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	03/12/2026

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and document review the facility failed to electronically submit direct care staffing information (including agency and contract staff) per day, based on payroll and other verifiable and auditable data to Centers for Medicare and Medicaid Services (CMS). The had the ability to impact all 171 residents residing at the care facility. Findings include:The care facilities Payroll Based Journal (PBJ) Staffing Data Report for fiscal year quarter 1 2026 (October 1 - December 31), dated 3/4/26, indicated the facility failed to submit data for the quarter. During an interview on 03/0926 at 12:24 p.m., the administrator stated the PBJ information was submitted through their corporate team, and he would look into how this was missed. During a follow up interview on 12:10 p.m., the administrator stated he spoke with his corporate team, and it was discovered the wrong facility's information was uploaded in place of their facility's staffing information and it didn't stick in the system. A facility policy titled Payroll Based Journal, dated 3/2/25, indicated it was the policy of the facility to adhere to the mandatory submission of staffing information based on payroll data with a deadline of February 14th for fiscal quarter 1 submissions. The policy further indicated, Section 6106 of the Affordable Care Act (ACA) requires facilities to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to notify the attending physician of a change in condition for 1 of 1 resident (R181) reviewed for discharge process.Findings include:R181 was admitted to the facility on [DATE] with an admission diagnosis of lumbar stenosis without neurogenic claudication, and other specified postprocedural state. R181 left the faciity on 1/10/26.R181's medical record was reviewed and lacked documentation about reporting R181's leaving the facility against medical advice (AMA) to his primary physician.R181's progress note dated 1/10/26 at 5:58 a.m., indicated R181's wife arrived at the facility at 4:50 a.m. and requested to get R181's medications ready because she was taking R181 home with her. The progress note indicated the nurse in charge educated R181 and his wife about AMA. The nurse in charge advised them the facility would not be able to release the medications. R181's progress note dated 1/13/26 at 3:09 p.m., documented a phone call from a spine center requesting an update about R181. The spine center wanted to verify R181 left the facility AMA, and without medications. During interview on 3/12/26 at 10:29 a.m., the assistant director of nursing/infection control preventionist (IP) reviewed R181's medical record and verified R181's primary physician was not updated about R181 leaving AMA.During interview on 3/12/26 at 10:42 a.m., the director of nursing (DON) stated the provider needed to be notified when a resident left AMA. DON stated she would look into R181's situation and provide further details. No additional information was received. Facility's policy titled Resident Leave Against Medical Advice dated 4/19/19, indicated the resident's assigned nurse will contact the primary physician to inform of the resident's decision to leave against medical advice.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to notify the State Long-Term Care (LTC) Ombudsman of facility-initiated transfers to an acute care facility on an emergent basis, and failed to ensure a written notice of bed hold was provided and documented in the electronic medical record (EMR) for 2 of 2 residents (R10, R17) reviewed for hospitalizations. Findings include:R10 R10's significant change in status (SCSA) Minimum Data Set, dated [DATE], identified R10 with severe cognitive impairment, and diagnoses of liver cancer, kidney disease, dementia, and psychosis (disconnection with reality, including hallucinations and delusions).R10's progress note (PN) dated 12/15/25, identified R10 had an unwitnessed fall with injury and was sent to the emergency department (ED). PN lacked indication a bed-hold or transfer form was offered and signed.R10's PN dated 1/24/26, identified a fall with major injury and was sent to the ED.PN lacked indication a bed-hold or transfer form was offered and signed.R17 R17's quarterly MDS dated [DATE], identified R17 with severe cognitive impairment and diagnoses of Alzheimer's, arthritis, dementia, anxiety, depression and fibromyalgia (chronic disorder involving pain, fatigue, sleep disturbances and cognitive issues).R17's emergency room (ER) After Visit Summary dated 2/19/26, identified R17 was sent to eh hospital on (date) and returned on (date) for a medication-related concern. PN failed to indicate if a bed-hold or transfer form was offered to her emergency contact.During interview with registered nurse (RN)-D on 3/11/26 at 12:48 p.m., RN-D stated when a resident was transferred to the hospital, the facility was expected to obtain a signed bed-hold and transfer policy from the resident or a verbal agreement prior to resident leaving the facility. RN-D stated she was expected to obtain a copy of the signed form and give it to the Health Unit Coordinator (HUC) who was then expected to download or scan it into the residents EMR. In addition, RN-D stated she would send the resident to the hospital with a face sheet, medication list, and a copy of a current Provider Order for Life Sustaining Treatment (POLST) form. RN-D stated she would call the guardian and emergency contact to obtain verbal consent if a resident was unable to provide it and then document this in a progress note in the EMR.During interview with licensed practical nurse (LPN)-D on 3/11/26 at 12:59 p.m., LPN-D stated whenever a resident was transferred to the hospital, the facility was expected to ask family or the resident's guardian for verbal permission to approve a bed-hold and transfer notice. LPN-D stated, I fill out form saying I have verbal permission, uploaded it into the residents EMR, wrote it in the progress note.During interview with RN-B on 3/11/26 at 1:26 p.m., RN-B stated whenever a resident was transported to the hospital that a signed bed-hold and transfer policy must be obtained each time they leave. RN-B stated a copy of the signed form is uploaded into the residents EMR and expectation was to document the bed hold in the progress note.During interview with HUC-A on 3/11/26 at 1:31 p.m., HUC-A stated bed-holds went with the resident to the emergency room and HUC-A scanned a copy of the signed form and put it in the EMR.During interview with LPN-H on 3/12/26 at 8:30 a.m., LPN-H stated when she sent a resident to the hospital she would fill out the written form to get consent, leave a copy at the facility to be scanned into the chart, and send a copy with the resident along with other paperwork to the hospital. LPN-H stated she was nurse on duty when R10 fell and broke his hip on 12/15/25 and was sent to the hospital. LPN-H stated she did not recall if she got the bed-hold and transfer form, but if she had, she would have entered it into R10's progress notes. LPN-H looked at R10's progress notes and verified there was no mention of providing or offering a bed-hold notice and transfer form to R10.During interview with health unit coordinator (HUC)-B on 3/12/26 at 8:43 a.m., HUC-B stated that when a resident was transferred to the hospital, the facility was expected to print out a resident face sheet, POLST, medication list and have the resident sign a copy of the bed-hold and transfer policy prior to leaving the facility. In instances where the resident was unable to acknowledge the bed-hold form then the guardian or emergency contact was informed, (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the nurse was required to document the discussion in the progress note of the EMR. In addition, the HUC was responsible for uploading a copy of the signed bed-hold and transfer form into the EMR.During interview with LPN-I on 3/12/26 at 10:03 a.m., LPN-I stated he was the nurse on duty when R17 fell and fractured his arm on 1/24/26 and was sent to the hospital. LPN-I stated he did not recall filling out bed-hold or transfer form prior to sending R17 to the hospital. LPN-I stated, it should be signed and scanned into the chart, but I do not recall it being done. LPN-I stated expectation of staff to print a face sheet, medication list, and POLST to accompany the resident to the hospital.During interview with registered nurse (RN)-A on 3/12/26 at 11:26 a.m., RN-A stated expectation of nursing staff to immediately provide a copy of the bed-hold policy and notice of transfer to the patient or guardian prior to transfer to hospital. In addition, the resident face sheet, medication list and current POLST to all accompany resident to the hospital. RN-A stated expectation of facility staff to upload a signed copy of the notice of transfer to the resident's electronic medical record (EMR). RN-A verified both R10 and R17's EMR lacked documentation of a bed-hold/transfer notice, and a progress note to indicate it was done.During interview with director of nursing (DON) on 3/12/26 at 11:04 a.m., DON stated expectation of staff to provide copy of bed-hold policy and notice of transfer when residents were leaving the building for hospitalizations. DON stated a signed copy should be scanned into the EMR. As for notifying the Office of the State Long-Term Care Ombudsman of discharges and transfers, DON stated the director of social services (SS)-D is responsible for that task.During interview with SS-D on 3/12/26 at 11:17 a.m., SS-D stated she was responsible for sending discharge notifications to the State Ombudsman monthly. However, SS-D stated she was unaware of needing to send notices of transfers and hospitalizations to the Office of the State Long-Term Care Ombudsman too., and stated, I did not know that I had to.Attempts to call/contact R10 and R17's guardian and primary emergency contacts and the Ombudsman were made but no answer or call back was obtained.Undated facility policy titled Transfer or Discharge Notice identified expectation of facility to provide transfer or discharge notice to resident where, An immediate transfer or discharge is required by the resident's urgent medical needs. In addition, The resident and/or representative will be notified in writing of the following information which included the facility bed-hold policy and, A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with the potential for inaccurate federal reimbursement and resident care planning for 3 of 5 residents (R5, R8, and R25) reviewed for MDS accuracy. Findings include: R5's Annual Minimum Data Set (MDS), dated [DATE] indicated R5 was admitted to the care facility on 1/13/25. Section GG Functional Abilities and Goals section of the MDS was dashed not assessed. R8's quarterly MDS, dated [DATE], indicated R8 was admitted to the care facility 11/22/24. Section GG Functional Abilities and Goals section of the MDS was dashed not assessed. R25's quarterly MDS dated [DATE], indicated R25 was not receiving hospice care and was admitted to the facility on [DATE]. R25's Order Summary Report dated 9/23/25 included an active order that indicated R25 had signed on to receive hospice care on 9/4/25 with a diagnosis of Parkinson's disease. During an interview on 3/12/26 at 8:01 a.m., licensed practical nurse (LPN)-E stated that R25 was receiving hospice care and had been since his admission to the facility. During an interview on 3/12/26 at 9:20 a.m., the MDS Coordinator (MDSC)-A stated the GG section of the MDS was discussed daily at their morning team meeting and was also assessed by utilizing the resident's electronic medical record (EMR) to determine how well a resident functions and how much support they need with activities of daily living (ADLs). The MDSC-A stated they attempt to coordinate baths for each resident to fall within the 3-day lookback period but that it can be challenging with the large size of their facility. The MDSC-A confirmed R5's and R8's GG section of their most current MDS was dashed as not assessed. The MDSC-A also stated it was their responsibility to indicated on the MDS if a resident was receiving hospice services which was determine based on a list the chaplain send out with all residents receiving hospice services listed. The MDSC-A confirmed R25's most current MDS did not indicated R25 was receiving hospice services, and it should. A facility policy titled Resident Assessments, dated 11/30/2021, indicated the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and document review, the facility failed to ensure a comprehensive care plan was developed and implemented for 1 of 1 resident (R13) reviewed for pain management.Findings include:R13's admission Minimum Assessment Data (MDS) dated [DATE], indicated R13 was cognitively intact, had no behaviors, and didn't refuse cares. MDS indicated R13 needed substantial assistance with toileting hygiene, bathing, dressing, personal hygiene, and transfers. The MDS assessment also indicated R13 received scheduled and as needed (PRN) pain medications, as well as opioid and antipsychotic medications.R13's Clinical Diagnosis Report dated 3/12/26, indicated diagnoses of chronic obstructive pulmonary disease, chronic pain, post-traumatic stress disorder, repeated falls, failure to thrive, and heart failure.R13's orders dated 3/12/25 included the following medications:Hydromorphone HCL 2 milligrams (mg) tablets. Give 0.5 tablet by mouth three times a day.Hydromorphone HCL 2 mg tablets. Give 0.5 tablet by mouth every 6 hours as needed (PRN)Acetaminophen oral tablet 500 mg. Give one tablet every 8 hours PRNLidocaine external cream 4%. Apply small amount to left chest wall twice a day.Gabapentin oral capsule 100 mg by mouth three times a day.R13's care plan dated 3/12/26, did not include a care plan for pain.During interview on 3/10/26 at 11:46 a.m., R13 stated he had chest surgery last year and since then he has experienced pain. During the interview R13 rated his pain as 7. R13 said the pain comes and goes.During interview on 3/10/26 at 3:21 p.m., nurse manager/licensed practical nurse (LPN)-C stated R13 had problems with pain. LPN-C stated R13 scheduled an appointment to see a doctor due to severe foot pain.During interview on 3/11/26 at 10:44 a.m., LPN-C verified his pain management had not been care-planned.During interview on 3/11/26 at 10:49 a.m., the director of nursing (DON) stated R13 should have had a care plan for pain and she expected the staff would assess resident's pain and monitor for side effects and pain therapy effectiveness.A facility policy titled Comprehensive Person-Centered Care Plans dated 11/30/21, indicated the comprehensive, person-centered care plan will include measurable objectives and timeframes, and describe the services that are furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to revise the care plan to include a comprehensive pain management plan for 2 of 3 residents (R6, R42) reviewed with a history of pain. Findings include: R6's quarterly minimum data set (MDS) dated [DATE], indicated R6 had moderately impaired cognition and a diagnosis of heart failure, kidney failure, and dementia. The MDS indicated R6 received scheduled pain medications, did not receive as-needed pain medications, and did not receive non-medication interventions for pain during the look-back period (LBP). R6's care plan dated 10/29/25, included a pain care plan that indicated R6 had acute pain/ chronic pain but did not further describe R6's pain. The care plan had a goal that the resident would report satisfactory pain control. The pain care plan included one intervention, which was as follows: evaluate for non-verbal indicators of pain. The pain care plan did not indicate what non-pharmacological interventions should be utilized for managing R6's pain. R6's order summary dated 3/10/26, indicated R6 had an order for 650 milligrams (mg) of acetaminophen (an over-the-counter pain medication) three times a day for chronic pain, with a start date of 7/14/25, a discontinued date of 3/9/26, and then reordered on 3/9/26. The summary included an order for a lidocaine pain relief patch to the mid-upper back every 12 hours, started on 8/26/25, discontinued on 3/9/25, and restarted on 3/9/26. The summary indicated R6 also had an order for 500 mg of methocarbamol (a muscle relaxant) every four hours as needed for pain, with a start date of 10/17/25. During an interview on 3/11/26 at 10:11 a.m., registered nurse (RN)-D confirmed she was R6's nurse for the day. RN-D stated that R6 had a history of chronic pain and had previously been seeing a pain medicine team for this pain. RN-D stated R6's pain was sporadic and varied in location but was sometimes in his back. RN-D stated that the non-pharmacological interventions she had used to assist R6 with his pain were music, redirection, snacks, and reminiscing, and she had found these effective. During an interview on 3/12/26 at 8:04 a.m., licensed practical nurse (LPN)-B confirmed she was R6's nurse for the day and stated that when R6 had pain, it was generally in his upper back and that non-pharmacological pain interventions such as heat or ice were implemented to assist with his pain. LPN-B stated she would look at the care plan to see what pain interventions were effective for R6 but was unsure if this was on the care plan or not. During an interview on 3/12/26 at 8:47 a.m., LPN-G, the unit nurse manager, stated that R6 had a history of upper back pain and utilized pain medications. When asked what nonpharmacological pain interventions had been found helpful with R6's pain, LPN-G stated that things such as fresh air, one-on-one time, and reassurance were helpful nonpharmacological interventions to assist R6 with his symptoms. LPN-G stated she and social services worked together to update resident care plans, but when asked if these nonpharmacological pain interventions were part of his care plan, LPN-G stated she was unsure. During an interview on 3/12/26 at 9:14 a.m., the director of nursing (DON) stated that she would (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expect nursing staff to assess and observe for signs and symptoms of resident pain, and as they see these signs or symptoms, they should attempt non-pharmacological pain interventions. The DON stated she would expect non-pharmacological pain interventions to be outlined in the care plan but acknowledged this might take some time to develop as they get to know the residents. R42's annual Minimum Data Set (MDS), dated [DATE], indicated R42 was admitted to the care facility on 12/26/23, had severe cognitive impairment, and was dependent on staff for all activities of daily living (ADLs). The MDS further indicated R42 received scheduled and as needed pain medication but did not receive and non-pharmacological pain interventions. R42's Orders indicated an order, dated 3/2/26, for Oxycodone (a narcotic pain medication) 5 milligrams (mg) once a day and every 6 hours as needed, not to exceed 3 doses. R42's orders, dated 5/7/25, indicated orders for methocarbamol (a muscle relaxant) 500mg three times a day for pain, diclofenac gel to right wrist three times a day for pain and Tylenol 650 mg three times a day for pain. R42's March medication administration record (MAR), indicated R42 had received as needed oxycodone seven times in the past ten days. R42's care plan, dated 11/2/24, indicated R42 had chronic pain related to upper extremity contracture and a history of shoulder injuries. The care plan indicated an intervention to medicate R42 with as needed medications if non-medication interventions were ineffective. The pain care plan did not indicate what non-pharmacological (non-medication) interventions should be utilized for managing R42's pain. R42's electronic medical record (EMR), to include progress notes, lacked evidence of documented or care planned non-pharmacological pain interventions that should be attempted prior to administering as needed pain medication. During observation on 3/9/26 at 5:58 p.m., R42 was out in the main living area in a broda chair. R42 appeared to be leaning to the right and in distress moaning and restless. Staff approached R42 to help reposition him in his broda chair. During an interview on 3/11/26 at 7:20 a.m., nursing assistant (NA)-D stated R42 would stay in bed until near lunch time, and she believed the nurses would give him something for pain prior to transferring him out of bed to help with his pain. NA-D stated if a resident appeared in pain, including R42, there were no non-medication interventions would try, she would tell the nurse. During an interview on 3/11/26 at 10:04 a.m., registered nurse (RN)-F stated R42 was unable to verbally communicate but could at times nod yes or no to simple questions such as are you in pain. RN-F stated staff often had to read his non-verbal signs of pain such as facial grimaces or groans. RN-F stated for non-pharmacological interventions staff would get him out of bed into his broda chair. During an interview on 3/11/26 at 1:03 p.m., nurse manager and licensed practical nurse (LPN)-C stated it was the expectation that non-pharmacological pain interventions be care planned and attempted and documented prior to as needed pain medication being administered. During a follow up interview on 3/11/26 at 2:35 p.m., nurse manager and LPN-C stated when staff notice R42 to be in pain they hold his hands, reposition him in his broda chair and if he still shows signs of pain they offer him pain medication. LPN-C confirmed that none of the non-pharmacological (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain interventions were care planned or documented as attempted. The facility's Comprehensive Person-Centered Care Plans policy dated 11/30/21, indicated that a person-centered care plan would be developed for each resident. The policy indicated care plan interventions would be derived through analysis of the information gathered as part of the comprehensive assessment. The policy indicated the care plan would include services that would be furnished to attain or maintain the resident's highest practicable well-being.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a resident was reassessed and failed to implement new interventions to prevent skin breakdown after developing a stage III pressure injury while a resident at the facility for 1 of 2 residents (R123) reviewed for pressure injuries. Findings include:R123's quarterly Minimum Data Set (MDS) dated [DATE], indicated R123 required substantial staff assistance with personal hygiene, dressing and bathing and was dependent on staff for toileting. The MDS indicated R123 was at risk but did not have any pressure ulcers.R123's care plan included a focus of potential for skin impairment related to immobility and incontinence last revised 12/19/23. Interventions included use of pressure reducing wheelchair cushion and pressure reducing mattress.R123's care plan, dated 1/16/26, indicated R123 had a coccyx wound requiring wound care and to keep resident skin clean and well lubricated. The care plan lacked any new, specific pressure reducing interventions to prevent R123 from developing new (or re-opening) pressure injuries. R123's wound note, dated 1/19/26, indicated R123 had a stage III pressure injury to her coccyx that had re-opened last week and the plan of care in place remained effective.R123's significant change MDS, dated [DATE], indicated R123 received hospice services and required substantial staff assistance with personal hygiene, dressing and bathing and was dependent on staff for toileting. The MDS further indicated R123 was at risk for pressure ulcers and had one stage III pressure injury not present on admission. R123's wound note, dated 2/23/26, indicated R123's coccyx wound had resolved. During an interview on 3/11/26 at 12:37 p.m., registered nurse (RN)-F stated staff used barrier cream and a silicone dressing for R123's bottom even without a pressure injury. RN-F stated R123 was not on any specific turning and reposition schedule. During an interview on 3/11/26 at 1:03 p.m., clinical manager and licensed practical nurse (LPN)-C stated R123's interventions depended on who the aide was that was working, stating R123 would often refuse cares but a few aides were able to get her up and out of bed. LPN-C stated the aides who worked with the residents rotated to different units but work well together. LPN-C confirmed the care plan needed to be updated to remove wound care and confirmed there had been no updates to the potential for skin impairment care plan since R123 developed a pressure injury in January. LPN-C stated she believed the current interventions were effective because R123. had the one issue and hasn't had anymore.During a follow up interview on 3/12/26 at 11:02 a.m., clinical manager and LPN-C stated R123 should not be getting a silicone dressing on her coccyx as the wound resolved and there were no new orders after the wound healed for continued dressing, only barrier cream. LPN-C also confirmed R123 was not on a specific turning and repositioning schedule. During an interview on 3/12/26 at 12:10 p.m., the director of nursing (DON) stated that even though R123 was on hospice care she would expect to see new care planned interventions for pressure injury prevention and skin protection after the development of a pressure injury, stating, we still don't want to see pressure injuries in hospice.A facility policy titled Prevention of Pressure Injuries, dated 3/6/25, instructed staff to reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team and to review the interventions and strategies for effectiveness on an ongoing basis.

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	245189	A. Building B. Wing	03/12/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to provide assessments and routine dental services to 2 of 2 residents (R87, R152) reviewed for dental care. Findings include: R152's significant change Minimum Data Set (MDS) dated [DATE], indicated intact cognition, diagnoses of traumatic subdural hemorrhage (brain bleed) with loss of consciousness, weakness, dysphagia, and required substantial assistance with oral hygiene. During observation and interview on 3/12/26 at 8:48 a.m., R152 was sitting on the edge of his bed in his room. He stated his mouth was sore and he opened his mouth where there were several missing teeth. He further stated he hadn't seen a dentist since he was admitted (9/16/24) and would like to. He told several staff members about his mouth pain but was unable to recall which staff members he told. R152's MDS dental assessment (completed by Apple Tree Dental) dated 9/2/25, indicated R152 had broken natural teeth, requires staff supervision with oral care, recommended a routine dental referral, and non-urgent dental care needs. R152's care plan dated 2/20/26, indicated R152 required the physical assistance of one staff for personal hygiene but did not address oral care specifically. R152's medical record lacked documentation of routine dental care (i.e. dental appointment). During interview on 8:55 a.m., the Health Unit Coordinator (HUC)-C stated orders for ancillary services (dental, podiatry, vision, etc.) were put in upon admission. Then MDS does an assessment to see what services are needed and the clinical manager can prescribe orders for a referral. When there are enough residents, they (dentist) will come to the facility. HUC-C further stated the residents should be seen within 6 months of the referral. Apple Tree Dental was scheduled to come on 3/17/26 but R152 was not scheduled to be seen. HUC-C stated there was not an official list of residents for this month's visit. The surveyor asked when R152's last dental visit was and HUC-C was unable to find that information. R87 R87's quarterly Minimum Data Set (MDS) dated [DATE], identified R87 with severe cognitive impairment and dependent on staff for all cares including oral hygiene. In addition, R87 had diagnoses of dementia and dysphagia (difficulty swallowing). R87's care plan dated 3/3/25 identified R87 with Impaired Dentition-edentulous, no dentures. R87's physician orders (PO) and electronic medical record (EMR) failed to indicate an order for dental services. During interview with licensed practical nurse (LPN)-H on 3/12/26 at 8:30 a.m., LPN-H stated expectations for orders to be obtained from provider and the Health Unit Coordinator (HUC) would then make the appointment and arrange transportation. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with HUC-B on 3/12/26 at 8:43 a.m., HUC-B stated expectation of facility to obtain a referral from a provider and HUC would then facsimile order and resident face sheet to the contracted dental provider for the facility who comes a couple times a year to facility to provide routine dental services. During interview with Registered Nurse (RN)-A on 3/12/26 at 10:26 a.m., RN-A stated expectation of all residents to be seen by a dentist usually yearly or every 6 months. RN-A looked in R87's electronic medical record and verified no dental assessments were done. RN-A stated, we should still ensure everyone has a dental visit or least offered yearly. During interview with director of nursing (DON) on 3/12/26 at 11:09 a.m., DON stated expectation of all residents, Should be seen annually at least and documented in the chart that it was done. DON verified R87 EMR failed to indicate any dental services were offered or provided. Attempts at contacting R87's responsible party were made but no answer or call back was obtained. The facility policy regarding dental services dated 2/8/22, indicated all dental services provided are recorded in the resident's medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn to prevent the spread of infection for 1 of 1 residents (R9) observed for enhanced barrier precautions (EBP), (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). Facility also failed to ensure hand hygiene was performed for 1 of 2 residents (R73) reviewed for transmission-based precautions (TBP).Findings Include: Review of Centers for Disease Control (CDC) guidance dated 4/1/24, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for EBP included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. R9's significant change MDS dated [DATE] indicated R9 was cognitively impaired, had physical behaviors toward others with no impact to the resident, and did not refuse cares. R9's MDS indicated he had a pressure ulcer and had an indwelling catheter. MDS indicated diagnoses of atrial fibrillation, hypertension, non-Alzheimer's dementia, depression, post-traumatic stress disorder, neurogenic bladder and obstructive and reflux uropathy. R9's Profile report indicated EBPs. R9's Clinical Orders included orders for a urinary catheter and sacrum/coccyx wound care. R9's care plan titled Risk for Urinary infection indicated R9 was on EBP. R9's functional care plan revised on 12/23/25, indicated R9 required extensive assistance of 2 person for transfers, dressing and toileting hygiene. R9's functional care plan also indicated he needed total assistance of 2 for transfers with mechanical lift. During observation on 3/10/26 at 12:50 p.m., an EBP sign was observed on R9's on the wall, next to his room's door. The sign directed staff to use a gown and gloves while providing personal cares and transfers. During observation and interview on 3/10/26 at 11:54 p.m., R9 was observed being transferred by two nursing assistants (NA) from his bed to his wheelchair after personal cares. With the sling under R9, one NA hooked the straps onto the lift, they elevated him off the bed and placed him in the wheelchair with the sling under his body. Once sitting on his wheelchair, they unhooked the sling. Neither of the NAs were wearing a gown. During interview on 3/10/26 at 12:58 p.m., NA-C stated she provided catheter care and peri care after an episode of bowel incontinence. NA-C stated after she provided personal cares, she removed her gown and then placed the sling under R9 to prepare to transfer him from his bed to the wheelchair. NA-C stated, I am supposed to wear a gown during transfers, and I did not use one. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/11/26 at 10:21 a.m., NA-B stated she helped NA-C to transfer resident from his bed to his wheelchair the previous day. NA-B stated she didn't touch R9, she only touched the Hoyer and added As long as I don't touch him, I don't need to wear a gown. During interview on 3/11/26 at 12:28 a.m., the director of nursing (DON) stated the staff should follow the sign instructions. DON stated the staff needed to use a gown during transfers to avoid transmitting infections. The facility's policy titled Isolation-Categories of Transmission-Based and Enhanced Precautions dated 10/2021, directed staff to wear gloves and gowns during high-contact resident care activities: Dressing Bathing/showering Transferring Providing hygiene Changing linens Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. Wound care: any skin opening requires a dressing. According to the Centers for Disease Control (CDC), Extended Spectrum Beta Lactamase (ESBL) is a group of bacteria that cause infections in healthcare settings and is resistant to many common antibiotics making infections hard to treat. Good hand hygiene and infection prevention practices can help reduce infection risk. R73 R73's quarterly Minimum Data Set (MDS) dated [DATE], identified R73 with intact cognition and was independent in personal cares. R73's diagnoses included anxiety and ulcerative colitis (inflammation of the inner lining of the colon). In addition, R73 had an ostomy (surgical opening in the abdominal wall that re-routes stool outside the body into a bag). R73's physician orders (PO) dated 9/12/23, indicated Resident may be placed in isolation precautions [sic] per facility infection control policy. R73's electronic medical record (EMR) banner identified R73 with Extended Spectrum Beta Lactamase (ESBL) with onset date of 9/7/25, with PPE Requirements Gloves, Gown. During medication observation and interview on 3/10/26 at 8:32 a.m., licensed practical nurse (LPN)-A stated R73 was placed on contact precautions due to colostomy and not ESBL despite R73s EMR banner. R73's door frame had a Contact Precautions sign posted on it stating, EVERYONE MUST: Clean their hands, including before entering and when leaving the room. LPN-A obtained medications (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from medication cart in the hallway and crushed them per PO. During the observation LPN-A opened and closed medication cart drawers and used the laptop to identify each medication that he was preparing. After placing each medication in the pill crusher and putting them into a medication cup LPN-A then locked the medication cart and closed down his laptop screen. During this time, LPN-A did not wash or sanitize hands. Then LPN-A knocked and entered R73's room without hand hygiene, gloves, or any other PPE. LPN-A offered R73 her crushed medications to take with applesauce. Then LPN-A exited room and sanitized hands. LPN-A verified he did not wash hands or apply gloves or PPE prior to entering R73's room to administer her medications. During interview with LPN-C on 3/10/26 at 8:43 a.m., LPN-C stated she was nursing manager of unit where R73 resided. LPN-C stated expectation of staff to wear [sic] PPE when entering the room to give meds for residents who were identified as being on Contact Precautions. LPN-C stated, hand hygiene is important to protect both the resident and staff. During interview with infection control preventionist (IP) on 3/10/26 at 8:49 a.m., IP stated expectations that if a resident was identified as being on contact precautions, and if [staff] was administrating medications, then there would be no need to wear any PPE but should use hand hygiene before entering the room. Facility policy titled Administering Medications, reviewed 12/13/2021 state, Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications.