



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2022

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 30, 2021, we notified you a remedy was imposed. On March 10, 2022 the Minnesota Department of Health 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 March 1, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 1, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 13, 2021, 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 March 1, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 1, 2022, 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 Therefore, the NATCEP prohibition is rescinded.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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Southview Acres Healthcare Center

March 14, 2022

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Program Assurance Unit

Health Regulation Division

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

PRINTED: 03/09/2022
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 02/07/2022
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 2/3/22 - 2/7/22, 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 complaints were found to be SUBSTANTIATED: H5189254C (MN80514), with deficiencies cited at F689, H5189255C (MN80591), with deficiencies cited at F697. H5189256C (MN80644), with deficiencies cited at F684. 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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		3/1/22	

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

TITLE

(X6) DATE

Electronically Signed

02/24/2022

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 684	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview, and record review the facility failed to implement treatment consistent with the resident's care plan for 1 of 3 residents assessed for neglect allegations. The facilities failure to provide the evening cares caused R1 to have transferred himself to bed and found to be fully dressed in bed incontinent of bowel and bladder. Findings include: R3's quarterly Minimum Data Set (MDS) dated 11/17/22, indicated R3 had a Brief Inventory of Mental Status (BIMS) score of 13 indicating intact cognitive response. R3 needed extensive assistance with transferring, walking and dressing, also noted was he was frequently incontinent of bowel and bladder. R3's diagnosis included acute kidney failure, type 2 diabetes, aphasia following cerebral infarction (loss of ability to understand or express speech caused by brain damage due to disrupted blood flow to the brain). R3's care plan dated 11/17/22, indicated R3 was receiving excessive assistance of 1 for bathing, bed mobility, dressing, location, toilet use, and transfers. Upon interview on 2/3/22, at 11:09 a.m. R3 reported that he often puts himself to bed as staff does not come to assist him. He stated "I don't mind sleeping in my clothing, I would prefer pajamas, however. When I'm tired, I put my wheelchair in front of the bed and plop myself in." R3 reported on the night his roommate complained he did not receive cares and he recalled which nursing assistant came in	F 684	R 3 care plan was reviewed and updated to include resident preferences, a risk management incident was initiated and thoroughly investigated for the root cause and care plan interventions updated and implemented. All existing residents who require transfer and toileting assistance care plan and group sheets were reviewed and updated as needed. Future residents will be assessed for care assistance and their care plan will be initiated and followed. Nursing staff will be in-serviced on Safety and Supervision of Residents, ADL Support Policy and Procedure and Routine Resident Check policy with emphasis on providing the level of care residents require and to ensure that the nurse aide assignments are correct and rounds are completed. Director of Nursing and/or designee is responsible for compliance. Audits on ADL care completion and care plan interventions will begin 2x week for 2 weeks, weekly x 3 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will bring audit results to QAPI for review and recommendation. Compliance: 03/01/2022		

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F 684	Continued From page 2 immediately on the night shift and cleaned him up with due to his incontinence of bowel and bladder. Upon interview on 2/3/22, at 12:21 p.m. nursing assistant (NA)-A reported that R3 often is found sleeping in his clothing. NA-A verified on the night 1/30/22, she came into start her shift and R3's roommate and pressed the call light to report R3 did not receive any cares that evening and there was an odor in the room coming from R3's side of the room. NA-A reported R3 was in his bed fully dressed and was incontinent of bowel and bladder "enough to soak through his incontinence pad, so there is no way he was even toileted prior to bed." Upon interview on 2/3/22, at 3:18 p.m. NA-B reported that R3 was on his group sheet that evening, but the facility was working short staffed, so he gave R3 to NA-C that evening. NA-B verified knowledge of R3 being incontinent and needing transfer assistance. NA-B denied follow-up with NA-C to see if all residents were cared for on the unit. Upon interview on 2/3/22, at 4:00 pm NA-C reported he did not have R3 on his sheet and denied telling NA-B that he would care for him. NA-C reported he was unaware that R3's cares were missed until the facility interviewed him for their investigation. Upon interview on 2/5/22, at 11:17 a.m. registered nurse (RN)-A reported that the 5-day report dated 2/5/22 was turned into the Minnesota Department of Health (MDH) indicating R3's care plan was updated, and he was independent and a minimal assist. RN-A verified the care plan had not been updated as of 2/8/22 by looking in Point Click Care, no assessment was documented, and the	F 684			

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F 684	Continued From page 3 Minimum Data Set had not been updated to indicate minimal assistance. Upon interview on 2/5/22, at 3:03 p.m. the director of nursing (DON) reported that the facility was unaware that R3 was not receiving his evening cares. She confirmed the staff need to be reporting off to the next shift coming onboard before they leave for the day. She stated she was unaware that the nursing assistants were not reporting to the next shift, there have been audits of this in the past, but not for quite some time. She stated the nursing assists should be working together, but not changing their schedule unless approved by the nursing staff. The DON stated she did not verify if the assessment or the plan of care had been updated as this is the responsibility of the clinical manager, RN-A. A policy about completion of cares was requested however not obtained from the facility.	F 684			
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 observation, interview and document review, the facility failed to supervisor and implement fall interventions to reduce the risk of falls for 1 of 2 residents (R3) who had repeated	F 689	R 1 had a risk management incident completed and thoroughly investigated for root cause and completed. In addition, R 1 fall care plan will be reviewed and		3/1/22

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F 689	Continued From page 4 falls. This resulted in actual harm for R3 who sustained a head injury and fracture during a fall. Findings include: R1's group assignment sheet, not dated, indicated she was a fall risk, needed assistance of 1 for her dressing, grooming and toileting, and was a contact guard assist (use of a gait belt and staff member with all transfers). R1's Minimum Data Set (MDS) dated 1/25/22, indicated a Brief Inventory of Mental Status of 13 indicating no cognitive impairment. R1 was noted to need physical assistance of 1 person for activities of daily living. The facility 5-day investigation report, dated 2/1/22, indicated R1 was reported to have a displaced intertrochanteric fracture of the left femur which required surgery after a fall at the facility on 1/26/22. The investigation indicated R1 was walking without footwear and a gait belt, from bathroom with NA-E. R1's foot got caught on walker and R1 fell. NA-E's personnel record was reviewed and contained medical information. Upon interview on 2/3/22, at 3:02 p.m. family (FA)-A reported receiving a call from the facility that R1 had fallen and was sent to the hospital. RN-D told FA-A R1 was walking with her walker without shoes and a gait belt was not used. FA-A stated, "I was in shock, so I called the facility back and reminded the staff she is supposed to have someone with at all times when she is walking and the use of a belt, and I did not receive an explanation other than my mother was impulsive."	F 689	updated as needed. All other residents who are high risk for falls, their care plans will be reviewed and updated as needed. Future residents who are high risk for falls, their care plan will be created and interventions will be implemented. Nursing staff will be in-serviced on the Safe Lifting and Movement Policy and Safety Supervision of Resident with focus on ensuring staff are trained on resident lifting and strategies to avoid resident injuries. Director of Nursing and/or designee is responsible for compliance. Audits on resident transfer and transfer training education and competency will begin 3x week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will bring audit results to QAPI for review and recommendation. Compliance: 03/01/2022		

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F 689	Continued From page 5 Upon interview on 2/3/22, at 3:27 p.m. R1 reported the day of her fall she was taken to the bathroom by a nursing assistant. She pressed the call light and the same nursing assistant assisted her with ambulating back to bed and she became unsteady and fell along with the nursing assistant. She stated "I am supposed to be wearing a belt. Do I need to be reminding staff?" Upon interview on 2/4/21, at 11:48 a.m. nursing assistant, (NA)-E reported she worked on 1/26/22. She was an agency staff member and was told she was working as a trained medication administrator (TMA) but was changed to working as a nursing assistant that day. She reported she was brought to the first floor of the building and told by the nurse manager to just start answering lights, that the unit was a transitional care unit (TCU), and most residents were independent. NA-E reported answering R1's call light, but by the time she entered the room, R1 was standing up with her walker. R1 told NA-E she had to go to the bathroom bad. "I did not have a gait belt, I did not know how she transferred, I could see she was unsteady, so I got behind her and put my hand on her walker to stabilize it and one hand on the back of her pants." NA-E reported she left R1 on the toilet, gave her the call light and told her to press it when she was finished in the bathroom. NA-E assisted another resident to the bathroom and then went back to assist R1. R1 stood up on her own and started walking with the walker. NA-E reported "Again she was unsteady, so I again placed my hand on the walker and one hand on her pants. She only had socks on. She made a jerk with one of her legs and it caught on the walker. She started to	F 689			

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F 689	Continued From page 6 fall, and I didn't let go, so I fell with her." NA-E stated R1 hit her shoulder on the wall next to her bed, and fell to the floor, so she was lying flat on her back. NA-E immediately got up and asked for assistance and a nurse came and assisted. R1 was taken out of the facility by ambulance. NA-E reported she had worked at the facility three times and had not received any orientation or training. She was unaware there was an orientation sheet and denied signing anything at the facility. NA-E reported after RN-D spoke with her about not having a belt on her uniform or using the belt in the room, NA-E stated she went to see where the belts was in the room and there was no belt. NA-E reported after the fall she was given a group sheet, used it the rest of the day and wore a gait belt. Upon interview on 2/4/22, at RN-D reported the fall happened and the root cause was R1 was too impulsive. "The NA had to make a decision about leaving her alone or leaving to get proper footwear and a gait belt." RN-D reported that due to COVID gait belts are being kept in the room on a hook. "I did tell the NA that after the incident, I don't know if there was one in the room or not. I also handed her a belt." The facility reported they are starting audits and education on the gait belts in the room following the incident on 1/30/22. RN-D verified R1 was a contact guard assist and that does mean a gait belt and hands on contact with all transfers. Upon interview on 2/4/22, at 10:17 a.m. housekeeper (HSK)-A reported being unaware of the duty of watching for or placing gait belts in rooms. "I was just told that this morning, I signed an education sheet. I know we are in the process	F 689			

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F 689	Continued From page 7 right now of putting out a bunch of belts, especially on the first floor, as this is a new unit, and many rooms don't have the belts yet." Upon interview on 2/7/22 at 11:18 a.m. NA-G stated she was not orientated to the facility and started working when she arrived and that she asks other staff or residents what she need to do. NA-G stated she did not sign any documents for training or orientation. Upon interview on 2/7/22 at 2:57 p.m. NA-F stated she did not have orientation or training, but I felt safe providing care because she asked for the plan of care and has experience. Upon interview on 2/7/22 at 3:13 p.m. the director of nursing (DON) stated the facility could not find the training for NA-G and NA-F. A facility policy Safe Lifting and Movement of Residents dated 2/4/22, indicated to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents.	F 689			
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interviews, and record review the	F 697			3/1/22
			R 3 has since discharged from the		

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F 697	Continued From page 8 facility failed to provide pain management for 1 or 3 residents assessed for pain control. The facility failed to administer the medication in a timely manner and did not have a plan to monitor R2's acute pain causing R2 to attempt elopement from the facility. Finding include: R3's admission Minimum Data Set (MDS) indicated R3 had a Brief Inventory for Mental Status (BIMS) score of 15 indicating no cognitive impairment. R3 was assessed at minimum assistance with activities of daily living. R3's diagnoses were nontraumatic subarachnoid hemorrhage (bleeding between the space in your brain and surrounding membrane, traumatic subdural hemorrhage with loss of consciousness, fracture of the skull and fracture of facial bones. R3's treatment administration record did not indicate any monitoring and/or interventions for pain. Upon interview on 2/3/22, at 11:18 a.m. R2 reported that a few days ago he was having a headache with a pain level of 6/10. R2 explained he was assaulted and had a traumatic brain injury and headaches were result of the assault. He reported that on 1/30/22, around 6 p.m. he asked the nursing assistant for a pain medication. The nursing assistant (NA)-D stated she would tell the nurse. After waiting about 45 minutes he approached NA-D asking for the pain medication again as he could not find the nurse. NA-D responded to him that she had told the nurse but would tell her again. R2 reported that he waited again almost another hour this time and got so upset he left his room and stated he was leaving	F 697	facility. Existing residents who received pain medication from survey exit until present were reviewed for pain medication effectiveness and their pain care plan was reviewed and interventions updated as needed. Future residents will have a pain care plan initiated and interventions implemented. Nursing staff was in-serviced on the policy Administering Pain Medications with emphasis on assessing the resident after the onset of pain and reassessed until relief is obtained. Director of Nursing and/or designee is responsible for compliance. Audits on pain medication administration and effectiveness will begin 2x week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will bring audit results to QAPI for review and recommendation. Compliance: 03/01/2022		

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F 697	Continued From page 9 the facility and going home. He reported he got out the front door when a nurse caught up with him, asked him to back in the building and gave him his pain medication immediately. R2 stated that he has some oral surgeries coming soon and he feared he will be at the facility and not have pain control. Upon interview on 2/3/22, at 12:42 p.m. registered nurse (RN)-B stated she could not remember if NA-D had told her that R2 needed a pain or not. She stated her back was hurting badly and she was trying to get a hold of the charge nurse to go home herself and was in the process of sending another resident to the emergency room. At the end of the interview RN-B stated, "I don't know maybe the NA did tell me, but I was so busy and in so much pain, I honestly can't confirm or deny, sorry". Upon interview on 2/3/22, at 2:19 p.m. NA-D stated that R2 asked for a pain medication on 1/30/22, between 5:30 and 6:00 p.m. She stated telling the nurse who was on break at the time, and she verified the nurse heard her as RN-B responded indicating she would give R2 the pain medication after her break. NA-D reported that about 45 minutes later R2 approached her again, this time outside his room asking for his pain medication. "I replied to him Yes I did tell her, but I will tell her again." She reported she found the nurse at the desk and told her again. She also reported around 8:00 p.m. hearing from other staff R2 get upset and attempted to leave the building about not getting his pain medication. "I was unaware that the nurse had left for the night." Upon interview on 2/3/22, at 3:45 p.m. licensed practical nurse, (LPN) - A reported on the evening	F 697			

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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 02/07/2022
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 697	Continued From page 10 of 1/30/22, the nurse who was working with him was upset was saying her back hurt and was. The RN-B and LPN-A counted the narcotics on RN-B's cart and RN-B reported all the work from group was completed up until 7 p.m., she didn't report that R2 was waiting on a pain medication. At about 7:45 p.m. LPN-A noticed R2 abruptly walking down the hall saying "I can't believe this place, I need out of here, they can't handle my pain." LPN-A reported following R2 and was R2 told LPN-A that he had been asking for a pain medication since 6:00 p.m. LPN-A reported calming R2 down and gave him the pain medication at 8:07 p.m. Upon interview on 2/4/22, at 10:10 a.m. RN-C, the nurse manager, stated he was not in the facility on the date of the incident however he reported R2 had education upon admission regarding use of call light, but has a TBI, so he was re-educated on using his call light. RN-C stated "We do not have an order to monitor him for pain, I don't think, it would be on the TAR if we did. Yes, we should be monitoring pain levels of residents with acute pain who are narcotics." He reported that to his knowledge staff was not re-educated on reporting pain to nursing staff if they are told in passing or if the resident turns on the call light and requests pain medication. Upon interview on 2/7/2, at 3:06 p.m. the director of nursing (DON) indicated that pain medication should be administered as soon as possible and that residents with acute pain concerns should be assessed at least daily and as needed to ensure pain is always under control. A facility policy Administering Pain Medications dated 10/7/21, indicated the purpose of the	F 697			

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

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F 697	Continued From page 11 procedure is to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication. The policy indicated for acute pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained.	F 697			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 23, 2022

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

Re: Event ID: DY3M11

Dear Administrator:

The above facility survey was completed on February 7, 2022 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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 23, 2022

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 13, 2021, we informed you that we may impose enforcement remedies.

On February 7, 2022, 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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 1, 2022

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 1, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 1, 2022.

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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

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 \$11,292, 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 March 1, 2022, 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 March 1, 2022. 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 June 1, 2022 (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:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462**

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

Southview Acres Healthcare Center

February 23, 2022

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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.

Feel free to contact me if you have questions.

Sincerely,



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