Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 14, 2025

Administrator
Southview Acres HealthCare Center
2000 OAKDALE AVENUE
WEST SAINT PAUL, MN 55118

RE: CCN: 245189
Cycle Start Date: June 26, 2025

Dear Administrator:

On July 29, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 10, 2025

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

RE: CCN: 245189
Cycle Start Date: June 26, 2025

Dear Administrator:

On June 26, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by September 26, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 26, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections

488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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July 10, 2025

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

Re: Event ID: MIG111

Dear Administrator:

The above facility survey was completed on June 26, 2025 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 feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245189	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southview Acres HealthCare Center	2000 OAKDALE AVENUE , WEST SAINT PAUL, Minnesota, 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
F0000	INITIAL COMMENTS On 6/24/25 through 6/26/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H51897694C (MN00114006) As a result of the investigation, a deficiency was cited at F610. 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.	F0000		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation	F0610	R1 risk management incident for 6/18/2025 will be reopened and comprehensively reviewed by the IDT and further action will be taken if indicated. R1's care plan review and revised as necessary to ensure safety and appropriateness of care. As of this writing, there are no allegations of abuse reported at this time. Future allegation of abuse will be reported timely, thoroughly investigated and documented The IDT team will be in-serviced on the abuse reporting policy with emphasis on item 6 and 7(h)(i)# which directs the administrator on thoroughly interviewing employees on all three shifts, interviewing residents and visitors and that any employee who has been accused of resident abuse is placed on leave with no resident	07/18/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further 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.

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

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F0610 SS = D	Continued from page 1 is in progress. §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: Based on interviews and document review the facility failed to thoroughly investigate an allegation of abuse for 1 of 3 residents (R1) reviewed for abuse. In addition, the facility failed to protect 1 of 3 residents (R1) while the investigation was conducted. Findings include: On 6/17/25 at 5:47 p.m., a Brief Interview for Mental Status (BIMS) was conducted. Summary score was 12 and indicated moderate impaired cognition. R1's care plan dated 6/24/25, identified at risk for falls related to restless leg syndrome (RLS), CVA, altered mental status, and lace of safety awareness. Noted to have uncontrolled movement of legs that pulled him out of bed. Staff were instructed to assist him with ambulation, transfers, utilizing therapy recommendations and encourage him to spend time in central location for increased supervision. He made statements and accusations which were unsubstantiated, unfounded and untrue. Family and friend reported this was not new behavior. Staff were directed to provide refused care at an alternative time per his preference, listen to his accusations/complaints and validate feelings behind them, investigate and evaluate resident statements, ensure safety of resident and others, refer to psychiatric evaluation, and establish boundaries and limits with two-person entry for cares. He had an identified behavior problem (placed self on floor) despite analysis of the five whys, and his perception of time was not real. Staff were directed to observe behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, situations, and document behavior and potential causes. His safety was at risk and there was a potential for abuse due to current use of medications and need for assistance with cares and mobility. Staff	F0610	Continued from page 1 contact until the investigation is complete. Social Services is responsible for compliance. Audits on thoroughly investigating allegations of abuse, including resident interviews if needed and if staff are suspended that they return after the OHFC report is submitted will be 1x week for x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 07/18/2025	

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F0610 SS = D	Continued from page 2 were directed to keep him safe and free from abuse by being removed from potentially dangerous situations. Review of Nursing assistant (NA) behavior monitoring and interventions from 6/6/25 through 6/19/25 identified: -6/6/25, 6/7/25, and 6/8/25, no behaviors observed for all shifts. -6/9/25 no behaviors noted on day or evening shift. During night shift at 4:43 a.m. he was noted to be physically aggressive (PA) towards others, repetitive motions (RM), and verbalized persistent beliefs (VP). Interventions: provided calm environment(CE), behaviors worsened (W), and reapproached (RA), unchanged response. -6/10/25 no behaviors noted on day or night shift. During evening shift at 8:10 p.m. he was noted to be agitated (A), accusing of others (AO), PA, redirected (RD), RA, behaviors better (B). -6/11/25, no behaviors observed for all shifts. -6/12/25 no behaviors noted on day and night shift. During the evening shift at 10:59 p.m. behaviors identified were AO, and cursing at others (CO). Interventions identified RD and behaviors B. -6/13/25, 6/14/25, and 6/15/25, no behaviors noted on day or evening shift. 6/13/25 at 9:42 p.m., 6/14/25 at 7:44 p.m., and 6/15/25 at 6:59 p.m. he expressed frustration/anger at others (FR), and PA. Interventions provided: RD, RA, and behaviors B. -6/16/25, 6/17/25, 6/18/25, and 6/19/25, no behaviors observed for all shifts. R1's progress notes from 6/6/25, 6/7/25, 6/11/25, and 6/18/25, identified: -On 6/6/25 at 3:06 p.m., resident was very rude to writer, licensed practical nurse (LPN)-A. He requested	F0610		

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F0610 SS = D	Continued from page 3 a cigarette to go outside for a smoke, writer informed him that he would need to wait until his friend arrived before the cigarette could be provided. Resident became upset and told the writer to stay quiet . . . he would call the police and report writer to the social worker . . . clinical manager and social worker were contacted to speak with resident . . . Later approached resident to check blood glucose level. Resident responded he did not want her to touch him and refused . . . at 6:20 p.m. resident approached LPN-A and apologized . . . -Late entry on 6/7/25 at 3:50 p.m., resident yelled and screamed at nurse . . . resident verbalized he was being abused by then nurses because they were not allowing him access to his cigarettes and lighter . . . reminded of facility smoking policy and safety precautions . . . not effective, agitated with social worker and called friend to assist him off grounds to smoke. -Late entry on 6/7/25 at 12:35 a.m., to clarify nurse (LPN-A) was kneeling behind resident by bedside. He elbowed nurse twice and then rolled onto the floor . . . call light used to ask two NAs to help resident off floor . . . -On 6/7/25 at 5:39 a.m., writer (LPN-A) found resident intentionally had rolled out of bed at 12:35 a.m., rushed to his room to prevent him from rolling out of bed and asked what are you doing? Resident pushed writer and stated leave me alone, do not touch me . . . place call light on and called two NAs to help transfer him back to bed. . . no injury. -No documentation in progress notes by nursing staff on 6/11/25. Seen by NP for follow up visit at 8:34 a.m. no concerns. -On 6/18/25 at 8:24 a.m. resident seen at bedside by nurse practitioner; staff notified her of accusations from him. He reported nurse knee [sic] on neck and then slapped face. Discussed incident with resident and he would not provide details but did respond saying he was safe. Denied injuries or pain, no sign of trauma, no bruising, erythema and seated in wheelchair. Police officer (PO) incident report dated 6/18/25 at 1:02 p.m., identified dispatch advised a male caller	F0610		

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F0610 SS = D	Continued from page 4 claimed elder abuse and wanted to speak to a police officer. Upon arrival, PO contacted R1 and he informed him around midnight he had fallen out of bed activated call light for assistance, staff walked by his room, ignored him on the ground asking for help. He was assisted up into his wheelchair where he was left for around three hours. Sometime on 6/11/25, between 3:30 a.m. and 4:00 a.m. he had fallen out of bed and an unknown head nurse came (described her) into his room, placed her knee down next to his head, struck him in the head once, and slapped him with her hand. . . he was upset staff were not responding to assist him in a timely manner and did not want to get anybody into trouble. PO was flagged down by a staff member, facility administrator, and informed him R1 had frequently filed false accusations against staff members and frequently upset when his care plan was changed. Administrator indicated he was aware of the alleged incident last week of a nurse in the transitional care unit (TCU) struck him in the head with her shin, placed her knee on his head, tapped him on his head, and told him to settle down. . . PO was informed by administrator that this incident was handled internally, due to a second staff member being present denying these accusations. With new information on a different date, the separate claims of a staff member kneeling next to him and slapped him (while by themselves) administrator informed PO he would request a further investigation into his claims. Email sent to PO by facility administrator on 6/18/25 at 4:08 p.m., identified the complaint received today has been investigated by our team and is nearly identical to an earlier episode that R1 shared while on our TCU (downstairs). When interviewed R1 stated that the head nurse kneed him with her shin, placed her knee on his head, tapped him on his head, and was told to settle down. The earlier instance referenced was very similar in that a head nurse was mentioned and said they placed their knee on his neck. Because we had an eyewitness able to clearly state that what he described did not happen we did not submit a Vulnerable Adult (VA) report to the state. Resident care plan was updated to include that type of behavior. However, with today's allegation and not having an eyewitness available and additional abuse alleged, we submitted a VA to Minnesota Department of Health (MDH) and the staff member in question was suspended as protocol. Facility investigation report dated 6/20/25 at 5:15 p.m., identified R1 reported whoever was in charge that night placed her shins on the side of my head, tapped	F0610		

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F0610 SS = D	Continued from page 5 me on the forehead and told me to settle down. He pushed perpetrator away and stated that was abuse. He also stated he thought they were all pissed off for the many times he had fallen. This was a mirrored event of what happened on 6/6/25 . . . After interviewing staff on Oakdale Avenue (2nd floor) they indicated they had not seen physical confrontation between staff and resident. He had a history of making false allegation, being untruthful, and threatening to call the police. He called police frequently (5 to 6 times since admission) to this facility . . . his sister reported he had same behavior at the Veterans Affairs (VA) . . . allegation was not verified. Interview on 6/24/25 at 11:55 a.m., R1 stated he was admitted to facility at the end of April 2025 and lived on the 1st floor TCU. He had moved him up to 2nd floor about one week ago. While he lived on TCU, was assaulted by a female staff charge nurse, and told by facility staff he lied about the incident. He had restless leg syndrome, once it started, he rolled from side to side and fell out of bed. It was later in the night, the charge nurse walked by his room while he laid on the floor and did not stop at first. When the nurse entered his room, she was angry with him, placed her shin bones against his head, he told her to stop that hurts and she tapped him on his head. He grabbed her calf muscle, pushed her away and said, "that hurts", she yelled at him to stop rolling. He told her to get out of his room, she was the only one in there at the time. Interview on 6/25/25 at 9:18 a.m., LPN-A stated on the evening of 6/6/25 she randomly checked on R1 and saw he rolled out of bed. She rushed into the room alone, his legs were on the floor and upper body remained on the bed. Per her reflex, she tried to support him with her thigh against his back, called for help, and he elbowed her with his left hand. She placed call light on and he told her to leave the room. By the time staff arrived to his room he had fallen to the floor. She did not use force, he swore at her, and she stayed out of his room after that. Two NAs assisted him back to bed. She was taken off work for one shift on 6/18/25, returned on 6/19/25, and had not taken care of him since. Interview on 6/25/25 at 11:00 a.m., licensed social worker (LSW) stated three staff nurses working on TCU were interviewed and asked two questions:	F0610		

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F0610 SS = D	Continued from page 6 -are there any known behaviors regarding R1 and, - did they noticed anything strange with the resident. LSW stated nursing staff were not asked about abuse, witnessed or alleged. The allegation made by R1 indicated LPN-A placed her shins on the side of his head, her thigh on the side of his body to help prevent the fall, could have been different but seemed similar. R1 was able to describe what the head/charge nurse looked like. LPN-A was suspended on 6/18/25, and the interview was completed. LPN-A was allowed to return to work on 6/19/25, night shift prior to completion of the investigation which was on 6/20/25. Our policy identified she should have been placed on leave without resident contact until the investigation was completed. It would have been important to be off work because there was an allegation of abuse, the residents are vulnerable, would want to be confident that abuse did not continue to happen, and all residents were safe. She stated would have been important to have completed interviews with those residents on TCU at minimum where he lived when it was identified the alleged incident may have taken place, and had only an explanation of what the staff nurse looked like. The facility policy was not followed. Interview on 6/25/25 at 11:30 a.m., designee social worker (DSW) stated he had completed the interviews with the residents on 2nd floor, where R1 currently lived. No residents and very few staff were interviewed on TCU where the allegation happened. He added it would have been important to follow the facility policy/protocol investigation process and interviews should have been completed with residents that lived in the TCU and staff that worked there to hear from everyone. Interview on 6/25/25 at 1:29 p.m., registered nurse (RN)-A stated R1 rolled out of bed frequently due to RLS and was able to make his needs known. There were days we were unable to predict when he would roll off his bed, had fragile skin, had some bruising, and skins tears. He heard how R1 had arguments with staff but had not heard or witnessed any physical abuse. He was not interviewed regarding any concerns/incidents with staff. Interview on 6/25/26 at 1:52 p.m., nursing assistant	F0610		

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F0610 SS = D	Continued from page 7 (NA)-B stated she had worked at facility for six months usually upstairs but had floated down to TCU occasionally. She was familiar with R1 and provided cares for him. She had not been interviewed by anyone regarding concerns. Interview on 6/25/25 at 2:09 p.m., NA-C stated she had worked at facility for approximately 3 years, usually the day shift on TCU. She was familiar with R1 and provided cares for him. She had not been interviewed by anyone regarding concerns or incidents related to abuse. During an interview on 6/25/25 at 3:04 p.m., clinical coordinator (RN)-C stated there were no residents and only a few nurses interviewed on TCU. Residents were interviewed on 2nd floor where he currently lived. It would have been important to interview residents and staff on TCU, he was unable to provide staff name but described what she looked like. The allegation was abuse and we would have wanted the residents kept safe. He described her as the hit nurse at night. The social worker would have been the one to identify who should be interviewed. She interviewed LPN-A with the SW but that was the only staff she had interviewed. The resident interviews could have possibly provided information to confirm if they had experienced anything similar as what R1 reported. During an interview on 6/26/25 at 10:01 a.m., director of nursing (DON) stated R1's perception of time was not accurate and his cognition was intact. Interviews where not completed with staff NAs or residents on the TCU unit. Interviews with residents and staff are useful to help determine the outcome in the allegation of abuse, in addition to R1's interview. She stated LPN-A worked on 6/17/25, placed on suspension on 6/18/25, and then allowed to come back to work the night shift of 6/19/25 (11:00 p.m.-7:00 a.m.). R1 was moved from TCU on 6/16/25, and LPN-A had not worked with him since the allegation. DON stated a witness was identified during the previous allegation, unsure of which staff it was, and unable to locate the interview. During the investigation, in hindsight, the residents' on TCU should have technically been interviewed prior to the completion of the investigation and prior to LPN-A's return to work. It would have been important to separate residents from a potential perpetrator. During an interview on 6/26/25 at 1:20 p.m.,	F0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245189	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0610 SS = D	Continued from page 8 administrator stated when there was an allegation of physical abuse the alleged perpetrator (AP) would be suspended from work until the investigation had been completed and determined whether it occurred or not. Staff and residents were interviewed after an allegation of abuse to help identify if there was a pattern. Our goal was to make sure the residents are safe and protect the staff if residents were physical with them. Facility policy Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating dated 2023, identified all reports of resident abuse (including injuries of unknown origin), neglect, exploitation or theft/misappropriation of resident property are reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of all investigation are documented and reported. The administrator ensures that the resident and person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. The individuals conducting the investigation as a minimum interviews any witness to the incident, interviews staff members on all shifts who have had contact with the resident during the period of the alleged incident, interviews other residents to whom the accused employee provides cares or services to and documents the investigation completely and thoroughly.	F0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/26/2025**

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20000	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 6/24/25 through 6/26/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was reviewed. H51897694C (MN00114006). No licensing orders were issued.	20000		

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/26/2025**

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. 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.	20000		