsible for compliance. Audits on abuse allegations being thoroughly investigated will begin weekly x 2 weeks then monthly to ensure sustained</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245189	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/28/2023
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 610	<p>Continued From page 2</p> <p>utilize yes or no questions to identify her needs.</p> <p>R3's quarterly Minimum Data Set (MDS) dated 7/7/23, indicated R3 had moderate cognitive impairment, required the extensive assistance from one staff to move in bed, transfer, dress, go to the bathroom, and complete hygiene needs. Her medical history included paralysis on her right side, an inability to communicate her thoughts, pseudobulbar affect (uncontrolled exaggerated outburst of crying or laughter,) and depression. In addition, she was always incontinent of urine and stool.</p> <p>R3's facility investigation file dated 8/4/23, indicated R3 told staff R4 blew kisses towards her and "touched her breast and vagina" on top of her clothing. R4 stated, he touched R3, and she touched his "penis." In addition, the report indicated both residents "enjoyed it, wanted it, not harmed." Staff were instructed to check on both residents every 30 minutes.</p> <p>Registered nurse (RN)-A's nursing note dated 8/4/23, indicated R3 told the staff she was touched by R4. R4 touched her breast and genital area above her clothing on 7/28/23. RN-A was unable to reach R3's guardian (G)-A. She contacted the local police department who conducted interviews with R3 and R4. Both residents were placed on hourly checks. RN-A indicated R3 had a cognitive impairment and aphasia (an inability to express thoughts and understand verbal communication) but she was able to communicate her needs and make her choices known.</p> <p>RN-A's nursing note dated 8/7/23, indicated R3's G-A was notified about the recent interaction</p>	F 610	<p>compliance.</p> <p>All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendation.</p> <p>Compliance: 10/18/2023</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245189	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/28/2023
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 610	<p>Continued From page 3</p> <p>between R3 and R4. RN-A documented G-A did not have any concerns regarding the 7/28/23 encounter.</p> <p>Licensed and independent social worker (LICSW)-A's assessment note dated 8/8/23, indicated R3 felt safe after the incident on 7/28/23, when R4 and herself were touching each other in a sexual manor. R3 assured her she would tell the facility staff if someone touched her against her wishes and she felt unsafe.</p> <p>R3's interdisciplinary team meeting (IDT) note dated 8/9/23, indicated R3 admitted to touching and being touched by R4. Staff did not observe any changes in R3's normal activities or behavior. Guardian (G)-A said it was consensual and okay to continue their relationship.</p> <p>R3's physician assistant (PA)-A assessment note dated 8/11/23, indicated R3 did not understand why such behavior was inappropriate. In addition, PA-A indicated R3 had poor "insight and judgment."</p> <p>R3's care plan dated 9/12/23, indicated R3 had touched female staff inappropriately .</p> <p>R3's medical provider MD-A note dated 9/14/23, indicated R3 had aphasia consequently she only had the capacity to use simple words to communicate her basic needs.</p> <p>R4's care plan dated 5/30/23, indicated he required partial assistance from staff to meet his "emotional, intellectual, physical, and social need related to cognitive, physical deficits."</p> <p>R4's care plan dated 6/21/23, indicated he had</p>	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245189	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/28/2023
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 610	<p>Continued From page 4</p> <p>impaired cognition and thought process related to his previous stroke, encephalopathy (brain damage causing altered mental status, confusion, and altered personality) and impaired communication.</p> <p>R4's quarterly MDS dated 8/14/23, indicated he had moderate cognitive impairment, required the extensive assistance from one staff to move in bed, transfer, eat, dress, go to the bathroom, and complete hygiene needs. He was always incontinent of urine and stool, and he took antidepressant medication. He had chronic respiratory failure, urinary tract infections, altered mental status, depression, lung, heart, kidney, and prostate disease, and one side of his body was paralyzed after a stroke.</p> <p>Nursing progress note dated 8/4/23 at 3:24 p.m., indicated R4 touched another resident's breast and genitalia on top of her clothing. He told the staff she "liked the touching and was not harmed." He stated R3 touched his penis. The local police department was notified and investigated the incident. He was placed on 30-minute checks later to be decreased to hourly checks. R4 was not fully oriented and had altered mental status related to a previous stroke and encephalopathy. He was able to move himself independently around the unit in his wheelchair and was able to make his needs known to the staff.</p> <p>R4's IDT meeting note dated 8/9/23, regarding the sexual relationship with R3 determined the event was consensual by both parties, His son was contacted and approved further consensual sexual relationships. He was offered a psychological assessment and care but declined.</p>	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245189	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/28/2023
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 610	<p>Continued From page 5</p> <p>During interview on 9/28/23 at 2:45 p.m., NP-B stated she was notified by the facility about the event on 7/28/23, with R4 and R3. NP-B stated she did not feel R4 had the mental capacity to consent to a consensual sexual relationship.</p> <p>During interview on 9/28/23 at 9:30 a.m., G-A stated she was updated by the facility regarding R3's sexual encounter with R4 on 7/28/23. The staff told her on 8/9/23, R3 and R4 were in the dayroom, and they were touching each other's private parts. She was taken back by what happened because the situation had never occurred before. G-A asked R3 if what happened on 7/28/23, with R4 was consensual and she said yes. Her intention was to find out if R3 agreed to the touching not to approve future sexual relationships with R4 or other residents.</p> <p>During interview on 9/28/23 at 10:26 a.m., nurse practitioner NP-A stated, she was notified on 8/5/23, regarding the 7/28/23 incident. She felt the facility's conclusion R3 gave consensual consent was "inappropriate" because R3 had an inability to express thoughts and understand verbal communication.</p> <p>During observation on 9/28/23 at 11:15 a.m. R3 was sitting in her wheelchair. Anytime staff spoke to her, she would scream aloud "love you" and laugh. The staff pushed R3's wheelchair into the day room by a table with other residents. The nurse approached R3 and offered her Tylenol for pain. R3 yelled out "no." The nurse told R3 the Tylenol was for pain and R3 responded "no." As the nurse began to walk away R3 yelled out "love you" and moved towards her. The nurse offered the Tylenol again and R3 nodded yes and took</p>	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245189	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/28/2023
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 610	<p>Continued From page 6</p> <p>the Tylenol without further conversation.</p> <p>During interview on 9/28/23 at 12:00 p.m., nursing assistant (NA)-B stated R3 was always happy and would scream aloud. NA-A added R3 would get frustrated when she was unable to communicate her needs with the staff. NA-A stated interactions with R3 was like playing a game of "Charades." NA-B stated she did not think R3 had the ability to make a consensual decision. In the past NA-B observed R3 being "flirtatious" with male residents, but primarily stayed close to her female core group of friends in the day room and during activities.</p> <p>During interview on 9/28/23 at 12:11 p.m., RN-A stated R3 and R4 were in a back room off the main dining room during an unknown time after dinner. RN-A stated R3 was vague about the details but indicated R4 touched her. R3 was unable to verbally explain what happened but pointed to her breast and said "yeah". When RN-A interviewed R4 he stated R3 touched him all over and both enjoyed the encounter. RN-A clarified R3 only responded to her questions with a yes or a no and pointed to her body. In the past R3 was witnessed saying "love you" to R4 and he said "love you" back. RN-A wondered if R4 believed R3 was giving him the "green light" during those interactions. RN-A concluded the incident was a one off because R3 primarily stayed in the day room with her core group, and R4 rarely left his room or ate a meal in the dining room. Both of their rooms were on opposite sides of the unit. After constant monitoring over one week the facility concluded there was no harm or adverse reactions observed and the incident was consensual. She informed R3's guardian and R4's son and they both approved it was okay for</p>	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245189	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/28/2023
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 610	<p>Continued From page 7</p> <p>them to have a consensual sexual relationship. She was unsure whether the facility had a policy regarding consensual sexual relationships, but she did notify the police. Lastly, she stated she should have communicated her findings in R3 and R4's care plan and Kardex. RN-A provided a current nursing assistant Kardex for both R3 and R4 to review.</p> <p>R3's care plan/Kardex received on 9/28/23 at 12:20 p.m. indicated she had an "inappropriate" behavior and encourage staff to help her find a separate way to express her emotions. The Kardex did not indicate if R3 had the ability to consent to a consensual sexual relationship.</p> <p>R4's care plan/Kardex received on 9/28/23 at 12:20 p.m. did not indicate he had inappropriate behaviors or whether he was able to consent to consensual relationship.</p> <p>During interview on 9/28/23 at 12:33 p.m., Social Worker (SW)-B stated she was aware of the incident between R3 and R4 on 7/28/23, but she was not involved with determining if both residents had the capacity to fully consent to a sexual relationship. She had never witnessed any type of relationship or encounters between R3 and R4 before.</p> <p>During interview on 9/28/23 at 2:56 p.m. the facility's corporate office regional nurse (CORN)-A stated they did not have or need to document if two residents had the capacity for a sexual relationship and the resident specific risk and benefits in doing so. She stated nursing staff should have documented the findings in both R3 and R4's care plan/Kardex. The administrator stated it would be exceedingly difficult to</p>	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245189	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/28/2023
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 610	<p>Continued From page 8</p> <p>determine the resident specific risk and benefits to have a safe consensual sexual relationship. The assistant director of nursing (ADON)-A stated the facility investigated the 7/28/23, incident, contacted the police, asked both residents if they agreed to the sexual relationship, and notified R3's guardian and R4's son who approved the relationship. They felt if GA-A did not fully understand what they asked her, it was not their fault. RN-A provided updated care plan/Kardex for each resident.</p> <p>R3's care plan/Kardex dated 9/28/23 received at 3:00 p.m., indicated her guardian approved future "sexual relations with other residents."</p> <p>R4's care plan/Kardex dated 9/28/23 received at 3:00 p.m., indicated his son was "okay with sexual relations with other residents."</p> <p>The facility policy, Identifying Sexual Abuse and Capacity to Consent dated 10/18/22, indicated the consent to have a consensual sexual relationship is not valid if the residents lack the capacity to consent. Non-consensual sexual contact is when the resident "lacks the cognitive ability to consent." The facility will investigate if the resident had the capacity to consent. First the staff will keep the residents safe, then report the allegation to the local police department and the state. Next the facility would complete a "thorough" investigation and determine if the resident had the capacity to consent. Finally, the investigation findings would be documented. A capacity to consent meant the residents had the ability to understand "potential" consequences associated with having a sexual relationship.</p> <p>The facility policy, Abuse Investigation and</p>	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245189	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/28/2023
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 610	Continued From page 9 Reporting dated 7/12/22, indicated the role of an investigator included a thorough documentation review plus analyzing the activities leading up to the event. The investigator would interview the resident, staff, witnesses, and other residents living at the facility. Lastly, the investigator would contact the medical provider and discuss the resident's current cognitive level, and medical condition.	F 610		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 9/27/23 through 9/28/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure</p> <p>The following complaints were reviewed with no</p>	2 000		
-------	---	-------	--	--

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

10/18/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/28/2023
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 1</p> <p>deficiency issued. H51895724C(MN96886). H51896246C(MN95812).</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.</p> <p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		