DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2024

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

RE: CCN: 245189
Cycle Start Date: November 30, 2023

Dear Administrator:

On January 26, 2024, we notified you a remedy was imposed. On February 27, 2024, 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 February 9, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 10, 2024, did not go into effect. (42 CFR 488.417 (b))

In our letter of January 26, 2024, 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 13, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 9, 2024, 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 Therefore, the NATCEP prohibition is rescinded.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.

Correction of the Life Safety Code deficiency(ies) cited under K222, K271, K341 at the time of the November 30, 2023 standard survey, has not yet been verified. Your plan of correction for this deficiency / these deficiencies, including your request for a temporary waiver with a date of completion of November 29, 2024, has been approved. Failure to come into substantial compliance with this deficiency / these deficiencies by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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March 7, 2024

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

Re: Reinspection Results
Event ID: GL5912

Dear Administrator:

On February 27, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 30, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered

February 20, 2024

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

RE: CCN: 245189
Cycle Start Date: November 30, 2024

Dear Administrator:

On December 13, 2023, we informed you that we may impose enforcement remedies.

On February 7, 2024, 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 February 10, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 10, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 10, 2024.

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 $11,995, 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 February 10, 2024, 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 February 10, 2024. 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, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - 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 May 30, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services

determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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

Steven.Delich@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 Steven.Delich@cms.hhs.gov.

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division

P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered
February 20, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: GL5911

Dear Administrator:

The above facility was surveyed on February 5, 2024 through February 7, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245189	A. BUILDING _____ B. WING _____	C 02/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/5/24 to 2/7/24, 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. H51899468C (MN00100382, MN00100471, MN00100469) with a deficiency issued at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to comprehensively assess a resident,	F 689	F 689 R 1 discharged from the facility on	2/9/24

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

Electronically Signed | 02/21/2024

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

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F 689	Continued From page 1 reevaluate interventions, or make changes to a care plan after a fall for one of three residents (R1) reviewed for falls when R1 had a previous fall with a history of letting go of the EZ stand lift grab bars. R1's recent fall resulted in fractures of her neck and back. Findings include: R1's admission record printed 2/5/24 stated R1 was initially admitted to the facility on 2/9/23 to the transitional care unit (TCU) and was transferred to long-term care (LTC) on 3/16/23 with a diagnosis of weakness and anemia. Additional diagnoses included multiple sclerosis, morbid obesity, tremors, gastric ulcers, and mild cognitive impairment. R1's care plan revised on 8/1/23 indicated R1 required assistance with activities of daily living (ADLs) due to her diagnosis of multiple sclerosis. One intervention is R1 required extensive assistance by one staff with a front wheel walker and gait belt for transfers during the day and for the evening/bedtime transfer R1 will use an EZ stand lift (An EZ stand lift is a transfer assist device and is designed primarily to transfer residents from chair, wheelchair, toilet, or bed. An EZ stand lift is used when a person can be actively involved in the standing process. There are two straps that should be used during the transferring process: the shin strap and the back harness. The shin strap is applied to the resident's legs to keep the resident's feet on the foot plate or their shins on the shin pad. The back hardness should be placed around the upper body of the resident, so the sides of the harness are between the patient's torso and arm, resting two to three inches below the underarm. This	F 689	1/29/2024. Current residents who use EZ Stand lifts had their lift assessments and care plans were reviewed and updated as needed. From survey exit until present, there has been no falls recorded from an EZ Stand lift. Future residents who fall will have a risk management incident created, a thorough investigation initiated for root cause and a new lift mobility and fall assessment completed and new interventions initiated. Licensed nurses and nurse aides were in-serviced on the EZ Stand Lift use with emphasis on resident requirement to follow instruction and assist in the transfer by bearing some weight and holding on with at least one hand. In addition, the clinical nurse leadership team and therapy staff were in-serviced on Safe Lifting and Movement of Residents Policy. The IDT team will implement a resident-centered fall prevention plan and if resident continue to fall, staff will implement additional or different interventions to try to minimize serious consequences of falling. Audits on utilizing EZ Stand lifts for safe transfers, initiation of lift assessments and interventions, fall and lift care plan review, update of interventions after falls, and lift mobility assessment completion will begin 2x week for 2 weeks, weekly x 4 weeks then monthly to ensure 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: 02/09/2024	

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F 689	Continued From page 2 harness is to ensure resident safety) The care plan stated R1 should wear her bilateral lower extremity ankle foot orthotics (AFOs) (AFO braces are external devices utilized on lower limbs to stabilize the joints to improve gait and physical functioning of the affected lower limb) braces to be in place when transferred or up in her chair. R1's Lift Mobility Status Assessment dated 12/15/23 indicated R1 can walk with no physical assistance, can stand, can pivot, can bear weight on at least one leg, and can grip the EZ stand lift with at least one hand with enough strength to actively participate in the EZ stand lift. The assessment indicated R1 was cooperative and non-combative. R1's Fall Risk Assessment dated 12/15/23 indicated R1 has not had any falls in the past three months and was chair bound and to assist with elimination. The assessment does not indicate how many staff R1 was dependent upon for assistance with elimination. The assessment did not indicate any gait problems but did indicate R1 required the use of assistive devices such as a cane, wheelchair, walker, or furniture. The assessment indicated R1 scored a 12 on the assessment which indicated high risk for falls. R1's quarterly MDS dated 12/16/23 indicated on J1800 that R1 had no falls since her prior MDS assessment on 9/15/23. R1's brief interview for mental status (BIMS) had a score of 11 indicating her cognition was moderately impaired. R1's progress note dated 1/14/24 indicated R1 purposefully let go of the EZ stand lift and slid herself out of the back harness and landed on the	F 689		

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F 689	Continued From page 3 toilet. The progress note did not indicate if the shin strap was used. The note indicated the intervention attempted was to re-educate R1 in order to use the EZ stand lift it required R1 to follow instructions and participate accordingly, otherwise the clinical manager will have to use the mechanical lift (a mechanical lift is a designed assist with transferring residents who can't safely walk or put weight on either leg. When transferring a resident via mechanical lift, a caregiver will use a sling that attaches to the lift. The sling wraps around the resident's high and crosses between the legs and then attaches to the lift). The note indicated the intervention was effective and that R1 stated her transfer mode of preference was with the walker. The note did not identify changes to R1's plan of care. R1's medical record did not identify an incident report for the fall on 1/14/24. R1's social services care conference dated 1/16/24 indicated R1 had a decline in cognition and memory. The care conference notes indicated R1 purposefully slid out of the back harness of the EZ stand lift on 1/14/23 during transfer to the toilet and indicated this was not the first time R1 has done this. The notes indicated staff educated R1 and family that if it happens again, they will have to downgrade to a mechanical lift. The notes indicated staff explained the risk of serious injury if R1 does not participate and follow instructions to use the EZ stand lift when transferring. R1's progress note dated 1/19/23 indicated R1 refused to use the EZ stand lift and the clinical manager offered to help R1 transfer using her walker instead of the EZ stand lift. The clinical	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 4 manager and the NA attempted to assist R1 into a standing position from her wheelchair but R1 was unable to do so regardless of the amount of support provided. The note indicated the clinical manager informed R1 she will need to be transferred using the EZ stand lift and she agreed. R1's incident report dated 1/29/24 indicated R1 let go of the EZ stand lift handles while being transferred from the toilet to her wheelchair and fell on the floor. The incident report indicated R1 refused to let nursing assistant (NA)-D put on the shin strap per protocol and demanded to be transferred via EZ stand lift without the shin strap. The incident report indicated R1 hit her head and complained of serious pain from her mid back to head. The report indicated R1 was transferred off the floor to her bed via mechanical lift and three persons assist. The nurse practitioner (NP) and family was notified, and R1 was sent to the emergency department (ED) for evaluation. The report indicated no injuries observed. The report indicated predisposing physiological factors included impaired memory and incontinence. R1's incident investigation report from 1/29/24 fall indicated R1 had a fall from the EZ stand lift when transferring. The report indicated NA-D was transferring R1 from the toilet back to her bed, NA-D attempted to place the shin strap and the back harness, but R1 demanded the shin strap and the back hardness not be used when in the EZ stand lift. The report indicated while moving the EZ stand lift towards the wheelchair the stand lift wheel got caught with the wheelchair and NA-D decided it was not safe to transfer to the wheelchair and started moving R1 towards the bed. The report indicated R1 stated "let me fall"	F 689		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5 and let go of the EZ stand lift handles and fell backwards through the harness. The report indicated R1 was rubbing her head and stating it hurt. R1 was transferred off the ground using a mechanical lift and the assistance of three staff members to her bed. The report indicated that during that transfer, R1 complained of moderate pain to her mid to upper back. The clinical manager alerted the NP and family that R1 had fallen and received orders to send R1 to the hospital for evaluation. The investigation indicated that other residents who used EZ stand lifts were interviewed and have had no issues with staff and transferring, and the use of EZ stand lifts were observed while transferring and no issues were noted. The investigation for R1 indicated the care plan was reviewed, resident and staff interviews were reviewed, and no changes were made to the policy and procedure after this incident occurred. The investigation indicated that R1 recently started letting of the EZ stand lift within the last six months with instances occurring on 1/14/24 and 9/10/23. The investigation indicated the care plan was updated and education was provided to staff about EZ stand lift training. R1's medication administration record (MAR) from January 2024, R1 had an order stated to evaluate and treat for difficult transfer and fall every shift for difficult transfer and fall. The start date of the order was 5/5/23 and the end date of the order was 2/1/24. The MAR stated that the only times this was indicated was starting the evening of 1/29/24 through 1/31/24 and that was due to R1 being hospitalized. All other dates and shifts indicated staff was completing this task. During an interview with FM-A 2/5/24 at 1:51 p.m., FM-A stated R1 had a fall on 1/29/24 and	F 689		

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	245189	A. BUILDING _____ B. WING _____	C 02/07/2024

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F 689	Continued From page 6 the clinical manager called her while R1 was on the floor telling me that she had a fall and while she was on the phone with the clinical manager, R1 was yelling in the background about her back. FM-A stated the clinical manager asked if she approved of the facility sending R1 to the emergency department and FM-A approved. FM-A stated she could not recall how many times R1 had fallen but though that the incident on 1/29/24 was about the fourth or fifth fall in the last six months. FM-A stated she asked the clinical manager several times to switch R1 from a EZ stand lift for transfers to a mechanical lift. FM-A stated once R1 was evaluated at the hospital it was determined that R1 had a broken neck and a broken back from the fall on 1/29/24. During an interview with NA-B on 2/5/24 at 2:19 p.m., NA-B stated he was trained on how to use the EZ stand lift when he first came to the facility. NA-B stated he had to demonstrate how to use the EZ stand lift to the leaders. NA-B stated he knows how each resident needs to be transferred by looking at the resident's care plans. NA-B stated that if a resident is refusing to transfer safely that he would leave the resident is a safe place and call for the nurse on duty. During an interview with NA-A on 2/5/24 at 2:30 p.m., NA-A stated that on his first day at the facility the leaders gave him paper documents about how to use the EZ stand lift and then he had to demonstrate to the leaders that he knew how to use the EZ stand lift. NA-A stated he looks at the resident's care plans to see how each resident is cared for. NA-A stated if a resident refuses to be transferred safely, he would report to the nurse before transferring the resident. NA-A stated when a resident falls, he would leave	F 689		

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F 689	Continued From page 7 the resident on the ground in a safe spot then he would report to the nurse. During an interview with trained medical assistant (TMA)-A on 2/6/24 at 11:17 a.m., TMA-A stated that he knows how each resident is transferred by looking at each resident's care plan. TMA-A stated if a resident is refusing to be transferred safely, he would leave the resident where they are and will call for back up from his manager. TMA-A stated he was trained on the EZ stand lift by the education director when he first came here, and the facility has in-service trainings. TMA-A stated that he looks at each resident's care plan each shift to look for any changes made. During an interview with licensed practical nurse (LPN)-A on 2/6/24 at 11:24 a.m., LPN-A stated he knows how to transfer each resident by looking in the resident's care plan. LPN-A stated if a resident is refusing to be transferred safely, he would leave the resident and then he will ask why the resident wants to be transferred a different way than the care plan stated. LPN-A stated he will then update the clinical manager and then the clinical manager would give him direction on how to transfer the resident. LPN-A stated he was trained on using the EZ stand lift when he first came to the facility about a year ago. During an interview with NA-C on 2/6/24 at 11:32 a.m., NA-C stated that she been here about six weeks. NA-C stated that she knows how a resident need to be transferred when she looks at the care plan. NA-C stated if a resident is refusing to be transferred safely, she would leave the resident is a safe position, look at the care plan to ensure I was transferring her according to the	F 689		

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F 689	Continued From page 8 plan, and then tell the nurse that the resident is not wanting to be transferred safely. NA-C stated she was trained on using the EZ stand lift during orientation in class by the director of staff development. NA-C stated that she was working the same floor and unit when R1 fell on 1/29/24. NA-C stated she was called to assist to help R1 off the floor. NA-C stated that R1 was wearing her AFO leg braces, and she was fully dressed including her shoes. During an interview with the director of staff development (DSD) on 2/6/24 at 12:16 p.m., the DSD stated that she does the training on the EZ stand lifts. The DSD stated she demonstrates how to use the EZ stand lift and then she requires the staff member to demonstrate how to use the EZ stand lift back to her. During an interview with the clinical manager on 2/6/24 at 1:08 p.m., the clinical manager stated it is all the leader's responsibilities to train and educate staff on using the EZ stand lift. The clinical manager stated her expectations if a resident is refusing to be transferred safely, that the staff member does not transfer the resident, keeps, or puts the resident in a safe spot, and consults with a leader. The clinical manager stated the guidelines for a resident to be able to use a EZ stand lift is that the resident needs to bare weight on at least one leg, hold on to the EZ stand lift grab bars with at least one arm, and follow instructions. The clinical manager stated a resident must be able to tolerate standing. The clinical manager stated when R1 fell on 1/29/24, R1 was demanding NA-D to transfer her from the toilet to her wheelchair without using the shin strap or back harness. The clinical manager stated the wheel of the EZ stand lift and the wheel	F 689		

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F 689	Continued From page 9 of the wheelchair got stuck in between each other and the resident was demanding NA-D to let her fall and then let go of the EZ stand lift grab bars. The clinical manager stated R1 was wearing a pair of jean shorts, a short sleeve shirt, her AFO leg braces, and a pair of socks at the time of the fall. The clinical manager cannot recall if R1 was wearing shoes. The clinical manager stated after R1 fell, NA-D left the room and came to get her around the corner and the clinical manager came into R1's room. R1 was holding her head, saying her head hurt, and she was moving around a lot. The clinical manager stated she attempted to get assess R1's vital signs but could not obtain a blood pressure due to R1 moving around. The clinical manager called R1's daughter while she was still on the floor to see if it would help calm R1 down enough to get a blood pressure from her which was unsuccessful. The clinical manager stated herself and two NA's transferred R1 from the floor to her bed using a mechanical lift. The clinical manager stated during the transfer, R1 started to complain of back pain, and she assessed her back and noticed there was some discomfort to her mid-back up to her neck. The clinical manager stated after R1 was transferred back to her bed she attempted to get a blood pressure reading which was unsuccessful. The clinical manager stated she called the NP to get orders on sending R1 to the emergency department for further evaluation and updated R1's daughter. The clinical manager stated R1 was not seeing physical therapy (PT) at the time. The clinical manager stated R1 had a fall on 1/14/24 due to her letting go of the EZ stand lift grab bars. The clinical manager stated during that fall, R1 had her shin strap and back harness on. The clinical manager stated R1 continued stating she had to use the toilet, R1 let go of the grab	F 689		

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F 689	Continued From page 10 bars on the EZ stand lift, held her arms in as she fell, slid through the back harness, and fell to the ground. The clinical manager stated R1 had a cognitive decline in the last few months. The clinical manager stated she told R1 she needed to be able to pivot transfer if she was not going to use the EZ stand lift so the next time R1 needed to use the toilet, R1 used the pivot transfer and completed the transfer successfully. The clinical manager stated R1 would then use the toilet the next time and would be too weak to do the pivot transfer and then R1 would need to use the EZ stand lift again. The clinical manager stated if R1 continued falling while using the EZ stand lift she would have to use the mechanical lift. The clinical manager stated the reason she did not change her care to use the mechanical lift after the falls on 9/10/23 and 1/14/24 is because she was trying to preserve R1's independence and her right to choose her care while still maintaining safety. The clinical manager stated her expectation if a resident is not wanting to be transferred safely, then the staff members stop the transfer or does not start the transfer. The clinical manager stated it is in her scope of practice to switch the mode of transfer if one mode of transfer is deemed unsafe for the resident. The clinical manager stated when a resident falls, the fall would be put on a building charge report and then IDT will meet to discuss the fall. The clinical manager stated it is the responsibility of the clinical managers to put in interventions into a resident's care plan after a fall. During an interview with the DON on 2/6/24 at 2:00 p.m., the DON stated the facility has a representative come in twice a year to train staff on the EZ stand lift and the last time the representative came to the facility was in fall	F 689		

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F 689	Continued From page 11 2023. The DON stated if a resident is refusing to be transferred safely, her expectation is the staff should stop and get a nurse. The DON stated the guidelines for determining if a resident is a good candidate for an EZ stand lift is if the resident can bare weight on one leg, hold on to the grab bar on the EZ stand lift with one arm, and follow simple instructions. The DON stated if a resident is unable to follow simple instructions the staff would cue the resident. The DON stated she knows R1 had a lot of falls but there were several instances of education with R1 that she needed to hold on to the grab bars on the EZ stand lifts during transfers. The DON stated educating R1 is the only intervention that she was aware of after R1's falls on 9/10/23 and 1/14/24. The DON stated she remembers R1's fall from 1/29/24. The DON stated she was informed R1 had a fall while R1 was still on the floor. The DON stated she went to R1's room and while the clinical manager and two additional NA's were transferring R1 from the floor to her bed, the DON educated NA-D stating he needed to use all the safety features on the EZ stand lift and if R1 didn't want to use the safety features of the lift that he needed to stop and not transfer her. The DON stated NA-D has been suspended after the fall on 1/29/24. The DON stated since R1's fall on 1/29/24, she done staff education about falls and EZ lift stands. During an interview with NA-D on 2/7/24 at 10:28 a.m., NA-D stated that he has worked in the facility for about a year. NA-D stated 1/29/24 was his second time working with R1. NA-D stated he was working between two residents, with R1 being one of those residents, during the last part of his shift. NA-D stated he had transferred R1 to the toilet and left her there to go help the other resident with their cares. R1 then used her call	F 689		

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F 689	Continued From page 12 light and NA-D went back to R1's room and he attempted to attach the shin strap and the back harness, and she was very demanding stating she did not want the shin strap or back harness. NA-D stated he was going to try transfer her to her wheelchair using the EZ stand lift without the straps and sling. NA-D stated the wheels of the EZ stand lift and the wheels of the wheelchair were caught between each other. NA-D stated R1 stated "just let me fall" and he told her to hang on for a few more moments and she let go of the EZ stand lift grab bars falling to the ground. NA-D stated right after the fall he notified the clinical manager. NA-D stated at the time of the fall R1 was wearing shorts, her disposable brief, her AFO leg braces, and her shoes. NA-D stated he did not know R1 had several falls in the past, that R1 lets go of the EZ stand lift grab bars, or if R1 had safety interventions in place from her previous falls. NA-D stated he was trained on the EZ stand lift when he first came to the facility. NA-D stated he was trained on how to use the EZ stand lift and then had to demonstrate it back to the leaders. NA-D stated because this was his second time working on the third floor, he would consult with the nurses on how to care for each resident. NA-D stated he did not review the resident's care plans before consulting with the nurses. NA-D stated if a resident is refusing to be transferred safely, he would refuse to transfer the resident and report it back to the nurse. During an interview with the clinical manager on 2/7/24 at 11:51 a.m., the clinical manager stated if the resident is seeing PT, then PT will determine a resident's mode of transfer and if the resident is not seeing PT, then the clinical managers can determine the mode of transfer. The clinical manager stated the reasoning behind her	F 689		

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F 689	Continued From page 13 decision on why she kept R1's mode of transfer an EZ stand lift was R1 had demonstrated to her multiple times she was able to use the EZ stand lift and pivot transfers safely. The clinical manager stated she was trying to preserve R1's independence by keeping R1 with the EZ stand lift. The clinical manager stated R1's fall from 1/29/24 was unavoidable because R1 purposefully let go of the grab bars on the EZ stand lift. The clinical manager stated she determined R1 purposefully let go of the EZ stand lift grab bars because she had talked to several staff and the staff had reported back to her that R1 would say "just let me fall" and then let go of the EZ stand lift grab bars. The clinical manager stated she does not believe this is a physical decline because R1 was not complaining of her legs, her hands were not shaking, or her legs were not shaking. The clinical manager stated she thought R1 purposefully let us go of the grab bar on the EZ stand lift because R1 is stubborn, she does not like the EZ stand lift machine, and she just wanted to sit down. The clinical manager stated R1 has never told her she is weak. The clinical manager stated after R1's fall on 1/14/24 she observed R1 with her walker, walk about five feet, pivot transfer, and then sit in her wheelchair successfully. The clinical manager stated she did not do any assessments on the EZ stand lift transfers after the fall on 1/14/24. The clinical manager stated no interventions were put into R1's care plan because R1 did not fall on the ground but she fell on the toilet and IDT determined that it was not a fall. The clinical manager stated the behavioral charting that she wrote on 1/14/24 stated the fall intervention was to re-educate the resident to use the stand lift and she monitored the effectiveness by observing R1's successful use of the walker, pivot transfer,	F 689		

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F 689	Continued From page 14 and not letting go of the grab bar on the EZ stand lift on that day. The clinical manager stated the intervention was monitored for just one day. The clinical manager stated she thought R1's fall on 1/14/24 was unavoidable because she let go of the grab bar on the EZ stand lift, brought her arms in, and slid through the sling and fell on to the toilet. The clinical manager states she did not do any assessments on R1 after her fall on 1/14/24. The clinical manager stated the care conference after R1's fall on 1/14/24 concluded the fall was an isolated event, and the facility would continue to monitor R1. The clinical manager stated the family was included in the care planning process and R1 refused the mechanical lift. A Falls and Fall Risk, Managing policy/procedure reviewed on 10/4/21 indicates staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. The policy indicates if falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. The policy states in conjunction with the attending physician, staff will identify and implement relevant interventions to try to minimize serious consequences of falling.	F 689		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/5/24 to 2/7/24, 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) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed. H51899468C (MN00100382, MN00100471, MN00100469) with a licensing order issued at 0830. 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	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to comprehensively assess a resident, reevaluate interventions, or make changes to a care plan after a fall for one of three residents (R1) reviewed for falls when R1 had a previous fall with a history of letting go of the EZ stand lift grab bars. R1's recent fall resulted in fractures of her neck and back.	2 830	Corrected	2/9/24

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	00102	A. BUILDING: _____ B. WING _____	C 02/07/2024

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2 830	Continued From page 3 Findings include: R1's admission record printed 2/5/24 stated R1 was initially admitted to the facility on 2/9/23 to the transitional care unit (TCU) and was transferred to long-term care (LTC) on 3/16/23 with a diagnosis of weakness and anemia. Additional diagnoses included multiple sclerosis, morbid obesity, tremors, gastric ulcers, and mild cognitive impairment. R1's care plan revised on 8/1/23 indicated R1 required assistance with activities of daily living (ADLs) due to her diagnosis of multiple sclerosis. One intervention is R1 required extensive assistance by one staff with a front wheel walker and gait belt for transfers during the day and for the evening/bedtime transfer R1 will use an EZ stand lift (An EZ stand lift is a transfer assist device and is designed primarily to transfer residents from chair, wheelchair, toilet, or bed. An EZ stand lift is used when a person can be actively involved in the standing process. There are two straps that should be used during the transferring process: the shin strap and the back harness. The shin strap is applied to the resident's legs to keep the resident's feet on the foot plate or their shins on the shin pad. The back hardness should be placed around the upper body of the resident, so the sides of the harness are between the patient's torso and arm, resting two to three inches below the underarm. This harness is to ensure resident safety) The care plan stated R1 should wear her bilateral lower extremity ankle foot orthotics (AFOs) (AFO braces are external devices utilized on lower limbs to stabilize the joints to improve gait and physical functioning of the affected lower limb) braces to be in place when transferred or up in her chair.	2 830		

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2 830	Continued From page 4 R1's Lift Mobility Status Assessment dated 12/15/23 indicated R1 can walk with no physical assistance, can stand, can pivot, can bear weight on at least one leg, and can grip the EZ stand lift with at least one hand with enough strength to actively participate in the EZ stand lift. The assessment indicated R1 was cooperative and non-combative. R1's Fall Risk Assessment dated 12/15/23 indicated R1 has not had any falls in the past three months and was chair bound and to assist with elimination. The assessment does not indicate how many staff R1 was dependent upon for assistance with elimination. The assessment did not indicate any gait problems but did indicate R1 required the use of assistive devices such as a cane, wheelchair, walker, or furniture. The assessment indicated R1 scored a 12 on the assessment which indicated high risk for falls. R1's quarterly MDS dated 12/16/23 indicated on J1800 that R1 had no falls since her prior MDS assessment on 9/15/23. R1's brief interview for mental status (BIMS) had a score of 11 indicating her cognition was moderately impaired. R1's progress note dated 1/14/24 indicated R1 purposefully let go of the EZ stand lift and slid herself out of the back harness and landed on the toilet. The progress note did not indicate if the shin strap was used. The note indicated the intervention attempted was to re-educate R1 in order to use the EZ stand lift it required R1 to follow instructions and participate accordingly, otherwise the clinical manager will have to use the mechanical lift (a mechanical lift is a designed assist with transferring residents who can't safely walk or put weight on either leg. When	2 830		

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2 830	Continued From page 5 transferring a resident via mechanical lift, a caregiver will use a sling that attaches to the lift. The sling wraps around the resident's high and crosses between the legs and then attaches to the lift). The note indicated the intervention was effective and that R1 stated her transfer mode of preference was with the walker. The note did not identify changes to R1's plan of care. R1's medical record did not identify an incident report for the fall on 1/14/24. R1's social services care conference dated 1/16/24 indicated R1 had a decline in cognition and memory. The care conference notes indicated R1 purposefully slid out of the back harness of the EZ stand lift on 1/14/23 during transfer to the toilet and indicated this was not the first time R1 has done this. The notes indicated staff educated R1 and family that if it happens again, they will have to downgrade to a mechanical lift. The notes indicated staff explained the risk of serious injury if R1 does not participate and follow instructions to use the EZ stand lift when transferring. R1's progress note dated 1/19/23 indicated R1 refused to use the EZ stand lift and the clinical manager offered to help R1 transfer using her walker instead of the EZ stand lift. The clinical manager and the NA attempted to assist R1 into a standing position from her wheelchair but R1 was unable to do so regardless of the amount of support provided. The note indicated the clinical manager informed R1 she will need to be transferred using the EZ stand lift and she agreed. R1's incident report dated 1/29/24 indicated R1 let go of the EZ stand lift handles while being	2 830		

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2 830	Continued From page 6 transferred from the toilet to her wheelchair and fell on the floor. The incident report indicated R1 refused to let nursing assistant (NA)-D put on the shin strap per protocol and demanded to be transferred via EZ stand lift without the shin strap. The incident report indicated R1 hit her head and complained of serious pain from her mid back to head. The report indicated R1 was transferred off the floor to her bed via mechanical lift and three persons assist. The nurse practitioner (NP) and family was notified, and R1 was sent to the emergency department (ED) for evaluation. The report indicated no injuries observed. The report indicated predisposing physiological factors included impaired memory and incontinence. R1's incident investigation report from 1/29/24 fall indicated R1 had a fall from the EZ stand lift when transferring. The report indicated NA-D was transferring R1 from the toilet back to her bed, NA-D attempted to place the shin strap and the back harness, but R1 demanded the shin strap and the back hardness not be used when in the EZ stand lift. The report indicated while moving the EZ stand lift towards the wheelchair the stand lift wheel got caught with the wheelchair and NA-D decided it was not safe to transfer to the wheelchair and started moving R1 towards the bed. The report indicated R1 stated "let me fall" and let go of the EZ stand lift handles and fell backwards through the harness. The report indicated R1 was rubbing her head and stating it hurt. R1 was transferred off the ground using a mechanical lift and the assistance of three staff members to her bed. The report indicated that during that transfer, R1 complained of moderate pain to her mid to upper back. The clinical manager alerted the NP and family that R1 had fallen and received orders to send R1 to the hospital for evaluation. The investigation indicated	2 830		

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2 830	Continued From page 7 that other residents who used EZ stand lifts were interviewed and have had no issues with staff and transferring, and the use of EZ stand lifts were observed while transferring and no issues were noted. The investigation for R1 indicated the care plan was reviewed, resident and staff interviews were reviewed, and no changes were made to the policy and procedure after this incident occurred. The investigation indicated that R1 recently started letting of the EZ stand lift within the last six months with instances occurring on 1/14/24 and 9/10/23. The investigation indicated the care plan was updated and education was provided to staff about EZ stand lift training. R1's medication administration record (MAR) from January 2024, R1 had an order stated to evaluate and treat for difficult transfer and fall every shift for difficult transfer and fall. The start date of the order was 5/5/23 and the end date of the order was 2/1/24. The MAR stated that the only times this was indicated was starting the evening of 1/29/24 through 1/31/24 and that was due to R1 being hospitalized. All other dates and shifts indicated staff was completing this task. During an interview with FM-A 2/5/24 at 1:51 p.m., FM-A stated R1 had a fall on 1/29/24 and the clinical manager called her while R1 was on the floor telling me that she had a fall and while she was on the phone with the clinical manager, R1 was yelling in the background about her back. FM-A stated the clinical manager asked if she approved of the facility sending R1 to the emergency department and FM-A approved. FM-A stated she could not recall how many times R1 had fallen but though that the incident on 1/29/24 was about the fourth or fifth fall in the last six months. FM-A stated she asked the clinical manager several times to switch R1 from a EZ	2 830		

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2 830	Continued From page 8 stand lift for transfers to a mechanical lift. FM-A stated once R1 was evaluated at the hospital it was determined that R1 had a broken neck and a broken back from the fall on 1/29/24. During an interview with NA-B on 2/5/24 at 2:19 p.m., NA-B stated he was trained on how to use the EZ stand lift when he first came to the facility. NA-B stated he had to demonstrate how to use the EZ stand lift to the leaders. NA-B stated he knows how each resident needs to be transferred by looking at the resident's care plans. NA-B stated that if a resident is refusing to transfer safely that he would leave the resident is a safe place and call for the nurse on duty. During an interview with NA-A on 2/5/24 at 2:30 p.m., NA-A stated that on his first day at the facility the leaders gave him paper documents about how to use the EZ stand lift and then he had to demonstrate to the leaders that he knew how to use the EZ stand lift. NA-A stated he looks at the resident's care plans to see how each resident is cared for. NA-A stated if a resident refuses to be transferred safely, he would report to the nurse before transferring the resident. NA-A stated when a resident falls, he would leave the resident on the ground in a safe spot then he would report to the nurse. During an interview with trained medical assistant (TMA)-A on 2/6/24 at 11:17 a.m., TMA-A stated that he knows how each resident is transferred by looking at each resident's care plan. TMA-A stated if a resident is refusing to be transferred safely, he would leave the resident where they are and will call for back up from his manager. TMA-A stated he was trained on the EZ stand lift by the education director when he first came here, and the facility has in-service trainings.	2 830		

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2 830	Continued From page 9 TMA-A stated that he looks at each resident's care plan each shift to look for any changes made. During an interview with licensed practical nurse (LPN)-A on 2/6/24 at 11:24 a.m., LPN-A stated he knows how to transfer each resident by looking in the resident's care plan. LPN-A stated if a resident is refusing to be transferred safely, he would leave the resident and then he will ask why the resident wants to be transferred a different way than the care plan stated. LPN-A stated he will then update the clinical manager and then the clinical manager would give him direction on how to transfer the resident. LPN-A stated he was trained on using the EZ stand lift when he first came to the facility about a year ago. During an interview with NA-C on 2/6/24 at 11:32 a.m., NA-C stated that she been here about six weeks. NA-C stated that she knows how a resident need to be transferred when she looks at the care plan. NA-C stated if a resident is refusing to be transferred safely, she would leave the resident is a safe position, look at the care plan to ensure I was transferring her according to the plan, and then tell the nurse that the resident is not wanting to be transferred safely. NA-C stated she was trained on using the EZ stand lift during orientation in class by the director of staff development. NA-C stated that she was working the same floor and unit when R1 fell on 1/29/24. NA-C stated she was called to assist to help R1 off the floor. NA-C stated that R1 was wearing her AFO leg braces, and she was fully dressed including her shoes. During an interview with the director of staff development (DSD) on 2/6/24 at 12:16 p.m., the DSD stated that she does the training on the EZ	2 830		

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2 830	Continued From page 10 stand lifts. The DSD stated she demonstrates how to use the EZ stand lift and then she requires the staff member to demonstrate how to use the EZ stand lift back to her. During an interview with the clinical manager on 2/6/24 at 1:08 p.m., the clinical manager stated it is all the leader's responsibilities to train and educate staff on using the EZ stand lift. The clinical manager stated her expectations if a resident is refusing to be transferred safely, that the staff member does not transfer the resident, keeps, or puts the resident in a safe spot, and consults with a leader. The clinical manager stated the guidelines for a resident to be able to use a EZ stand lift is that the resident needs to bare weight on at least one leg, hold on to the EZ stand lift grab bars with at least one arm, and follow instructions. The clinical manager stated a resident must be able to tolerate standing. The clinical manager stated when R1 fell on 1/29/24, R1 was demanding NA-D to transfer her from the toilet to her wheelchair without using the shin strap or back harness. The clinical manager stated the wheel of the EZ stand lift and the wheel of the wheelchair got stuck in between each other and the resident was demanding NA-D to let her fall and then let go of the EZ stand lift grab bars. The clinical manager stated R1 was wearing a pair of jean shorts, a short sleeve shirt, her AFO leg braces, and a pair of socks at the time of the fall. The clinical manager cannot recall if R1 was wearing shoes. The clinical manager stated after R1 fell, NA-D left the room and came to get her around the corner and the clinical manager came into R1's room. R1 was holding her head, saying her head hurt, and she was moving around a lot. The clinical manager stated she attempted to get assess R1's vital signs but could not obtain a blood pressure due to R1 moving around. The	2 830		

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2 830	Continued From page 11 clinical manager called R1's daughter while she was still on the floor to see if it would help calm R1 down enough to get a blood pressure from her which was unsuccessful. The clinical manager stated herself and two NA's transferred R1 from the floor to her bed using a mechanical lift. The clinical manager stated during the transfer, R1 started to complain of back pain, and she assessed her back and noticed there was some discomfort to her mid-back up to her neck. The clinical manager stated after R1 was transferred back to her bed she attempted to get a blood pressure reading which was unsuccessful. The clinical manager stated she called the NP to get orders on sending R1 to the emergency department for further evaluation and updated R1's daughter. The clinical manager stated R1 was not seeing physical therapy (PT) at the time. The clinical manager stated R1 had a fall on 1/14/24 due to her letting go of the EZ stand lift grab bars. The clinical manager stated during that fall, R1 had her shin strap and back harness on. The clinical manager stated R1 continued stating she had to use the toilet, R1 let go of the grab bars on the EZ stand lift, held her arms in as she fell, slid through the back harness, and fell to the ground. The clinical manager stated R1 had a cognitive decline in the last few months. The clinical manager stated she told R1 she needed to be able to pivot transfer if she was not going to use the EZ stand lift so the next time R1 needed to use the toilet, R1 used the pivot transfer and completed the transfer successfully. The clinical manager stated R1 would then use the toilet the next time and would be too weak to do the pivot transfer and then R1 would need to use the EZ stand lift again. The clinical manager stated if R1 continued falling while using the EZ stand lift she would have to use the mechanical lift. The clinical manager stated the reason she did not change	2 830		

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2 830	Continued From page 12 her care to use the mechanical lift after the falls on 9/10/23 and 1/14/24 is because she was trying to preserve R1's independence and her right to choose her care while still maintaining safety. The clinical manager stated her expectation if a resident is not wanting to be transferred safely, then the staff members stop the transfer or does not start the transfer. The clinical manager stated it is in her scope of practice to switch the mode of transfer if one mode of transfer is deemed unsafe for the resident. The clinical manager stated when a resident falls, the fall would be put on a building charge report and then IDT will meet to discuss the fall. The clinical manager stated it is the responsibility of the clinical managers to put in interventions into a resident's care plan after a fall. During an interview with the DON on 2/6/24 at 2:00 p.m., the DON stated the facility has a representative come in twice a year to train staff on the EZ stand lift and the last time the representative came to the facility was in fall 2023. The DON stated if a resident is refusing to be transferred safely, her expectation is the staff should stop and get a nurse. The DON stated the guidelines for determining if a resident is a good candidate for an EZ stand lift is if the resident can bare weight on one leg, hold on to the grab bar on the EZ stand lift with one arm, and follow simple instructions. The DON stated if a resident is unable to follow simple instructions the staff would cue the resident. The DON stated she knows R1 had a lot of falls but there were several instances of education with R1 that she needed to hold on to the grab bars on the EZ stand lifts during transfers. The DON stated educating R1 is the only intervention that she was aware of after R1's falls on 9/10/23 and 1/14/24. The DON stated she remembers R1's fall from 1/29/24. The	2 830		

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2 830	Continued From page 13 DON stated she was informed R1 had a fall while R1 was still on the floor. The DON stated she went to R1's room and while the clinical manager and two additional NA's were transferring R1 from the floor to her bed, the DON educated NA-D stating he needed to use all the safety features on the EZ stand lift and if R1 didn't want to use the safety features of the lift that he needed to stop and not transfer her. The DON stated NA-D has been suspended after the fall on 1/29/24. The DON stated since R1's fall on 1/29/24, she done staff education about falls and EZ lift stands. During an interview with NA-D on 2/7/24 at 10:28 a.m., NA-D stated that he has worked in the facility for about a year. NA-D stated 1/29/24 was his second time working with R1. NA-D stated he was working between two residents, with R1 being one of those residents, during the last part of his shift. NA-D stated he had transferred R1 to the toilet and left her there to go help the other resident with their cares. R1 then used her call light and NA-D went back to R1's room and he attempted to attach the shin strap and the back harness, and she was very demanding stating she did not want the shin strap or back harness. NA-D stated he was going to try transfer her to her wheelchair using the EZ stand lift without the straps and sling. NA-D stated the wheels of the EZ stand lift and the wheels of the wheelchair were caught between each other. NA-D stated R1 stated "just let me fall" and he told her to hang on for a few more moments and she let go of the EZ stand lift grab bars falling to the ground. NA-D stated right after the fall he notified the clinical manager. NA-D stated at the time of the fall R1 was wearing shorts, her disposable brief, her AFO leg braces, and her shoes. NA-D stated he did not know R1 had several falls in the past, that R1 lets go of the EZ stand lift grab bars, or if R1	2 830		

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2 830	Continued From page 14 had safety interventions in place from her previous falls. NA-D stated he was trained on the EZ stand lift when he first came to the facility. NA-D stated he was trained on how to use the EZ stand lift and then had to demonstrate it back to the leaders. NA-D stated because this was his second time working on the third floor, he would consult with the nurses on how to care for each resident. NA-D stated he did not review the resident's care plans before consulting with the nurses. NA-D stated if a resident is refusing to be transferred safely, he would refuse to transfer the resident and report it back to the nurse. During an interview with the clinical manager on 2/7/24 at 11:51 a.m., the clinical manager stated if the resident is seeing PT, then PT will determine a resident's mode of transfer and if the resident is not seeing PT, then the clinical managers can determine the mode of transfer. The clinical manager stated the reasoning behind her decision on why she kept R1's mode of transfer an EZ stand lift was R1 had demonstrated to her multiple times she was able to use the EZ stand lift and pivot transfers safely. The clinical manager stated she was trying to preserve R1's independence by keeping R1 with the EZ stand lift. The clinical manager stated R1's fall from 1/29/24 was unavoidable because R1 purposefully let go of the grab bars on the EZ stand lift. The clinical manager stated she determined R1 purposefully let go of the EZ stand lift grab bars because she had talked to several staff and the staff had reported back to her that R1 would say "just let me fall" and then let go of the EZ stand lift grab bars. The clinical manager stated she does not believe this is a physical decline because R1 was not complaining of her legs, her hands were not shaking, or her legs were not shaking. The clinical manager stated	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 02/07/2024

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2 830	Continued From page 15 she thought R1 purposefully let us go of the grab bar on the EZ stand lift because R1 is stubborn, she does not like the EZ stand lift machine, and she just wanted to sit down. The clinical manager stated R1 has never told her she is weak. The clinical manager stated after R1's fall on 1/14/24 she observed R1 with her walker, walk about five feet, pivot transfer, and then sit in her wheelchair successfully. The clinical manager stated she did not do any assessments on the EZ stand lift transfers after the fall on 1/14/24. The clinical manager stated no interventions were put into R1's care plan because R1 did not fall on the ground but she fell on the toilet and IDT determined that it was not a fall. The clinical manager stated the behavioral charting that she wrote on 1/14/24 stated the fall intervention was to re-educate the resident to use the stand lift and she monitored the effectiveness by observing R1's successful use of the walker, pivot transfer, and not letting go of the grab bar on the EZ stand lift on that day. The clinical manager stated the intervention was monitored for just one day. The clinical manager stated she thought R1's fall on 1/14/24 was unavoidable because she let go of the grab bar on the EZ stand lift, brought her arms in, and slid through the sling and fell on to the toilet. The clinical manager states she did not do any assessments on R1 after her fall on 1/14/24. The clinical manager stated the care conference after R1's fall on 1/14/24 concluded the fall was an isolated event, and the facility would continue to monitor R1. The clinical manager stated the family was included in the care planning process and R1 refused the mechanical lift. A Falls and Fall Risk, Managing policy/procedure reviewed on 10/4/21 indicates staff, with the input of the attending physician, will implement a	2 830		

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2 830	Continued From page 16 resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. The policy indicates if falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. The policy states in conjunction with the attending physician, staff will identify and implement relevant interventions to try to minimize serious consequences of falling. 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.	2 830		