



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 13, 2021

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

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

Dear Administrator:

On December 1, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 1, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 1, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Southview Acres Healthcare Center

December 13, 2021

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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a large, stylized 'K' and 'F'.

Kamala Fiske-Downing

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 09/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245189	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/01/2021
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/1/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5189218C (MN78719), with deficiencies cited at F600. The following complaint was found to be UNSUBSTANTIATED: H5189217C (MN78718). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600			12/28/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/23/2021

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 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from abuse for 2 of 3 residents (R2, R3) reviewed for abuse, who were observed hitting one another by staff, and had physician orders and care planned interventions for frequent safety checks, which were not being completed. Findings include: The facility Nursing Home Incident Report dated 11/21/21, at 8:39 p.m. indicated at approximately 6:25 p.m. R2 and R3 were observed sitting in their wheelchairs yelling, hitting one another, and using vulgar language. R2's Face Sheet printed 12/1/21, indicated R2's diagnosis included Alzheimer's, delusional disorders, dementia, anxiety, and depressive disorders. R2's significant change Minimum Data Set (MDS) dated 10/26/21, indicated R2 had a moderate cognitive impairment, no mood or behavior concerns, and required extensive assistance with activities of daily living (ADLs). R2's care plan dated 11/23/21, indicated R2 exhibited physical and verbal aggression towards staff or other residents, and was to have safety	F 600	R 2 and R 3 were separated immediately. R3 is currently on hourly checks and will continue to follow IDT recommendations for supervision. Risk management incidents were created for both and the root cause was identified. Both R2 and R3 care plans were reviewed and updated as needed. All other residents were reviewed and there were no residents identified needing close supervision. Future resident/resident incidents, the care plan intervention will be implemented and documentation will be reviewed regularly for documentation compliance. Nursing staff and social service staff were in-serviced on the resident to resident policy and procedure with focus on items 2f and 2g to make necessary changes in the care plan and record all interventions and their effectiveness. Nurse aides were in-serviced on behavior monitoring charting. Social Services and/or designee will be responsible for compliance. Audits on care plan intervention update and charting intervention frequency will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audits will be reviewed by the DON and Administrator or designees, audit results will be brought to QAPI for review and		

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F 600	Continued From page 2 checks every 30 minutes. R2's nursing assistant (NA) task sheet updated 11/12/21, lacked direction for staff to conduct 15 minute safety checks. R3's Face Sheet printed 12/1/21, indicated R3's diagnosis included dementia with behavioral disturbance, adjustment disorder, unspecified symptoms and signs involving cognitive function and awareness. R3's significant change MDS dated 11/6/21, indicated R3 had a severe cognitive impairment, no mood or behavior concerns, and required supervision with most ADLs. R3's care plan dated 11/11/21, indicated R3 wandered into patients' rooms, made inappropriate comments and/or touched female staff butts related to dementia. The plan directed R3 was to be on every two hour safety checks. The care plan also directed staff to minimize potential for R3's disruptive behaviors, provide 30 minute wellbeing checks from 5:00 p.m. to 7:00 a.m." R3's Physician Orders dated 10/19/21, directed every 2 hour wellbeing checks. R3's NA task sheet updated 11/12/21, lacked direction for staff to conduct wellbeing checks. On 11/21/21, at 12:20 a.m. a progress note indicated registered nurse (RN)-C was in a resident's room and heard loud yelling. RN-C observed R2 and R3 sitting in their wheelchairs in the hallway, hitting each other. Nursing assistant (NA)-C and RN-C immediately separated them.	F 600	recommendations. Compliance 12/28/2021		

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F 600	Continued From page 3 The facility Investigation Report Summary dated 11/26/21, indicated care plans would be updated with the following interventions: R2's interventions included an escort when able to and from destinations, updated care plan, and increased supervision. R3's interventions included increased supervision. On 12/1/21, at 11:15 a.m. R2 was observed to propel himself in the wheelchair, down the hallway towards the common area where R3 was seated. At 11:17 a.m. R3 sat in his wheelchair near the common room and began propelling himself towards R2. At 11:18 a.m. staff physically moved R2 in his wheelchair away from R3. On 12/1/21, at 11:45 a.m. R3 was observed to propelled himself into his room. Staff were in this room completing care for R3's roommate, and directed R3 to leave the room. At 11:46 a.m. trained medication assistant (TMA)-A assisted R3 back to his room. When interviewed on 12/1/21, at 10:30 a.m. and 11:20 a.m. NA-A stated no residents on the unit required frequent checks. NA-A stated R2 did not have frequent checks in place, and she did not document on R2's activity or behaviors unless there were "problems." NA-A stated R3 was placed on a 1:1 staffing pattern in the evenings, but otherwise he did not have frequent checks. NA-A stated she would reference her NA care sheet, as well as the care plan located on the computer, for directives on resident care including safety checks. When interviewed on 12/1/21, at 11:29 a.m. NA-B stated R2 spent most of his time in the common	F 600			

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F 600	Continued From page 4 room, so staff did not perform or record formal frequent checks on R2. When interviewed on 12/1/21, at 11:45 a.m. TMA-A stated R2 used to be very combative, but now was "always ok," and there were no frequent checks in place for R2. TMA-A staffed R3 was 1 hour checks and stated, "Sometimes he is ok sometimes he is not." When interviewed on 12/1/21, at 12:00 p.m. RN-B stated R2 was previously on one-hour checks, but did not believe R2 had frequent checks in place anymore. RN-B stated safety checks were documented on paper at the nursing station. RN-B was unable to locate this paper for R2. RN-B asked RN-A where frequent checks were documented, RN-A stated it was in the computer. RN-B stated R3 was on 1:1 staffing during the evening/overnight shifts, and was not aware of frequent checks during the day for R3. When interviewed on 12/1/21, at 12:18 p.m. RN-A stated R2 was previously on 30-minute checks but was now on two-hour checks. RN-A reviewed R2's care plan and verified it still called for 30-minute checks. RN-A reviewed R2's NA task sheet, and verified it did not direct for frequent checks. RN-A verified R3 was ordered to have every 2 hour safety checks which should be record in EMR (electronic medical record). RN-A reviewed R2 and R3's EMRs, and verified frequent checks were not being completed in accordance with the care plan. RN-A stated her expectation was for checks to be completed as written in the plan of care and physician orders, and then updated care plans and task sheets for R2 and R3.	F 600			

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F 600	Continued From page 5 When interviewed on 12/1/21, at 12:36 p.m. NA-C stated on 11/22/21, she observed R2 and R3 hitting one another and calling each other the "f-word." NA-C stated she yelled for help and RN-C came to assist her. R2 was taken into the dining room and R3 was taken into the kitchenette. NA-C stated she believed R2 was on every 15 minute checks "or something like that" and R3 was the same, every 15 or every 30 minute checks. NA-C stated staff were supposed to check on the residents and record what the residents were doing in the computer. When interviewed on 12/1/21, at 1:10 p.m. the assistant director of nursing (ADON) stated 30-minute checks were put in place for R2 after his resident-to-resident altercation with R3 which occurred on 11/21/21. ADON stated R3 was on 1:1 supervision overnight and should have every 2 hour checks during the day. ADON verified staff did not document checks for R2 or R3, and the expectation was for checks to be performed and documented in accordance with the plan of care to ensure resident safety. The facility policy titled Medication Orders reviewed 2/8/21, directed when recording treatment orders, specify the treatment, frequency, and duration of the treatment.	F 600			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 13, 2021

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

Re: Event ID: 5TY511

Dear Administrator:

The above facility survey was completed on December 1, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/01/2021
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118		
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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 12/1/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/23/21

Minnesota Department of Health

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2 000	Continued From page 1 SUBSTANTIATED: H5189218C (MN78719), however, no licensing tags were issued. The following complaint was found to be UNSUBSTANTIATED: H5189217C (MN78718). The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			