Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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	03/26/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to treat a wound when first discovered for one of one resident (R1) when the facility staff identified a wound on 3/16/26, applied a dressing, and then notified the provider and initiated treatment on 3/23/26. Findings include:R1's provider encounter note dated 3/4/26 did not include a skin assessment of R1. R1's minimum data set (MDS) dated [DATE] indicated R1 was admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia with other behavioral disturbances. R1's additional diagnoses included vascular dementia without behavioral disturbance, acquired absence of left leg above knee, acquired absence of right leg above knee, vascular disease, and reduced mobility. R1 had no ulcers, wounds, or skin problems. R1's weekly bath audit dated 3/17/26 indicated under the title Skin Status i.e., bruises, skin tears, rashes, redness, blisters, or any other open areas. R1 had non-tender lymph nodes observed on right upper hip. R1's progress note dated 3/23/26 indicated R1 had a new skin issue located right above his knee on his amputation site. This wound was staged at a stage four pressure ulcer/injury with full thickness skin and tissue loss. The progress note indicated R1's bone was exposed and had erythema/edema. The wound was measured 1.56 centimeters (cm) in length and 1.64 cm wide. The wound had 29% granulation and 80% slough. There was moderate amount of serosanguineous exudate. The progress note indicated the dressing was intake and there was 26%-75% dressing saturation. R1's provider order dated 3/23/26 indicated registered nurse (RN)-B called NP indicating R1 had an ulcer on his right stump and there was slough at wound bed and exposed bone. NP ordered doxycycline monohydrate 100 milligrams (mg) by mouth twice a day for seven days for an infection of the skin and/or soft tissue. R1's skin issues assessment dated [DATE] indicated R1 had a new would to his above the knee amputation stump. The wound measured 1.56 by 1.64, and the wound bed is 20% granulation and 80% slough with a small area of exposed bone. There was erythema to the peri wound with no order or pain. The assessment indicated R1's wound was a stage four pressure ulcer/injury with full-thickness skin and tissue loss. R1's dressing appeared intact, and the dressing had moderate amount of saturation. R1's progress note dated 3/23/26 indicated R1 had a new would to his above the knee amputation stump. The wound measured 1.56 by 1.64, and the wound bed is 20% granulation and 80% slough with a small area of exposed bone. There was erythema to the peri wound with no order or pain. The nurse practitioner (NP) was updated and reviewed the picture, and determined the wound was a diabetic ulcer with R1's peripheral vascular disease and severe protein-calorie malnutrition as contributing factors. NP ordered doxycycline for possible cellulitis due to the erythema. Wound order treatment consisted of UrgoTul Ag, calcium alginate, and a bordered foam dressing. R1's guardian was updated. R1's medication admission record (MAR) dated 3/23/26 indicated R1 would receive Doxycycline Monohydrate 100 mg by mouth twice a day for infection of the skin and/or soft tissue for seven days. This order was marked completed on 3/23/26 at 8:00 p.m., 3/24/26 at 9:00 a.m. and 8:00 p.m., 3/25/26 at 9:00 a.m. and 8:00 p.m., and 3/26/26 at 9:00 a.m. R1's MAR dated 3/24/26 indicated the nurse would provide wound treatment to right stump daily and as needed by cleansing with Vashe and let moistened gauze remain on would bed for 3 minutes, apply skin prep to peri wound, place UrgoTul on wound bed followed by calcium alginate and cover with a (continued on next page)

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.

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

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 03/26/2026
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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F 0684 Level of Harm - Actual harm Residents Affected - Few	bordered form dressing. This order was marked and completed on 3/24/26 and 3/25/26. R1's weekly bath audit dated 3/24/26 under the title Skin Status R1 had no new skin alterations i.e., bruises, skin tears, rashes, redness, blisters, or any other open areas. During an interview on 3/26/26 at 8:30 a.m., guardian-A indicated he was notified about the wound during a care conference on 3/23/26. Guardian-A indicated there was a progress note in R1's medical records between 3/21/26 and 3/22/26 about R1's wound. During an interview on 3/26/26 at 9:34 a.m., licensed practical nurse (LPN)-A stated if she saw a resident had a wound, she would let the provider know right away and get treatment orders. During an interview on 3/26/26 at 11:24 a.m., RN-B stated she received a note on 3/22/26 that R1 had a wound on his right stump and RN-B had assessed it on 3/23/26. After RN-B assessed the wound, RN-B had a care conference with guardian-A. During an interview on 3/26/26 at 1:10 p.m., LPN-B stated she had discovered the wound on 3/23/26. LPN-B was providing cares for R1 when she saw the wound dressing on his stump, the dressing was dated 3/16/26, but there were no initials to indicate who applied the dressing. LPN-B asked other nurses working if they had noticed the wound on R1's stump and none of the other nurses knew about the wound. During an interview on 3/26/26 at 1:12 p.m., RN-C stated she worked the overnight shift on 3/16/26, 3/17/26, 3/18/26, and 3/19/26. RN-C stated she did not notice a wound on R1's stump during any of her shifts. If she found a resident had a wound, she would contact the provider and then use the house standing orders for treatment while she waited for treatment from the provider. During an interview on 3/26/26 at 1:33 p.m., LPN-C stated she worked the evening shift on 3/16/26, 3/17/26, 3/18/26, and 3/20/26 and she did not notice a wound on R1's stump during any of her shifts. If she discovered a wound on a resident, she would assess the wound, then contact the provider for treatment and update the family. During an interview on 3/26/26 at 1:40 p.m., LPN-E stated she worked with R1 on the evening of 3/16/26. LPN-E stated she did not see any dressing applied to R1's stump. During an interview on 3/26/26 at 1:46 p.m., LPN-D stated she worked with R1 on 3/16/26 during the day shift and she did not see R1's wound on 3/16/26. LPN-D stated she did recall seeing a band-aid with a date on his stump during her shift but could not recall the date noted. During an interview on 3/26/26 at 2:00 p.m., LPN-A stated she did not see R1's wound when she worked on 3/16/26 because she was not looking for a wound. LPN-A stated she did not know how or who applied R1's dressing on 3/16/26. During an interview on 3/26/26 at 2:15 p.m., RN-B stated when she assessed R1's wound on 3/23/26, there had already been a dressing on the wound. RN-B did not recall where the dressing came from or who applied dressing on the wound. RN-B stated the dressing had a date of 3/16/26 but did not have initials of the staff member who applied the dressing. During an interview on 3/26/26 at 4:22 p.m., RN-D stated it is the expectation that when a nurse discovers a wound, the nurse would notify the provider the day the wound was found and then treat the wound based on what the provider orders. RN-D stated the wound should be assessed at the duration the provider orders. The facility's Standing Orders for Skilled Nursing Facility revised in 2025 indicated if the facility wound management process was not available staff should assess all wounds and dressings daily and change dressings every three days and as needed. The Standing Orders indicated the nurse could treat the wound with normal saline or non-cytotoxic wound cleaner and cover with a non-adherent dressing and secure appropriate cover dressing while avoiding tape to the skin. Staff should notify the provider the next business day of a new wound or injury.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records that are accurately documented for five of six residents (R1, R2, R3, R5, and R6) when their weekly bath audits did not indicate wounds that they were being treated for.Findings include: R1's minimum data set (MDS) dated [DATE] indicated R1 was admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia with other behavioral disturbances. R1's additional diagnoses included vascular dementia without behavioral disturbance, acquired absence of left leg above knee, acquired absence of right leg above knee, vascular disease, and reduced mobility. R1 had no ulcers, wounds, or skin problems. R1's weekly bath audit dated 3/17/26 indicated under the title Skin Status i.e., bruises, skin tears, rashes, redness, blisters, or any other open areas. R1 had non-tender lymph nodes observed on right upper hip. R1's weekly bath audit dated 3/24/26 indicated under the title Skin Status i.e., bruises, skin tears, rashes, redness, blisters, or any other open areas. R1 did not have any new or old skin alterations. R1's wound documentation indicated R1 was receiving treatment on his stage four pressure ulcer/injury on his right above the knee amputation from 3/23/26 through 3/25/26. R2's MDS dated [DATE] indicated R2 was admitted to the facility on [DATE] with a primary diagnosis of paraplegia. R2's additional diagnoses included pressure-induced deep tissue damage of left hip, pressure ulcer of other site, pressure ulcer of other site stage three, pressure ulcer of right ankle stage three, pressure ulcer of left hip stage four, pressure ulcer of right heel stage four, and pressure ulcer of left heel stage three. R2's weekly bath audits dated 1/7/26, 1/14/26, 1/21/26, 1/28/26, 2/4/26, 2/18/26, 2/25/26, 3/4/26, 3/11/26, and 3/18/26 indicated R2 did not have any new or old skin alterations. R2's wound documentation indicated R2 was receiving treatment for his open lesion on his right Achillies on 1/5/26, 1/12/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/7/26, 3/9/26, 3/16/26, and 3/23/26. R2 was receiving treatment for stage three pressure ulcers on his right heel on 1/5/26, 1/12/26, 1/19/26, 1/26/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/7/26, 3/9/26, 3/16/26, and 3/23/26. R2 was receiving treatment for his left shin wound on 3/9/26 and 3/23/26. R2 was receiving treatment for his stage three right medial calf wound on 1/5/26, 1/12/26, 1/19/26, 1/26/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/7/26, 3/9/26, and 3/23/26. R2 was receiving treatment for his unstageable right medial malleolus wound on 1/5/26, 1/12/26, 1/19/26, 1/26/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/7/26, 3/9/26, 3/16/26, and 3/23/26. R2 was receiving treatment for his stage three left heel pressure ulcer/injury on 1/5/26, 1/12/26, 1/19/26, 1/26/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/7/26, 3/9/26, 3/16/26, 3/21/26, and 3/23/26. R3's MDS dated [DATE] indicated R3 was admitted to the facility on [DATE] with a primary diagnosis of malignant neoplasm of prostate. R3's additional diagnoses included pressure ulcer of left heel stage three, pressure ulcer of other site stage three, pressure ulcer of other site unspecified stage, and pressure ulcer of sacral region stage four. R3's weekly bath audit dated 3/25/26 indicated R3 did not have any new or old skin alterations. R3's wound document indicated R3 received treatment to his right heel pressure ulcer/injury on 3/23/26. R5's MDS dated [DATE] indicated R5 was admitted to the facility on [DATE] with a primary diagnosis of type two diabetes mellitus with other skin ulcers. R5's additional diagnoses included pressure-induced deep tissue damage of left ankle, pressure ulcer of left heel stage four, and non-pressure chronic ulcer of other part of left foot with other specified severity. R5's weekly bath audits dated 2/10/26, 2/17/26, 3/3/26, 3/17/26, and 3/24/26 indicated R5 did not have any new or old skin alterations. R5's wound documentation indicated R5 received treatment for his diabetic ulcer on left heel on 2/9/26, 2/23/26, 3/2/26, 3/16/26, 3/23/26, and 3/25/26. R5 received treatment for his diabetic ulcer on left medial calf on 2/23/26, 3/2/26, 3/9/26, 3/16/29, 3/23/26, and 3/25/26. R6's MDS dated [DATE] indicated R6 was admitted to the facility on [DATE] with a primary diagnosis of end stage renal disease. R6's additional diagnosis included (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	peripheral vascular disease. R6's weekly bath audits dated 1/8/26, 1/15/26, 1/22/26, 2/5/26, 2/12/26, 2/19/26, and 3/12/26 indicated R6 did not have any new or old skin alterations. R6's wound documentation indicated R6 received treatment for his unstageable pressure ulcer/injury to his left dorsum second digit on 1/26/26, 2/2/26, 2/16/26, 2/23/26, 3/2/26, 3/9/26, 3/16/26, and 3/23/26. R6 received treatment for an abscess on his coccyx on 1/5/26, 1/12/26, 1/26/26, 2/2/26, 2/9/26, 2/16/26, 2/23/26, 3/2/26, 3/9/26, 3/16/26, and 3/23/26. During an interview on 3/26/26 at 11:24 a.m., registered nurse (RN)-A stated she was unsure why R1's skin alterations were not documented on the weekly bath audit on 3/24/26. RN-A stated that education would be provided to the nurse who completed the bath audit. During an interview on 3/26/26 at 1:10 p.m., licensed practical nurse (LPN)-B stated when a resident takes a bath, the nursing aid will alert the nurse who will complete the skin audit. The nurse will check for redness, swelling, and open wounds. If there are any new skin alterations, she would note that on the weekly bath audit. If there are no new skin alterations, LPN-B stated she would chart nothing new. During an interview on 3/26/26 at 1:12 p.m., RN-C stated when a resident is taking a bath, they would complete the weekly skin audit. If RN-C found a new wound or skin alteration, she would make a report in risk management. During an interview on 3/26/26 at 1:33 p.m., LPN-C stated when she is completing a skin audit on a resident, she is looking for any marks under the breasts, under the arms, groin, buttocks, and feet. If there is a new wound, she would document that in the weekly bath audit. During an interview on 3/26/26 at 1:40 p.m., LPN-E stated when a resident is taking a bath, they would complete the resident's weekly bath audit. LPN-E stated she would document what she found on the resident's skin on the weekly bath audit. During an interview on 3/26/26 at 1:46 p.m., LPN-D stated the nurse will check a resident's skin when the resident is taking a nap. If the resident has a new or old wound, LPN-D would document that on the weekly bath audit. During an interview on 3/26/26 at 4:22 p.m., RN-D stated any new or existing wound should be noted on the weekly bath audit. RN-D stated before three months ago staff was instructed not to put the existing wounds on the weekly bath audits, but nurses are now expected to note both new and existing wounds on the weekly bath audit. A policy on weekly bath audits was requested and none was received.