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	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southview Acres Healthcare Center	2000 Oakdale Avenue West Saint Paul, MN 55118

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews and document review the facility failed to thoroughly investigate an allegation of abuse for 1 of 3 residents (R1) reviewed for abuse. In addition, the facility failed to protect 1 of 3 residents (R1) while the investigation was conducted. Findings include: On 6/17/25 at 5:47 p.m., a Brief Interview for Mental Status (BIMS) was conducted. Summary score was 12 and indicated moderate impaired cognition. R1's care plan dated 6/24/25, identified at risk for falls related to restless leg syndrome (RLS), CVA, altered mental status, and lace of safety awareness. Noted to have uncontrolled movement of legs that pulled him out of bed. Staff were instructed to assist him with ambulation, transfers, utilizing therapy recommendations and encourage him to spend time in central location for increased supervision. He made statements and accusations which were unsubstantiated, unfounded and untrue. Family and friend reported this was not new behavior. Staff were directed to provide refused care at an alternative time per his preference, listen to his accusations/complaints and validate feelings behind them, investigate and evaluate resident statements, ensure safety of resident and others, refer to psychiatric evaluation, and establish boundaries and limits with two-person entry for cares. He had an identified behavior problem (placed self on floor) despite analysis of the five whys, and his perception of time was not real. Staff were directed to observe behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, situations, and document behavior and potential causes. His safety was at risk and there was a potential for abuse due to current use of medications and need for assistance with cares and mobility. Staff were directed to keep him safe and free from abuse by being removed from potentially dangerous situations. Review of Nursing assistant (NA) behavior monitoring and interventions from 6/6/25 through 6/19/25 identified: -6/6/25, 6/7/25, and 6/8/25, no behaviors observed for all shifts. -6/9/25 no behaviors noted on day or evening shift. During night shift at 4:43 a.m. he was noted to be physically aggressive (PA) towards others, repetitive motions (RM), and verbalized persistent beliefs (VP). Interventions: provided calm environment(CE), behaviors worsened (W), and reapproached (RA), unchanged response. -6/10/25 no behaviors noted on day or night shift. During evening shift at 8:10 p.m. he was noted to be agitated (A), accusing of others (AO), PA, redirected (RD), RA, behaviors better (B). (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-6/11/25, no behaviors observed for all shifts. -6/12/25 no behaviors noted on day and night shift. During the evening shift at 10:59 p.m. behaviors identified were AO, and cursing at others (CO). Interventions identified RD and behaviors B. -6/13/25, 6/14/25, and 6/15/25, no behaviors noted on day or evening shift. 6/13/25 at 9:42 p.m., 6/14/25 at 7:44 p.m., and 6/15/25 at 6:59 p.m. he expressed frustration/anger at others (FR), and PA. Interventions provided: RD, RA, and behaviors B. -6/16/25, 6/17/25, 6/18/25, and 6/19/25, no behaviors observed for all shifts. R1's progress notes from 6/6/25, 6/7/25, 6/11/25, and 6/18/25, identified: -On 6/6/25 at 3:06 p.m., resident was very rude to writer, licensed practical nurse (LPN)-A. He requested a cigarette to go outside for a smoke, writer informed him that he would need to wait until his friend arrived before the cigarette could be provided. Resident became upset and told the writer to stay quiet . he would call the police and report writer to the social worker . clinical manager and social worker were contacted to speak with resident . Later approached resident to check blood glucose level. Resident responded he did not want her to touch him and refused . at 6:20 p.m. resident approached LPN-A and apologized . -Late entry on 6/7/25 at 3:50 p.m., resident yelled and screamed at nurse . resident verbalized he was being abused by then nurses because they were not allowing him access to his cigarettes and lighter . reminded of facility smoking policy and safety precautions . not effective, agitated with social worker and called friend to assist him off grounds to smoke. -Late entry on 6/7/25 at 12:35 a.m., to clarify nurse (LPN-A) was kneeling behind resident by bedside. He elbowed nurse twice and then rolled onto the floor . call light used to ask two NAs to help resident off floor . -On 6/7/25 at 5:39 a.m., writer (LPN-A) found resident intentionally had rolled out of bed at 12:35 a.m., rushed to his room to prevent him from rolling out of bed and asked what are you doing? Resident pushed writer and stated leave me alone, do not touch me . place call light on and called two NAs to help transfer him back to bed. no injury. -No documentation in progress notes by nursing staff on 6/11/25. Seen by NP for follow up visit at 8:34 a.m. no concerns. -On 6/18/25 at 8:24 a.m. resident seen at bedside by nurse practitioner; staff notified her of accusations from him. He reported nurse knee [sic] on neck and then slapped face. Discussed incident with resident and he would not provide details but did respond saying he was safe. Denied injuries or pain, no sign of trauma, no bruising, erythema and seated in wheelchair. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Police officer (PO) incident report dated 6/18/25 at 1:02 p.m., identified dispatch advised a male caller claimed elder abuse and wanted to speak to a police officer. Upon arrival, PO contacted R1 and he informed him around midnight he had fallen out of bed activated call light for assistance, staff walked by his room, ignored him on the ground asking for help. He was assisted up into his wheelchair where he was left for around three hours. Sometime on 6/11/25, between 3:30 a.m. and 4:00 a.m. he had fallen out of bed and an unknown head nurse came (described her) into his room, placed her knee down next to his head, struck him in the head once, and slapped him with her hand. he was upset staff were not responding to assist him in a timely manner and did not want to get anybody into trouble. PO was flagged down by a staff member, facility administrator, and informed him R1 had frequently filed false accusations against staff members and frequently upset when his care plan was changed. Administrator indicated he was aware of the alleged incident last week of a nurse in the transitional care unit (TCU) struck him in the head with her shin, placed her knee on his head, tapped him on his head, and told him to settle down. PO was informed by administrator that this incident was handled internally, due to a second staff member being present denying these accusations. With new information on a different date, the separate claims of a staff member kneeling next to him and slapped him (while by themselves) administrator informed PO he would request a further investigation into his claims. Email sent to PO by facility administrator on 6/18/25 at 4:08 p.m., identified the complaint received today has been investigated by our team and is nearly identical to an earlier episode that R1 shared while on our TCU (downstairs). When interviewed R1 stated that the head nurse kneed him with her shin, placed her knee on his head, tapped him on his head, and was told to settle down. The earlier instance referenced was very similar in that a head nurse was mentioned and said they placed their knee on his neck. Because we had an eyewitness able to clearly state that what he described did not happen we did not submit a Vulnerable Adult (VA) report to the state. Resident care plan was updated to include that type of behavior. However, with today's allegation and not having an eyewitness available and additional abuse alleged, we submitted a VA to Minnesota Department of Health (MDH) and the staff member in question was suspended as protocol. Facility investigation report dated 6/20/25 at 5:15 p.m., identified R1 reported whoever was in charge that night placed her shins on the side of my head, tapped me on the forehead and told me to settle down. He pushed perpetrator away and stated that was abuse. He also stated he thought they were all pissed off for the many times he had fallen. This was a mirrored event of what happened on 6/6/25 . After interviewing staff on Oakdale Avenue (2nd floor) they indicated they had not seen physical confrontation between staff and resident. He had a history of making false allegation, being untruthful, and threatening to call the police. He called police frequently (5 to 6 times since admission) to this facility . his sister reported he had same behavior at the Veterans Affairs (VA) . allegation was not verified. Interview on 6/24/25 at 11:55 a.m., R1 stated he was admitted to facility at the end of April 2025 and lived on the 1st floor TCU. He had moved him up to 2nd floor about one week ago. While he lived on TCU, was assaulted by a female staff charge nurse, and told by facility staff he lied about the incident. He had restless leg syndrome, once it started, he rolled from side to side and fell out of bed. It was later in the night, the charge nurse walked by his room while he laid on the floor and did not stop at first. When the nurse entered his room, she was angry with him, placed her shin bones against his head, he told her to stop that hurts and she tapped him on his head. He grabbed her calf muscle, pushed her away and said, that hurts, she yelled at him to stop rolling. He told her to get out of his room, she was the only one in there at the time. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/25/25 at 9:18 a.m., LPN-A stated on the evening of 6/6/25 she randomly checked on R1 and saw he rolled out of bed. She rushed into the room alone, his legs were on the floor and upper body remained on the bed. Per her reflex, she tried to support him with her thigh against his back, called for help, and he elbowed her with his left hand. She placed call light on and he told her to leave the room. By the time staff arrived to his room he had fallen to the floor. She did not use force, he swore at her, and she stayed out of his room after that. Two NAs assisted him back to bed. She was taken off work for one shift on 6/18/25, returned on 6/19/25, and had not taken care of him since. Interview on 6/25/25 at 11:00 a.m., licensed social worker (LSW) stated three staff nurses working on TCU were interviewed and asked two questions: -are there any known behaviors regarding R1 and, - did they noticed anything strange with the resident. LSW stated nursing staff were not asked about abuse, witnessed or alleged. The allegation made by R1 indicated LPN-A placed her shins on the side of his head, her thigh on the side of his body to help prevent the fall, could have been different but seemed similar. R1 was able to describe what the head/charge nurse looked like. LPN-A was suspended on 6/18/25, and the interview was completed. LPN-A was allowed to return to work on 6/19/25, night shift prior to completion of the investigation which was on 6/20/25. Our policy identified she should have been placed on leave without resident contact until the investigation was completed. It would have been important to be off work because there was an allegation of abuse, the residents are vulnerable, would want to be confident that abuse did not continue to happen, and all residents were safe. She stated would have been important to have completed interviews with those residents on TCU at minimum where he lived when it was identified the alleged incident may have taken place, and had only an explanation of what the staff nurse looked like. The facility policy was not followed. Interview on 6/25/25 at 11:30 a.m., designee social worker (DSW) stated he had completed the interviews with the residents on 2nd floor, where R1 currently lived. No residents and very few staff were interviewed on TCU where the allegation happened. He added it would have been important to follow the facility policy/protocol investigation process and interviews should have been completed with residents that lived in the TCU and staff that worked there to hear from everyone. Interview on 6/25/25 at 1:29 p.m., registered nurse (RN)-A stated R1 rolled out of bed frequently due to RLS and was able to make his needs known. There were days we were unable to predict when he would roll off his bed, had fragile skin, had some bruising, and skins tears. He heard how R1 had arguments with staff but had not heard or witnessed any physical abuse. He was not interviewed regarding any concerns/incidents with staff. Interview on 6/25/26 at 1:52 p.m., nursing assistant (NA)-B stated she had worked at facility for six months usually upstairs but had floated down to TCU occasionally. She was familiar with R1 and provided cares for him. She had not been interviewed by anyone regarding concerns. Interview on 6/25/25 at 2:09 p.m., NA-C stated she had worked at facility for approximately 3 years, usually the day shift on TCU. She was familiar with R1 and provided cares for him. She had not been interviewed by anyone regarding concerns or incidents related to abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/25 at 3:04 p.m., clinical coordinator (RN)-C stated there were no residents and only a few nurses interviewed on TCU. Residents were interviewed on 2nd floor where he currently lived. It would have been important to interview residents and staff on TCU, he was unable to provide staff name but described what she looked like. The allegation was abuse and we would have wanted the residents kept safe. He described her as the hit nurse at night. The social worker would have been the one to identify who should be interviewed. She interviewed LPN-A with the SW but that was the only staff she had interviewed. The resident interviews could have possibly provided information to confirm if they had experienced anything similar as what R1 reported. During an interview on 6/26/25 at 10:01 a.m., director of nursing (DON) stated R1's perception of time was not accurate and his cognition was intact. Interviews where not completed with staff NAs or residents on the TCU unit. Interviews with residents and staff are useful to help determine the outcome in the allegation of abuse, in addition to R1's interview. She stated LPN-A worked on 6/17/25, placed on suspension on 6/18/25, and then allowed to come back to work the night shift of 6/19/25 (11:00 p.m.-7:00 a.m.). R1 was moved from TCU on 6/16/25, and LPN-A had not worked with him since the allegation. DON stated a witness was identified during the previous allegation, unsure of which staff it was, and unable to locate the interview. During the investigation, in hindsight, the residents' on TCU should have technically been interviewed prior to the completion of the investigation and prior to LPN-A's return to work. It would have been important to separate residents from a potential perpetrator. During an interview on 6/26/25 at 1:20 p.m., administrator stated when there was an allegation of physical abuse the alleged perpetrator (AP) would be suspended from work until the investigation had been completed and determined whether it occurred or not. Staff and residents were interviewed after an allegation of abuse to help identify if there was a pattern. Our goal was to make sure the residents are safe and protect the staff if residents were physical with them. Facility policy Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating dated 2023, identified all reports of resident abuse (including injuries of unknown origin), neglect, exploitation or theft/misappropriation of resident property are reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of all investigation are documented and reported. The administrator ensures that the resident and person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. The individuals conducting the investigation as a minimum interviews any witness to the incident, interviews staff members on all shifts who have had contact with the resident during the period of the alleged incident, interviews other residents to whom the accused employee provides cares or services to and documents the investigation completely and thoroughly.