DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 7, 2026

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

RE: CCN: 245189

Cycle Start Date: March 12, 2026

Dear Administrator:

On April 6, 2026, we notified you a remedy was imposed. On April 28, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 15, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective April 21, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 6, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 21, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 15, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

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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May 7, 2026

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

Re: Reinspection Results
Event ID: 1E3F00-H2 and 22C023-H2

Dear Administrator:

On April 20, 2026 and April 28, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on March 12, 2026 and March 26, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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April 6, 2026

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

RE: CCN: 245189
Cycle Start Date: March 12, 2026

Dear Administrator:

On March 30, 2026, we informed you that we may impose enforcement remedies.

On March 26, 2026, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), 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 location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 21, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 21, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 21, 2026.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 $13,343, 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 April 21, 2026, 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 April 21, 2026. 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:

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
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 - 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 September 12, 2026 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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

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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April 6, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 22C023-H1

Dear Administrator:

The above facility survey was completed on March 26, 2026 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 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:

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/26/2026**

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
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 3/26/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		04/15/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/26/2026**

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
20000	Continued from page 1 The following complaints were reviewed. H51899400C (Intake 2962443) with a licensing order issued at 0625, 0875. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the 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.	20000		
20625	Clinical Record Contents; In General CFR(s): MN Rule 4658.0450 Subp. 1 A-P Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of	20625	Corrected	04/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/26/2026**

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Southview Acres HealthCare Center	**2000 OAKDALE AVENUE , WEST SAINT PAUL, Minnesota, 55118**

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20625	Continued from page 2 admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and	20625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/26/2026**

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20625	Continued from page 3 P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to maintain medical records that are accurately documented for five of six residents (R1, R2, R3, R5, and R6) when their weekly bath audits did not indicate wounds that they were being treated for. Findings include: R1's minimum data set (MDS) dated 3/17/26 indicated R1 was admitted to the facility on 7/11/25 with a primary diagnosis of unspecified dementia with other behavioral disturbances. R1's additional diagnoses included vascular dementia without behavioral disturbance, acquired absence of left leg above knee, acquired absence of right leg above knee, vascular disease, and reduced mobility. R1 had no ulcers, wounds, or skin problems. R1's weekly bath audit dated 3/17/26 indicated under the title Skin Status i.e., bruises, skin tears, rashes, redness, blisters, or any other open areas. R1 had non-tender lymph nodes observed on right upper hip. R1's weekly bath audit dated 3/24/26 indicated under the title Skin Status i.e., bruises, skin tears, rashes, redness, blisters, or any other open areas. R1 did not have any new or old skin alterations. R1's wound documentation indicated R1 was receiving treatment on his stage four pressure ulcer/injury on his right above the knee amputation from 3/23/26 through 3/25/26. R2's MDS dated 3/4/26 indicated R2 was admitted to the facility on 10/18/24 with a primary diagnosis of paraplegia. R2's additional diagnoses included pressure-induced deep tissue damage of left hip, pressure ulcer of other site, pressure ulcer of other site stage three, pressure ulcer of right ankle stage three, pressure ulcer of left hip stage four, pressure	20625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/26/2026**

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20625	Continued from page 4 ulcer of right heel stage four, and pressure ulcer of left heel stage three. R2's weekly bath audits dated 1/7/26, 1/14/26, 1/21/26, 1/28/26, 2/4/26, 2/18/26, 2/25/26, 3/4/26, 3/11/26, and 3/18/26 indicated R2 did not have any new or old skin alterations. R2's wound documentation indicated R2 was receiving treatment for his open lesion on his right Achillies on 1/5/26, 1/12/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/7/26, 3/9/26, 3/16/26, and 3/23/26. R2 was receiving treatment for stage three pressure ulcers on his right heel on 1/5/26, 1/12/26, 1/19/26, 1/26/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/7/26, 3/9/26, 3/16/26, and 3/23/26. R2 was receiving treatment for his left shin wound on 3/9/26 and 3/23/26. R2 was receiving treatment for his stage three right medial calf wound on 1/5/26, 1/12/26, 1/19/26, 1/26/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/7/26, 3/9/26, and 3/23/26. R2 was receiving treatment for his unstageable right medial malleolus wound on 1/5/26, 1/12/26, 1/19/26, 1/26/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/7/26, 3/9/26, 3/16/26, and 3/23/26. R2 was receiving treatment for his stage three left heel pressure ulcer/injury on 1/5/26, 1/12/26, 1/19/26, 1/26/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/7/26, 3/9/26, 3/16/26, 3/21/26, and 3/23/26. R3's MDS dated 1/7/26 indicated R3 was admitted to the facility on 4/26/24 with a primary diagnosis of malignant neoplasm of prostate. R3's additional diagnoses included pressure ulcer of left heel stage three, pressure ulcer of other site stage three, pressure ulcer of other site unspecified stage, and pressure ulcer of sacral region stage four. R3's weekly bath audit dated 3/25/26 indicated R3 did not have any new or old skin alterations. R3's wound document indicated R3 received treatment to his right heel pressure ulcer/injury on 3/23/26. R5's MDS dated 12/24/25 indicated R5 was admitted to the facility on 6/25/25 with a primary diagnosis of type two diabetes mellitus with other skin ulcers. R5's additional diagnoses included pressure-induced deep tissue damage of left ankle, pressure ulcer of left heel stage four, and non-pressure chronic ulcer of	20625		

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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
20625	Continued from page 5 other part of left foot with other specified severity. R5's weekly bath audits dated 2/10/26, 2/17/26, 3/3/26, 3/17/26, and 3/24/26 indicated R5 did not have any new or old skin alterations. R5's wound documentation indicated R5 received treatment for his diabetic ulcer on left heel on 2/9/26, 2/23/26, 3/2/26, 3/16/26, 3/23/26, and 3/25/26. R5 received treatment for his diabetic ulcer on left medial calf on 2/23/26, 3/2/26, 3/9/26, 3/16/29, 3/23/26, and 3/25/26. R6's MDS dated 2/27/26 indicated R6 was admitted to the facility on 8/20/25 with a primary diagnosis of end stage renal disease. R6's additional diagnosis included peripheral vascular disease. R6's weekly bath audits dated 1/8/26, 1/15/26, 1/22/26, 2/5/26, 2/12/26, 2/19/26, and 3/12/26 indicated R6 did not have any new or old skin alterations. R6's wound documentation indicated R6 received treatment for his unstageable pressure ulcer/injury to his left dorsum second digit on 1/26/26, 2/2/26, 2/16/26, 2/23/26, 3/2/26, 3/9/26, 3/16/26, and 3/23/26. R6 received treatment for an abscess on his coccyx on 1/5/26, 1/12/26, 1/26/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/2/26, 3/9/26, 3/16/26, and 3/23/26. During an interview on 3/26/26 at 11:24 a.m., registered nurse (RN)-A stated she was unsure why R1's skin alterations were not documented on the weekly bath audit on 3/24/26. RN-A stated that education would be provided to the nurse who completed the bath audit. During an interview on 3/26/26 at 1:10 p.m., licensed practical nurse (LPN)-B stated when a resident takes a bath, the nursing aid will alert the nurse who will complete the skin audit. The nurse will check for redness, swelling, and open wounds. If there are any new skin alterations, she would note that on the weekly bath audit. If there are no new skin alterations, LPN-B stated she would chart "nothing new". During an interview on 3/26/26 at 1:12 p.m., RN-C	20625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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20625	Continued from page 6 stated when a resident is taking a bath, they would complete the weekly skin audit. If RN-C found a new wound or skin alteration, she would make a report in risk management. During an interview on 3/26/26 at 1:33 p.m., LPN-C stated when she is completing a skin audit on a resident, she is looking for any marks under the breasts, under the arms, groin, buttocks, and feet. If there is a new wound, she would document that in the weekly bath audit. During an interview on 3/26/26 at 1:40 p.m., LPN-E stated when a resident is taking a bath, they would complete the resident's weekly bath audit. LPN-E stated she would document what she found on the resident's skin on the weekly bath audit. During an interview on 3/26/26 at 1:46 p.m., LPN-D stated the nurse will check a resident's skin when the resident is taking a nap. If the resident has a new or old wound, LPN-D would document that on the weekly bath audit. During an interview on 3/26/26 at 4:22 p.m., RN-D stated any new or existing wound should be noted on the weekly bath audit. RN-D stated before "three months ago" staff was instructed not to put the existing wounds on the weekly bath audits, but nurses are now expected to note both new and existing wounds on the weekly bath audit. A policy on weekly bath audits was requested and none was received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	20625		
20875	Adequate and Proper Nursing Care; Monitor TPR CFR(s): MN Rule 4658.0520 Subp. 2 I	20875	Corrected	04/15/2026

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20875	Continued from page 7 Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to treat a wound when first discovered for one of one resident (R1) when the facility staff identified a wound on 3/16/26, applied a dressing, and then notified the provider and initiated treatment on 3/23/26. Findings include: R1’s provider encounter note dated 3/4/26 did not include a skin assessment of R1. R1’s minimum data set (MDS) dated 3/17/26 indicated R1 was admitted to the facility on 7/11/25 with a primary diagnosis of unspecified dementia with other behavioral disturbances. R1’s additional diagnoses included vascular dementia without behavioral disturbance, acquired absence of left leg above knee, acquired absence of right leg above knee, vascular disease, and reduced mobility. R1 had no ulcers, wounds, or skin problems. R1’s weekly bath audit dated 3/17/26 indicated under the title Skin Status i.e., bruises, skin tears, rashes, redness, blisters, or any other open areas. R1 had non-tender lymph nodes observed on right upper hip. R1’s progress note dated 3/23/26 indicated R1 had a new skin issue located right above his knee on his amputation site. This wound was staged at a stage four pressure ulcer/injury with full thickness skin and tissue loss. The progress note indicated R1’s bone was exposed and had erythema/edema. The wound was measured 1.56 centimeters (cm) in length and 1.64 cm wide. The wound had 29% granulation and 80% slough. There was moderate amount of serosanguineous exudate. The progress note indicated the dressing was intake and there was 26%-75% dressing saturation.	20875		

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20875	Continued from page 8 R1's provider order dated 3/23/26 indicated registered nurse (RN)-B called NP indicating R1 had an ulcer on his right stump and there was slough at wound bed and exposed bone. NP ordered doxycycline monohydrate 100 milligrams (mg) by mouth twice a day for seven days for an infection of the skin and/or soft tissue. R1's skin issues assessment dated 3/23/26 indicated R1 had a new would to his above the knee amputation stump. The wound measured 1.56 by 1.64, and the wound bed is 20% granulation and 80% slough with a small area of exposed bone. There was erythema to the peri wound with no order or pain. The assessment indicated R1's wound was a stage four pressure ulcer/injury with full-thickness skin and tissue loss. R1's dressing appeared intact, and the dressing had moderate amount of saturation. R1's progress note dated 3/23/26 indicated R1 had a new would to his above the knee amputation stump. The wound measured 1.56 by 1.64, and the wound bed is 20% granulation and 80% slough with a small area of exposed bone. There was erythema to the peri wound with no order or pain. The nurse practitioner (NP) was updated and reviewed the picture, and determined the wound was a diabetic ulcer with R1's peripheral vascular disease and severe protein-calorie malnutrition as contributing factors. NP ordered doxycycline for possible cellulitis due to the erythema. Wound order treatment consisted of UrgoTul Ag, calcium alginate, and a bordered foam dressing. R1's guardian was updated. R1's medication admission record (MAR) dated 3/23/26 indicated R1 would receive Doxycycline Monohydrate 100 mg by mouth twice a day for infection of the skin and/or soft tissue for seven days. This order was marked completed on 3/23/26 at 8:00 p.m., 3/24/26 at 9:00 a.m. and 8:00 p.m., 3/25/26 at 9:00 a.m. and 8:00 p.m., and 3/26/26 at 9:00 a.m. R1's MAR dated 3/24/26 indicated the nurse would provide wound treatment to right stump daily and as needed by cleansing with Vashe and let moistened gauze remain on would bed for 3 minutes, apply skin prep to peri wound, place UrgoTul on wound bed followed by calcium alginate and cover with a bordered form dressing. This order was marked and completed on 3/24/26 and 3/25/26.	20875		

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20875	Continued from page 9 R1's weekly bath audit dated 3/24/26 under the title Skin Status R1 had no new skin alterations i.e., bruises, skin tears, rashes, redness, blisters, or any other open areas. During an interview on 3/26/26 at 8:30 a.m., guardian-A indicated he was notified about the wound during a care conference on 3/23/26. Guardian-A indicated there was a progress note in R1's medical records between 3/21/26 and 3/22/26 about R1's wound. During an interview on 3/26/26 at 9:34 a.m., licensed practical nurse (LPN)-A stated if she saw a resident had a wound, she would let the provider know right away and get treatment orders. During an interview on 3/26/26 at 11:24 a.m., RN-B stated she received a note on 3/22/26 that R1 had a wound on his right stump and RN-B had assessed it on 3/23/26. After RN-B assessed the wound, RN-B had a care conference with guardian-A. During an interview on 3/26/26 at 1:10 p.m., LPN-B stated she had discovered the wound on 3/23/26. LPN-B was providing cares for R1 when she saw the wound dressing on his stump, the dressing was dated 3/16/26, but there were no initials to indicate who applied the dressing. LPN-B asked other nurses working if they had noticed the wound on R1's stump and none of the other nurses knew about the wound. During an interview on 3/26/26 at 1:12 p.m., RN-C stated she worked the overnight shift on 3/16/26, 3/17/26, 3/18/26, and 3/19/26. RN-C stated she did not notice a wound on R1's stump during any of her shifts. If she found a resident had a wound, she would contact the provider and then use the house standing orders for treatment while she waited for treatment from the provider. During an interview on 3/26/26 at 1:33 p.m., LPN-C stated she worked the evening shift on 3/16/26, 3/17/26, 3/18/26, and 3/20/26 and she did not notice a wound on R1's stump during any of her shifts. If she discovered a wound on a resident, she would assess the wound, then contact the provider for treatment and update the family.	20875		

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20875	Continued from page 10 During an interview on 3/26/26 at 1:40 p.m., LPN-E stated she worked with R1 on the evening of 3/16/26. LPN-E stated she did not see any dressing applied to R1's stump. During an interview on 3/26/26 at 1:46 p.m., LPN-D stated she worked with R1 on 3/16/26 during the day shift and she did not see R1's wound on 3/16/26. LPN-D stated she did recall seeing a band-aid with a date on his stump during her shift but could not recall the date noted. During an interview on 3/26/26 at 2:00 p.m., LPN-A stated she did not see R1's wound when she worked on 3/16/26 because she was not looking for a wound. LPN-A stated she did not know how or who applied R1's dressing on 3/16/26. During an interview on 3/26/26 at 2:15 p.m., RN-B stated when she assessed R1's wound on 3/23/26, there had already been a dressing on the wound. RN-B did not recall where the dressing came from or who applied dressing on the wound. RN-B stated the dressing had a date of 3/16/26 but did not have initials of the staff member who applied the dressing. During an interview on 3/26/26 at 4:22 p.m., RN-D stated it is the expectation that when a nurse discovers a wound, the nurse would notify the provider the day the wound was found and then treat the wound based on what the provider orders. RN-D stated the wound should be assessed at the duration the provider orders. The facility's Standing Orders for Skilled Nursing Facility revised in 2025 indicated if the facility wound management process was not available staff should assess all wounds and dressings daily and change dressings every three days and as needed. The Standing Orders indicated the nurse could treat the wound with normal saline or non-cytotoxic wound cleaner and cover with a non-adherent dressing and secure appropriate cover dressing while avoiding tape to the skin. Staff should notify the provider the next business day of a new wound or injury. SUGGESTED METHOD OF CORRECTION: The Director of Nursing	20875		

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20875	Continued from page 11 or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	20875		

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 03/26/2026

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F0000	INITIAL COMMENTS On 3/26/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H51899400C (Intake 2962443) with a deficiency issued at F684, and F842. 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		04/15/2026
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to treat a wound when first discovered for one of one resident (R1) when the facility staff identified a wound on 3/16/26, applied a dressing, and then notified the provider and initiated treatment on	F0684	R1 had a skin check performed, a comprehensive skin review completed, a risk management incident initiated to identify root cause and a new Braden assessment completed. R1 orders and care plan were reviewed and updated as needed. Provider and guardian were made aware of skin status. All current residents that score high risk for skin breakdown, their most recent weekly bath audit and skin was assessed, orders and care plan reviewed and updated as needed. Future residents who admit and have wounds develop will have new wound orders initiated timely and provider and resident representative notified. Licensed nurses and nurse aides will be in-serviced on Weekly Skin Care Policy with focus on items 6 and 7 that full visual inspection of the skin will occur along with any new or ineffectively managed skin problems will be referred to the appropriate health professional. In addition, licensed nurses will be in-serviced on the Standing Orders for Nursing Facilities that permit the nurse to initiate treatment	04/15/2026

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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F0684 SS = G	Continued from page 1 3/23/26. Findings include: R1's provider encounter note dated 3/4/26 did not include a skin assessment of R1. R1's minimum data set (MDS) dated 3/17/26 indicated R1 was admitted to the facility on 7/11/25 with a primary diagnosis of unspecified dementia with other behavioral disturbances. R1's additional diagnoses included vascular dementia without behavioral disturbance, acquired absence of left leg above knee, acquired absence of right leg above knee, vascular disease, and reduced mobility. R1 had no ulcers, wounds, or skin problems. R1's weekly bath audit dated 3/17/26 indicated under the title Skin Status i.e., bruises, skin tears, rashes, redness, blisters, or any other open areas. R1 had non-tender lymph nodes observed on right upper hip. R1's progress note dated 3/23/26 indicated R1 had a new skin issue located right above his knee on his amputation site. This wound was staged at a stage four pressure ulcer/injury with full thickness skin and tissue loss. The progress note indicated R1's bone was exposed and had erythema/edema. The wound was measured 1.56 centimeters (cm) in length and 1.64 cm wide. The wound had 29% granulation and 80% slough. There was moderate amount of serosanguineous exudate. The progress note indicated the dressing was intake and there was 26%-75% dressing saturation. R1's provider order dated 3/23/26 indicated registered nurse (RN)-B called NP indicating R1 had an ulcer on his right stump and there was slough at wound bed and exposed bone. NP ordered doxycycline monohydrate 100 milligrams (mg) by mouth twice a day for seven days for an infection of the skin and/or soft tissue. R1's skin issues assessment dated 3/23/26 indicated R1 had a new would to his above the knee amputation stump. The wound measured 1.56 by 1.64, and the wound bed is 20% granulation and 80% slough with a small area of exposed bone. There was erythema to the peri wound with no order or pain. The assessment indicated R1's wound was a stage four pressure ulcer/injury with	F0684	Continued from page 1 orders for wounds and that the provider must be notified the next business day. Director of Nursing and/or designee is responsible for compliance. Audits on weekly bath audits for new and existing wound identification, new wound treatment order and provider/resident representative notification to begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 04/15/2026	

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F0684 SS = G	Continued from page 2 full-thickness skin and tissue loss. R1's dressing appeared intact, and the dressing had moderate amount of saturation. R1's progress note dated 3/23/26 indicated R1 had a new would to his above the knee amputation stump. The wound measured 1.56 by 1.64, and the wound bed is 20% granulation and 80% slough with a small area of exposed bone. There was erythema to the peri wound with no order or pain. The nurse practitioner (NP) was updated and reviewed the picture, and determined the wound was a diabetic ulcer with R1's peripheral vascular disease and severe protein-calorie malnutrition as contributing factors. NP ordered doxycycline for possible cellulitis due to the erythema. Wound order treatment consisted of UrgoTul Ag, calcium alginate, and a bordered foam dressing. R1's guardian was updated. R1's medication admission record (MAR) dated 3/23/26 indicated R1 would receive Doxycycline Monohydrate 100 mg by mouth twice a day for infection of the skin and/or soft tissue for seven days. This order was marked completed on 3/23/26 at 8:00 p.m., 3/24/26 at 9:00 a.m. and 8:00 p.m., 3/25/26 at 9:00 a.m. and 8:00 p.m., and 3/26/26 at 9:00 a.m. R1's MAR dated 3/24/26 indicated the nurse would provide wound treatment to right stump daily and as needed by cleansing with Vashe and let moistened gauze remain on would bed for 3 minutes, apply skin prep to peri wound, place UrgoTul on wound bed followed by calcium alginate and cover with a bordered form dressing. This order was marked and completed on 3/24/26 and 3/25/26. R1's weekly bath audit dated 3/24/26 under the title Skin Status R1 had no new skin alterations i.e., bruises, skin tears, rashes, redness, blisters, or any other open areas. During an interview on 3/26/26 at 8:30 a.m., guardian-A indicated he was notified about the wound during a care conference on 3/23/26. Guardian-A indicated there was a progress note in R1's medical records between 3/21/26 and 3/22/26 about R1's wound. During an interview on 3/26/26 at 9:34 a.m., licensed practical nurse (LPN)-A stated if she saw a resident	F0684		

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F0684 SS = G	Continued from page 3 had a wound, she would let the provider know right away and get treatment orders. During an interview on 3/26/26 at 11:24 a.m., RN-B stated she received a note on 3/22/26 that R1 had a wound on his right stump and RN-B had assessed it on 3/23/26. After RN-B assessed the wound, RN-B had a care conference with guardian-A. During an interview on 3/26/26 at 1:10 p.m., LPN-B stated she had discovered the wound on 3/23/26. LPN-B was providing cares for R1 when she saw the wound dressing on his stump, the dressing was dated 3/16/26, but there were no initials to indicate who applied the dressing. LPN-B asked other nurses working if they had noticed the wound on R1's stump and none of the other nurses knew about the wound. During an interview on 3/26/26 at 1:12 p.m., RN-C stated she worked the overnight shift on 3/16/26, 3/17/26, 3/18/26, and 3/19/26. RN-C stated she did not notice a wound on R1's stump during any of her shifts. If she found a resident had a wound, she would contact the provider and then use the house standing orders for treatment while she waited for treatment from the provider. During an interview on 3/26/26 at 1:33 p.m., LPN-C stated she worked the evening shift on 3/16/26, 3/17/26, 3/18/26, and 3/20/26 and she did not notice a wound on R1's stump during any of her shifts. If she discovered a wound on a resident, she would assess the wound, then contact the provider for treatment and update the family. During an interview on 3/26/26 at 1:40 p.m., LPN-E stated she worked with R1 on the evening of 3/16/26. LPN-E stated she did not see any dressing applied to R1's stump. During an interview on 3/26/26 at 1:46 p.m., LPN-D stated she worked with R1 on 3/16/26 during the day shift and she did not see R1's wound on 3/16/26. LPN-D stated she did recall seeing a band-aid with a date on his stump during her shift but could not recall the date noted.	F0684		

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F0684 SS = G	Continued from page 4 During an interview on 3/26/26 at 2:00 p.m., LPN-A stated she did not see R1's wound when she worked on 3/16/26 because she was not looking for a wound. LPN-A stated she did not know how or who applied R1's dressing on 3/16/26. During an interview on 3/26/26 at 2:15 p.m., RN-B stated when she assessed R1's wound on 3/23/26, there had already been a dressing on the wound. RN-B did not recall where the dressing came from or who applied dressing on the wound. RN-B stated the dressing had a date of 3/16/26 but did not have initials of the staff member who applied the dressing. During an interview on 3/26/26 at 4:22 p.m., RN-D stated it is the expectation that when a nurse discovers a wound, the nurse would notify the provider the day the wound was found and then treat the wound based on what the provider orders. RN-D stated the wound should be assessed at the duration the provider orders. The facility's Standing Orders for Skilled Nursing Facility revised in 2025 indicated if the facility wound management process was not available staff should assess all wounds and dressings daily and change dressings every three days and as needed. The Standing Orders indicated the nurse could treat the wound with normal saline or non-cytotoxic wound cleaner and cover with a non-adherent dressing and secure appropriate cover dressing while avoiding tape to the skin. Staff should notify the provider the next business day of a new wound or injury.	F0684		
F0842 SS = E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records.	F0842	R1, R2, R3, R5 had a skin check performed and R1, R2, R3, R5 skin concerns were recorded on the weekly bath audit. R6 has since been discharged from the facility. All current and future residents will continue to have a weekly bath audit completed and the weekly audit will include new and existing wounds per facility policy. Licensed nurses and nurse aides will be in-serviced on Weekly Skin Care Policy updated 04/10/2026 with focus on items 6 and 7 that full visual inspection of the skin will occur along with any new or ineffectively managed skin problems will be referred to the appropriate health professional. New and old skin concerns will be documented on the weekly bath audit. Director of Nursing and/or designee is responsible for compliance.	04/15/2026

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F0842 SS = E	Continued from page 5 §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F0842	Continued from page 5 Audits on weekly bath audits for new and existing wound identification, new wound treatment order and provider/resident representative notification to begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 04/15/2026	

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F0842 SS = E	Continued from page 6 §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to maintain medical records that are accurately documented for five of six residents (R1, R2, R3, R5, and R6) when their weekly bath audits did not indicate wounds that they were being treated for. Findings include: R1's minimum data set (MDS) dated 3/17/26 indicated R1 was admitted to the facility on 7/11/25 with a primary diagnosis of unspecified dementia with other behavioral disturbances. R1's additional diagnoses included vascular dementia without behavioral disturbance, acquired absence of left leg above knee, acquired absence of right leg above knee, vascular disease, and reduced mobility. R1 had no ulcers, wounds, or skin problems. R1's weekly bath audit dated 3/17/26 indicated under the title Skin Status i.e., bruises, skin tears, rashes, redness, blisters, or any other open areas. R1 had non-tender lymph nodes observed on right upper hip. R1's weekly bath audit dated 3/24/26 indicated under the title Skin Status i.e., bruises, skin tears, rashes, redness, blisters, or any other open areas. R1 did not have any new or old skin alterations.	F0842		

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F0842 SS = E	Continued from page 7 R1's wound documentation indicated R1 was receiving treatment on his stage four pressure ulcer/injury on his right above the knee amputation from 3/23/26 through 3/25/26. R2's MDS dated 3/4/26 indicated R2 was admitted to the facility on 10/18/24 with a primary diagnosis of paraplegia. R2's additional diagnoses included pressure-induced deep tissue damage of left hip, pressure ulcer of other site, pressure ulcer of other site stage three, pressure ulcer of right ankle stage three, pressure ulcer of left hip stage four, pressure ulcer of right heel stage four, and pressure ulcer of left heel stage three. R2's weekly bath audits dated 1/7/26, 1/14/26, 1/21/26, 1/28/26, 2/4/26, 2/18/26, 2/25/26, 3/4/26, 3/11/26, and 3/18/26 indicated R2 did not have any new or old skin alterations. R2's wound documentation indicated R2 was receiving treatment for his open lesion on his right Achillies on 1/5/26, 1/12/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/7/26, 3/9/26, 3/16/26, and 3/23/26. R2 was receiving treatment for stage three pressure ulcers on his right heel on 1/5/26, 1/12/26, 1/19/26, 1/26/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/7/26, 3/9/26, 3/16/26, and 3/23/26. R2 was receiving treatment for his left shin wound on 3/9/26 and 3/23/26. R2 was receiving treatment for his stage three right medial calf wound on 1/5/26, 1/12/26, 1/19/26, 1/26/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/7/26, 3/9/26, and 3/23/26. R2 was receiving treatment for his unstageable right medial malleolus wound on 1/5/26, 1/12/26, 1/19/26, 1/26/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/7/26, 3/9/26, 3/16/26, and 3/23/26. R2 was receiving treatment for his stage three left heel pressure ulcer/injury on 1/5/26, 1/12/26, 1/19/26, 1/26/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/7/26, 3/9/26, 3/16/26, 3/21/26, and 3/23/26. R3's MDS dated 1/7/26 indicated R3 was admitted to the facility on 4/26/24 with a primary diagnosis of malignant neoplasm of prostate. R3's additional diagnoses included pressure ulcer of left heel stage three, pressure ulcer of other site stage three, pressure ulcer of other site unspecified stage, and pressure ulcer of sacral region stage four. R3's weekly bath audit dated 3/25/26 indicated R3 did	F0842		

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F0842 SS = E	Continued from page 8 not have any new or old skin alterations. R3's wound document indicated R3 received treatment to his right heel pressure ulcer/injury on 3/23/26. R5's MDS dated 12/24/25 indicated R5 was admitted to the facility on 6/25/25 with a primary diagnosis of type two diabetes mellitus with other skin ulcers. R5's additional diagnoses included pressure-induced deep tissue damage of left ankle, pressure ulcer of left heel stage four, and non-pressure chronic ulcer of other part of left foot with other specified severity. R5's weekly bath audits dated 2/10/26, 2/17/26, 3/3/26, 3/17/26, and 3/24/26 indicated R5 did not have any new or old skin alterations. R5's wound documentation indicated R5 received treatment for his diabetic ulcer on left heel on 2/9/26, 2/23/26, 3/2/26, 3/16/26, 3/23/26, and 3/25/26. R5 received treatment for his diabetic ulcer on left medial calf on 2/23/26, 3/2/26, 3/9/26, 3/16/29, 3/23/26, and 3/25/26. R6's MDS dated 2/27/26 indicated R6 was admitted to the facility on 8/20/25 with a primary diagnosis of end stage renal disease. R6's additional diagnosis included peripheral vascular disease. R6's weekly bath audits dated 1/8/26, 1/15/26, 1/22/26, 2/5/26, 2/12/26, 2/19/26, and 3/12/26 indicated R6 did not have any new or old skin alterations. R6's wound documentation indicated R6 received treatment for his unstageable pressure ulcer/injury to his left dorsum second digit on 1/26/26, 2/2/26, 2/16/26, 2/23/26, 3/2/26, 3/9/26, 3/16/26, and 3/23/26. R6 received treatment for an abscess on his coccyx on 1/5/26, 1/12/26, 1/26/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/2/26, 3/9/26, 3/16/26, and 3/23/26. During an interview on 3/26/26 at 11:24 a.m., registered nurse (RN)-A stated she was unsure why R1's skin alterations were not documented on the weekly bath audit on 3/24/26. RN-A stated that education would be provided to the nurse who completed the bath audit.	F0842		

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F0842 SS = E	Continued from page 9 During an interview on 3/26/26 at 1:10 p.m., licensed practical nurse (LPN)-B stated when a resident takes a bath, the nursing aid will alert the nurse who will complete the skin audit. The nurse will check for redness, swelling, and open wounds. If there are any new skin alterations, she would note that on the weekly bath audit. If there are no new skin alterations, LPN-B stated she would chart “nothing new”. During an interview on 3/26/26 at 1:12 p.m., RN-C stated when a resident is taking a bath, they would complete the weekly skin audit. If RN-C found a new wound or skin alteration, she would make a report in risk management. During an interview on 3/26/26 at 1:33 p.m., LPN-C stated when she is completing a skin audit on a resident, she is looking for any marks under the breasts, under the arms, groin, buttocks, and feet. If there is a new wound, she would document that in the weekly bath audit. During an interview on 3/26/26 at 1:40 p.m., LPN-E stated when a resident is taking a bath, they would complete the resident’s weekly bath audit. LPN-E stated she would document what she found on the resident’s skin on the weekly bath audit. During an interview on 3/26/26 at 1:46 p.m., LPN-D stated the nurse will check a resident’s skin when the resident is taking a nap. If the resident has a new or old wound, LPN-D would document that on the weekly bath audit. During an interview on 3/26/26 at 4:22 p.m., RN-D stated any new or existing wound should be noted on the weekly bath audit. RN-D stated before “three months ago” staff was instructed not to put the existing wounds on the weekly bath audits, but nurses are now expected to note both new and existing wounds on the weekly bath audit. A policy on weekly bath audits was requested and none was received.	F0842		