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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HTYK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00885

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245596**

2.STATE VENDOR OR MEDICAID NO.
(L2) **201042900**

3. NAME AND ADDRESS OF FACILITY
(L3) **SOUTH SHORE CARE CENTER**
(L4) **1307 SOUTH SHORE DRIVE PO BOX 69**
(L5) **WORTHINGTON, MN** (L6) **56187**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 09/26/2013 (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **64** (L18)

13.Total Certified Beds **64** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

Post Certification Revisit to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective September 23, 2013, the facility is certified for 64 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE NEII 11/07/13 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/26/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/21/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5596 December 26, 2013

Ms. Barbara Atchison, Administrator
South Shore Care Center
1307 South Shore Drive Po Box 69
Worthington, Minnesota 56187

Dear Ms. Atchison:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 23, 2013, the above facility is certified for:

64 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

November 7, 2013

Ms. Barbara Atchison, Administrator
South Shore Care Center
1307 South Shore Drive
PO Box 69
Worthington, Minnesota 56187

RE: Project Number S5596023

Dear Ms. Atchison:

On September 9, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 22, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 26, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 22, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 22, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 23, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 22, 2013, effective September 23, 2013 and therefore remedies outlined in our letter to you dated September 9, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245596	A. Building B. Wing	9/26/2013

Name of Facility	Street Address, City, State, Zip Code
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **09/19/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **09/19/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **09/19/2013**
ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **09/19/2013**	ID Prefix **F0361** Reg. # **483.35(a)** LSC	Correction Completed **09/19/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **09/23/2013**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/19/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/19/2013**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **09/19/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/AK	11/07/2013	10160	09/26/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/22/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245596	A. Building B. Wing 01 - MAIN BUILDING 01	10/22/2013

Name of Facility	Street Address, City, State, Zip Code
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0020	09/06/2013	ID Prefix Reg. # NFPA 101 LSC K0029	09/14/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	11/07/2013	22373	10/22/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
8/26/2013	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: HTYK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00885

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245596**
2.STATE VENDOR OR MEDICAID NO.
(L2) **201042900**

3. NAME AND ADDRESS OF FACILITY
(L3) **SOUTH SHORE CARE CENTER**
(L4) **1307 SOUTH SHORE DRIVE PO BOX**
(L5) **69 WORTHINGTON, MN** (L6) **56187**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/22/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **64** (L18)

13.Total Certified Beds **64** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Robin Lewis, HFE NE II — 09/24/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 11/21/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/21/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN# 245596

At the time of the standard survey completed August 22, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 6954

September 9, 2013

Ms. Barbara Atchison, Administrator
South Shore Care Center
1307 South Shore Drive P.O. Box 69
Worthington, Minnesota 56187

RE: Project Number S5596023

Dear Ms. Atchison:

On August 22, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (507) 206-2731
Fax: (507) 206-271

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 1, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 1, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter.

Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by November 22, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 February 22, 2014 (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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____ SEP 23 2013 MN Dept of Health	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	**THE FOLLOWING PROVIDER RESPONSES ARE NEITHER AN ADMISSION OF NOR AGREEMENT WITH THE HEREIN ALLEGED DEFICIENCIES AND THEY SHOULD NOT BE CONSTRUED AS SUCH.**	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157 9-24-13 JPN	F 157 It is the policy and procedure of the facility to notify resident's physician timely of significant changes in condition, including weight loss. The facility does have a policy on Guidelines for Notifying Physicians of Clinical Problems. The facility did provide a fax to the primary physician on 5/24/13 requesting a supplement order as R-76 demonstrated weight loss. The fax did not clearly identify a significant weight loss. On 8/21/13 the resident's physician was notified of a significant weight loss. Subsequent to physician notification interventions were put into place to aid in maintaining/preventing future weight loss.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara Atchison — TITLE: Administrator — (X6) DATE: 9/20/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____ SEP 23 2013 MN Dept of Health	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician timely of a significant weight loss for 1 of 3 residents (R7) reviewed for nutrition. Findings include: R76 was admitted to the facility on 3/11/13 and weighed 202 pounds. On 5/21/13 weighted 176 pounds a loss of 26 pounds in two months. On 8/19/13 weighed 155 pounds a loss of 21 more pounds in three months. The significant weight loss had not been reported to the physician to determine what interventions should be started to stabilize weight. R76 was admitted on 3/11/2013, with diagnoses that included, dementia, hypertension, cardiomegaly, peripheral vascular disease and chronic kidney disease A dietary significant change assessment note dated 5/ 21/13, completed by the dietary manager (DM) indicated R76 was on a regular pureed diet with nectar thickened liquids. R76 weighs 176 pounds (lbs.), a loss of 26 lbs. since admission assessment. R76 ' s ideal body weight was determined to be from 176-216 lbs. and body	F 157	The facility will have an all staff in-service on 9/19/13 to train staff on the updated policy and procedure for weight loss and expected guidelines for timely notification to the primary physician with regards to identified "significant weight loss." The facility guidelines for notifying the physicians of clinical problems will also be reviewed with all staff. The Director of Nursing will monitor for continued facility compliance in the notification to the primary physician with regards to identified significant changes in condition including weight loss. Results of monitoring will be reviewed at quarterly Quality Assurance Committee meetings. Completion Date: 9/19/13	9-19-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ SEP 23 2013 B. WING _____ MN Dept of Health	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 157	Continued From page 2 mass index was 22. R76 had been eating 99% of meals and on average drinks 1281 cubic centimeter (cc) of fluids with meals. R76 was independent in eating, required some assist for set up and filled out own menu slips. R76 was on 4 ounces of arginaid twice a day (BID) due to a foot ulcer and a fax was out to give 4 ounces of house supplement BID. Dietary would continue to monitor. Continue with current plan of care. A dietary quarterly assessment note dated 8/6/13, completed by the DM indicated R76 was on a national dysphasia diet level one with nectar thick liquids. R76 had been averaging 69% of meals and drank 1107 cubic centimeter (CC) of fluids with meals. R76 received arginaid twice a day (BID) for healing an open wound and four ounce house supplement bid with med pass due to weight loss. R76 weighed 158 pounds, down 18 pounds since his last assessment. R76 was independent with eating and filled out his menu slips for meals. R76 required assist with set up for meals. Dietary would continue to monitor his weight, food/fluid intake and labs and will continue current plan of care. On 8/20/13 after the surveyor brought the significant weighed loss for R76 to the staff ' s attention, R76 had been weighed and was at 155 pounds. This was a loss of 21 pounds in the last three months and for the past six months R76 lost 47 pounds. R76 had a physician order dated 5/28/13, that read house supplement four ounces twice a day. However, there is no other documentation that the physician was aware of the continued weight loss in the past two months.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 157	Continued From page 3 On 8/21/13 at 9:20 a.m., the DM stated R76 was admitted on 3/11/13 and his weight was 202 lbs. The DM stated R76 weighed 158 as of 7/23/13. The weight dated 7/23/13 was the last weight the DM was able to locate during the interview as there were no other weights in the computer system for R76. The DM stated when a concern was identified regarding weight loss her process was to speak with the resident care coordinator and have the RCC address the weight loss since she is currently not certified as a dietary manager. The DM verified she had not communicated R76 ' s significant weight loss to his physician. On 8 /21/13 at 10:18 a.m., the RN-B stated she knew R76 ' s weight loss was discussed with the physician, however verified that at this time she was unable to locate any documentation from nursing home staff the physician was notified of resident ' s significant weight loss. RN-B also verified she was unable locate any documentation from the physician that addressed R76's significant weight loss. On 8-21-13 at 1:08 p.m., the physician stated he did not recall the facility speaking to him regarding R76's weight loss. When asked what interventions he would expect to be put into place for a resident with significant weight loss, he stated he would expect facility to document on oral intake, place resident on a high protein diet, have the nutritionist involved to evaluate intake, and measure if resident is having adequate protein intake. The physician stated, "Yes!" he would expect the facility to notify him of the significant weight loss for R76. The physician verified he considered R76 to have had a	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 157	Continued From page 4 significant weight loss as R76 weighed 202 pounds upon admission to the facility on 3/11/13 and weighed 155 pounds on 8/20/13. Physician nursing home visits for R76 dated 4/9/13, 6/28/13, and 7/2/13 were reviewed and had not address weight loss for R76. During interview on 8/21/13, at 1:26 p.m. the director of nursing (DON) indicated they would expect the physician to be updated with rounds and should be notified of a significant weight loss. The DM indicated a fax was sent to the primary physician about the weight loss. DM verified the fax requested a confirmation of diet order and request for supplement. The DM indicated the dietician had updated the physician regarding a request for arginaid (supplement used for wound healing). The DON confirmed there was definitely a system error in place regarding weights and identifying weight loss. At 1:42 p.m. the DON indicated would have expected the physician to be notified of the weight loss by the resident care coordinator.	F 157		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	F 279 It is the policy and procedure of the facility to ensure that a comprehensive care plan is developed for all residents. R-59 individualized plan of care was updated on 8/22/13 to reflect the use/care of a urinary catheter. Updates of the comprehensive care plan include problem, measurable goals, and approaches.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 279	Continued From page 5 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive care plan was developed for 2 of 2 residents (R59 and R25) reviewed for urinary catheter usage. Findings include: R59's care plan had not addressed the use and preventative measures to reduce urinary tract infections and pain when an indwelling Foley catheter was used. R59 was readmitted to the facility on 7/6/13, with diagnoses that included but not limited to diabetes, hyper tonicity of bladder. R59 had a Foley catheter placed on 7/30/13 due to retention of urine. During observation on 8/21/13 at 6:33 a.m. it had been noted R59 had an indwelling Foley catheter in place. During review of R59 ' s care plan it had no information in regards to the use/care of the Foley catheter.	F 279	R-25 individualized plan of care was updated on 9/11/13 to reflect the use/care of a urinary catheter. Care plan included problems, goals, and approaches to management of an indwelling urinary catheter. The Resident Care Coordinators will review all residents on their respective nursing units and insure that any resident who has an indwelling urinary catheter has this identified on their comprehensive plan of care. The facility will review the facility policy/procedure on comprehensive care plan development and revision at an all staff in-service on 9/19/13. The Director of Nursing will monitor to insure facility compliance with the development of a comprehensive plan of care. Results of monitoring will be reviewed at quarterly Quality Assurance Committee meetings. Completion Date: 9/19/13	9-19-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 279	Continued From page 6 During interview on 8/20/13 at 3:11 p.m., registered nurse (RN)-B verified the Foley catheter was not on the care plan and stated she needed to get that done. RN-B proceeded to add the Foley catheter information to the care plan and verified the information had been added on 8/20/13 after the surveyor brought it to RN-B ' s attention. During interview on 8/21/13, at 1:07 p.m. the director of nursing (DON) indicated they routinely looked at urinary catheters and made sure they had appropriate justification for the use. DON expectation would be the Foley catheter would have been care planned along with the intent to reevaluate the Foley catheter. R25's comprehensive care plan had not addressed the use, care, preventative measures to prevent pain and urinary tract infections with the use of an indwelling Foley catheter. R25 was readmitted to the facility on 7/30/13, with diagnoses that included but not limited to chronic kidney disease and urinary retention. R25 was readmitted to the facility with a physician order for and indwelling Foley catheter. During observation on 8/20/13 at 3:10 p.m. and again on 8/21/13 at 7:21 a.m. R25 had an indwelling Foley catheter in place. During review of R25 ' s comprehensive care plan there had been no documentation as to the use, care, preventative measures in regards to the indwelling Foley catheter. During interview on 8/21/13, at 8:29 a.m.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 279	Continued From page 7 registered nurse (RN)-A indicated would be responsible for updating the care plan with Minimum Data Set and as needed for changes in residents. RN-A verified indwelling Foley catheter was not on the care plan. During interview on 8/21/13, at 1:07 p.m. the director of nursing (DON) indicated routinely looked at catheters and made sure had appropriate justification. DON expectation would be the Foley catheter would have been care planned along with the intent to reevaluate the Foley catheter. During review of policy entitled comprehensive care plan development dated October 24, 2012, identified an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs would be developed for each resident.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280	F 280 It is the policy and procedure of the facility to monitor and assess care plan interventions for effectiveness and revise the care plan as needed. The facility completed the assessment "Identified/Unplanned Weight Loss on 8/27/13 and R-76 plan of care was updated to reflect nutritional interventions following significant weight loss.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 280	Continued From page 8 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to reassess the effectiveness of nutritional interventions following significant weight loss after admission and five months after admission and revise the plan of care to include nutritional interventions to prevent further weight loss for 1 of 3 residents (R76) reviewed for nutrition due to a significant weight loss of 44 pounds from admission on March 11, 2013 to May 2013. Findings include: R76 was assessed to have an ideal body weight (IBW) range of 176 to 216 pounds and when the residents weight dropped from 202 pounds on admission (March 11, 2013) to 176 pounds a loss of 26 pounds a nutritional assessment was done and interventions put in place. However, the resident had another nutrition assessment August 6, 2013 due to weight being at 158 pounds a loss of 18 pounds in three months and after the nutritional assessment was completed there had been no reassessment of interventions put in place prior to this current weight loss nor were new interventions to prevent further weight loss developed. R76 was admitted on 3/11/2013, with diagnoses	F 280	The facility did update the Weight Loss Policy on 9/9/13 to insure that any resident who may demonstrate identified weight loss will be assessed by the Resident Care Coordinator and interventions implemented on the plan of care. The facility will review the policies for weight loss and Development and Revision of the Comprehensive Care Plan at an all staff in-service on 9/19/13. The Director of Nursing will monitor for facility compliance and insure that nutritional interventions following significant weight loss is identified and appropriate interventions are implemented and on the residents individualized plan of care. Results of monitoring will be reviewed at quarterly Quality Assurance Committee meetings. Completion Date: 9/19/13	9-19-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 280	Continued From page 9 that included, dementia, hypertension, cardiomegaly, peripheral vascular disease and chronic kidney disease A dietary significant change assessment note dated 5/ 21/13, completed by the dietary manager (DM) indicated R76 was on a regular pureed diet with nectar thickened liquids. R76 weighs 176 pounds (lbs.), a loss of 26 lbs. since last assessment. R76's ideal body weight was 176-216 lbs. and body mass index was 22. R76 had been eating 99% of meals and on average drinks 1281 cubic centimeter (cc) of fluids with meals. R76 was independent in eating, required some assist for set up and filled out own menu slips. R76 was on 4 ounces of arginade twice a day (BID) due to a foot ulcer and a fax was out to give 4 ounces of house supplement BID. Dietary would continue to monitor. Continue with current plan of care. A dietary quarterly assessment note dated 8/6/13, completed by the DM indicated R76 was on a national dysphasia diet level one with nectar thick liquids. R76 had been averaging 69% of meals and drank 1107 cubic centimeter (CC) of fluids with meals. R76 received arginade twice a day (BID) for healing an open wound and four ounce house supplement bid with med pass due to weight loss. R76 weighed 158 pounds, down 18 pounds since his last assessment. R76 was independent with eating and filled out his menu slips for meals. R76 required assist with set up for meals. Dietary would continue to monitor his weight, food/fluid intake and labs and will continue current plan of care. R76's care plan revised of 5/21/13, identified the	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 280	Continued From page 10 problem as nutrition, with a goal for R76 to eat greater than 75 % meals, maintain weight and feed self. Interventions included weight weekly, monitor weekly by the DM. IBW range: 176-216 lbs. Dietary supplements as ordered by physician or RD. Offer snacks three times a day and was to receive a national dysphasia diet level one. On 8-21-13 at 12:45 p.m., the DM stated the dietary staff had started to give R76 a high calorie pudding in July 1013 with dinner and supper. She was unaware of the specific date the intervention was initiated. The DM verified the high calorie pudding was not on plan of care and verified the facility had not reassessed the effectiveness of nutritional interventions or revised the nutrition plan of care for R76. The weight loss policy dated 8/3/13 read: Procedure: 11. If an identified weight loss is identified the inter-departmental team will be directed to review the nutritional plan of care and implement individualized interventions to prevent further weight loss. 12. Interventions for undesirable weight loss should focus first on food. Nutritional supplement per facility guidelines may be implemented if the resident intake remains inadequate despite changes in food offered. (The facility nutritional supplement is 2 cal [calorie] HN 60 CC [cubic centimeters] po [orally] tid [three times per day]) the physician may order tests, appetite stimulants, or medications as appropriate.	F 280		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 325	Continued From page 11 assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently monitor and reassess significant weight loss for 2 of 3 residents (R76 and R75) who had been reviewed for nutritional status. Findings include: R76 had lost 47 pounds from admission on March 11, 2013 to August 19, 2013. Even though the facility had completed nutritional assessments the facility did not evaluate the effectiveness of a nutritional supplement, resident food likes and dislikes, nor did they consistently monitor weights to determine if R76 had continued to lose weight. R76's weights from admission on 3/11/13 to 8/19/13 a six month period of time are: 202 pounds (lbs.) on 3/11/13; (Admission weight) 191 lbs. on 3/26/12; (4.5% weight loss in 1 month) 184 lbs. on 4/30/13; (8% weight loss in 2 months) 176 lbs. on 5/21/13; (12% weight loss in 3 months) 155 lbs. on 8/19/13; ((24% weight loss in 6	F 325	F 325 It is the policy and procedure of the facility to ensure that residents maintain acceptable parameters of nutritional status unless a resident's clinical condition demonstrates that this is not possible and provide therapeutic diets when there is a nutritional problem. The facility completed the assessment "Identified/Unplanned Weight Loss on 8/27/13 for R-76. Interventions were put into place to aid in maintaining current weight and preventing further weight loss. On 8/22/13 a swallow study was completed secondary to significant weight loss, poor dentition, and oropharyngeal dysphagia. Recommendations following the swallow study have been implemented and documented on the comprehensive plan of care. The resident's primary physician rounded on 9/11/13 and clearly identified recognition of a significant weight loss and specifically provided direction on frequency of weight to be obtained. R-75 was discharged from the facility on 4/6/13. On 9/9/13 the facility updated the procedure for weight loss. The policy specifically identifies how often to obtain resident weights unless otherwise ordered by the primary physician.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 325	Continued From page 12 months) This was a total of 47 pounds over the past six months. R76 was admitted on 3/11/2013, with diagnoses that included dementia, hypertension, cardiomegaly, peripheral vascular disease and chronic kidney disease. On 8/19/2013, at 4:34 p.m., R76 was eating his meal in the dining room and was asked how the meal was and R76 stated, "I don't care for it" referring to the food served. During an observation on 8/21/13 at 7:44 a.m., R76 was observed to be eating breakfast in the main dining room. R76 had scrambled eggs, cream of wheat hot cereal, orange juice, hot chocolate and milk. R76 was eating independently, and a nursing assistant (NA)-C was sitting by him. R76 stated the food was "good" when asked. At 7:56 a.m., NA-C asked R76 if he was done eating and he stated, "Yes." R76 had eaten less than 25 % of the breakfast meal. On 8/21/12 at 11:17 a.m. interview concerning R76's meal choices was completed. R76 said that he did not have any concerns related to having a pureed diet or the taste of the foods. R76 then stated, "Sometimes the food is dry and it doesn't seem to go down easy." R76 verified he had not told anybody about his concern with the food being dry at times and being hard to swallow. On asking about the consistent weight loss since admission R76 said he had been unaware he had weight loss. R76 stated, "I had a weight loss? I didn't know I had lost weight." R76 stated the facility staff had not talked to him about his weight	F 325	On 9/19/13 the facility will conduct an all staff in-service to review the updated procedure for weight loss to insure consistent monitoring and reassessment of weight loss. The Resident Care Coordinators will be responsible for monitoring for compliance to insure that adequate monitoring and reassessment of residents who demonstrate weight loss are receiving adequate nutritional status unless weight loss is unavoidable. Results of monitoring will be reviewed at quarterly Quality Assurance Committee meetings. Completion Date: 9/19/13	9-19-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 325	Continued From page 13 loss. When asked if the staff encourage him to eat during meal time, R76 stated, "No not too much." Then R76 stated, "I am not always hungry." During an observation on 8/22/13 at 7:55 a.m., R76 was observed to be sitting at the dining room table with registered nurse (RN)-B sitting beside him. RN-B was assisting R76 to eat breakfast. R76 did cough after eating a spoonful of his eggs. RN-B stated they would be evaluating his swallowing abilities and a referral had been for a speech evaluation as he has had difficulty swallowing. R76's initial nutritional assessment dated 3/13/13 completed by the registered dietician, identified R76's usual body weight was 200 lbs. and weight was 202 lbs. R76's diet order was regular with thickened liquids as needed. Recommended speech consult related to swallowing concerns. The initial nutritional assessment completed by the RD was the only assessment provided. Dietician Consulting Reports were reviewed dated 3/13/13 and 5/15/13 and did not address R76's weight loss. No further documentation was provided from the dietitian regarding interventions to maintain weight or monitoring of current nutrition interventions. A dietary significant change assessment note dated 5/21/13, by the dietary manager (DM) indicated R76 was on a regular pureed diet with nectar thickened liquids. R76 weighs 176 pounds (lbs.), a loss of 26 lbs. since last nutritional assessment on March 13, 2013. R76's ideal body weight (IBW) was assessed to be 176-216 lbs. and body mass index was 22. R76 had been eating 99% of meals and on average drank 1281	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 325	Continued From page 14 cubic centimeter (cc) of fluids with meals. R76 was independent in eating, required some assist for set up and filled out own menu slips. R76 was on 4 ounces of arginade (protein rich dietary supplement) twice a day (BID) due to a foot ulcer and a fax order for 4 ounces of house supplement BID (which was initially implemented but did not continue). Dietary would continue to monitor. Continue with current plan of care. R76's significant change of condition Minimum Data Set (MDS) (a comprehensive assessment tool) dated 5/30/13, identified R76 had no cognitive impairments, required supervision with eating and had a weight loss of 5% or more in one month or 10% or more in six months. A dietary quarterly assessment note dated 8/6/13, completed by the DM indicated R76 was on a national dysphasia diet level one (this diet consists of pureed, homogenous, and cohesive foods. Food should be "pudding-like." No coarse textures, raw fruits or vegetables, nuts, and so forth are allowed. Any food that require bolus formation, controlled manipulation, or mastication are excluded, with nectar thick liquids. R76 had been averaging 69% of meals and drank 1107 cubic centimeter of fluids with meals. R76 received arginaid twice a day for healing an open wound and four ounce house supplement bid with med pass due to weight loss. R76 weighed 158 pounds, down 18 pounds since his last assessment (which was done on March 13, 2013.) R76 was independent with eating and filled out his menu slips for meals. R76 required assist with set up for meals. Dietary would continue to monitor his weight, food/fluid intake and labs and will continue current plan of care.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 325	Continued From page 15 R76's quarterly MDS dated 8/14/13, identified he had no cognitive impairments, required limited assist with eating and had weight loss of 5% or more in one month or 10% or more in six months. R76's care plan revised of 5/21/13, identified a nutrition problem, with a goal for R76 to eat greater than 75 % meals, maintain weight and feed self. Interventions included: weight weekly, monitor weekly by the DM, IBW range of 176 to 216 lbs. Dietary supplements as ordered by physician or RD. Offer snacks three times a day and was to receive a national dysphasia diet level one. On 8/21/13 at 9:20 a.m., the DM stated R76 was admitted on 3/11/13 and his weight was 202 lbs. The DM stated R76 weighed 158 lbs. as of 7/23/13. The weight dated 7/23/13 was the last weight the DM was able to locate during the interview as there were no other weights in the computer system for R76. The DM stated R76 was supposed to be weighed weekly on his bath date (this was not being done). The DM stated she was very frustrated and had communicated her concerns to nursing and had sent out two messages to the nursing assistants regarding the importance of weighing residents weekly and documenting the weights in the kiosk system (computer) or bath book. The DM stated she had made suggestions to the resident care coordinator (RCC) for R76 regarding high calorie shakes and this suggestion was not acted upon. The DM stated when a concern was identified regarding weight loss her process was to speak with the RCC and have the RCC address the weight loss since she was not currently certified as a dietary manager. The DM stated there was a care conference for R76 on 8/20/13 and the	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 325	Continued From page 16 decision was made to move R76 to a table in the dining room where he would receive more encouragement by staff to eat and the facility would start providing high calorie snacks one mid-morning and one in the afternoon. The DM verified she had not communicated R76's significant weight loss to R76's physician. On 8/21/13 at 10:18 a.m., RN-B stated R76 was referred to the dietician for weight loss and wound healing in March of 2013. RN-B stated she knew R76's weight loss was discussed with the physician, however verified that at this time she was unable to locate any documentation from nursing home staff or physician that addressed R76's significant weight loss. RN-B verified the facility currently has a systems issue with obtaining weights for residents. RN-B stated there had been a system issue since they changed the staffing to have the NA on the wing obtain the weights on the resident bath day. RN-B stated the change was made due to low resident census in the building and occurred in May or June of 2013. On 8/21/13 at 12:06 p.m., NA-B stated R76 ate pretty good and had been eating 50% to all of his meals and just needed cueing at times to eat. When asked how R76's clothes were fitting, NA-B responded his pants were too big and did not fit very well lately. NA-B stated residents were to be weighed weekly on bath days. NA-B stated they are to document weights in the book in the bathroom and some staff entered weights in the kiosk. NA-B stated she tried to document in both the bath book and the kiosk. NA-B stated staff could tell by the bath book if there had been a change in weight for a resident. NA-B stated if she noticed a change in weight, she notified the charge nurse. NA-B verified that weights are not	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 325	Continued From page 17 always written in the bath book by staff on resident bath day and that was frustrating to her. On 8/21/13 at 12:45 p.m., the DM stated the dietary staff had started to give R76 a high calorie pudding in July 2013 with dinner and supper. She was unaware of the specific date the intervention was initiated, however, there was a physician order dated 5/28/13, that read house supplement four ounces twice a day. The DM stated the facility had been out of the pudding for the last couple days and she needed to order more. The DM verified R76 did not have a physician ' s order for the pudding and stated she did not know whether or not she was supposed to get an order for the high calorie pudding. The DM verified staff was not monitoring R76's pudding consumption and stated as far as she knew he was getting the pudding with his dinner and supper meals. On 8/21/13 at 2:06 p.m., dietary aide (DA)-B verified she was responsible for placement of supplements on residents' trays in the dining room when she worked. She stated she was unaware R76 was to have a high calorie pudding supplement with dinner and supper. She stated she worked in the dining room seven days a pay period in the evenings and verified she had never provided R76 with a high calorie pudding supplement with his meals. DA-B verified there was no dietary communication form completed for R76 that instructed the dietary staff to provide R76 with a supplement. NA-B stated the only communication to the dietary staff regarding R76 was dated 3/20/13 and was in a note book which instructed the dietary staff to provide a pureed diet with nectar thick liquids. On 8/21/13 at 2:13 p.m., the DM stated she	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 325	Continued From page 18 informed one of the cooks to start adding the pudding to R76's supper and dinner meals. The DM stated her expectation was the cook would communicate this to the rest of the kitchen staff. The DM verified she did not follow up with the kitchen staff to see if the pudding was being provided to R76 or if R76 was eating the pudding. The DM verified there was no written communication to the kitchen staff to provide the pudding to the R76 and stated she did not use a dietary communication forms to communicate with her staff. The DM stated she uses a piece of scrap paper as she did not have any of the dietary communication forms to use to communicate to her staff. On 8/21/13 at 2:25 p.m., NA-D stated R76 ate independently, did not have much of an appetite and staff watched him during meals as he had swallowing concerns. NA-D stated she did not know if R76 received a high calorie pudding during meal time. On 8/22/13 at 8:34 a.m., when asked how R76's cloths fit him, NA-E answered his pants were too big around his waist and stated she noticed that this morning as she did not usually work on the wing R76. NA-E stated R76 was not a good eater and observed this during her shifts when she worked in the dining room to help serve and provide assist with eating. NA-E stated his intake was usually 25% or less of meal. NA-E Stated R76 could eat independently but stated he was moved to the restorative table this week (reference to week of August 22, 2013) for meals. On 8/22/13 at 9:15 a.m., RCC-B stated R76 ate 100% of his pureed eggs and muffin this morning. RCC-B stated he did not eat the cream of wheat	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 325	Continued From page 19 as he started to cough when eating it and a referral to speech for an evaluation of swallowing had been made. RCC stated R76 told her somebody had talked to him about his weight and proceeded to eat a teaspoon of butter from a butter pack at breakfast. RCC-D confirmed she assisted R76 to eat his breakfast as she would be monitoring him more closely now, but stated he was able to drink liquids independently and drank 360 cc of liquids. On 8/21/13 at 1:08 p.m., the physician stated he did not recall the facility speaking to him regarding R76's weight loss. When asked what interventions he would expect to be put into place for a resident with significant weight loss, he stated he would expect facility to document on oral intake, place resident on a high protein diet, have the nutritionist involved to evaluate intake, and measure if resident is having adequate protein intake. The physician stated, "Yes" he would expect the facility to notify him of the significant weight loss for R76. The physician verified he considered R76 to have had a significant weight loss as R76 weighed 202 pounds upon admission to the facility on 3/11/13 and weighed 155 pounds on 8/20/13. Physician nursing home visits for R76 dated 4/9/13, 6/28/13, and 7/2/13 were reviewed and had not addressed weight loss. On 8/21/13, at 1:26 p.m. the director of nursing (DON) indicated the nursing assistant that completed the resident bath would document the weight and if a change in three or more pounds was noted a reweigh was expected to be done. DON verified there was a system error now with not having the nursing assistant here that	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 325	Continued From page 20 routinely completed the resident baths and documented the weights. DON continued saying every nursing assistant was responsible for documenting the resident weight after completing the bath and indicated they needed to find a back- up protocol for when baths were not documented. DON confirmed the resident care coordinator together with the dietary manager were responsible for monitoring the resident weights. DON indicated they had not addressed weights not being completed with nursing assistants and had now been working on a policy for unplanned weight loss. At 1:30 p.m. the DM indicated they try to look at resident weights for the care conference. The DM verified they had not looked at weights weekly but at least try to once a month to review the weights. The DM indicated R76 was getting nutritional supplements and pudding and was moved yesterday (August 20, 2013) to a restorative table for encouragement. Also high calorie snacks were to be offered in afternoon and morning. The DON indicated they would expect the physician to be updated with rounds (planned visit to the facility by MD) and should have been notified of significant weight loss timely. The DM indicated a fax was sent to the primary physician about the weight loss. DM verified the fax requested a confirmation of diet order and request for supplement. The DM indicated the dietician had updated the physician regarding a request for arginaid (supplement used for wound healing). The DON confirmed there was definitely a system error in place regarding weights and identifying weight loss. The DON indicated social services; resident care coordinators and dietary manager go through each resident during risk management meetings and discuss weight loss. At 1:40 p.m. the DON printed off a form dated	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 325	Continued From page 21 8/3/2009, of the policy that the DON expected staff to follow and should have been completed. The DM indicated the form had not been fully completed. At 1:42 p.m. the DON indicated they would have expected the physician to be notified of the weight loss by the RCC. R75 had not maintained acceptable parameters of nutritional status related to a significant weight loss and was not addressed by the facility. R75 was admitted on 3/1/13, with diagnoses that included fracture of the neck of the femur and hypertension. R75's discharge Minimum Data Set dated 4/17/13, identified moderate cognitive impairment, was independent with eating with no oversight or help needed and was on a physician prescribed weight loss regimen. R75's weights for the month of March 2013 were: Admission (03/08/2013): 125 lbs.; 15 days after admission (03/14/2013): 107 lbs. (which is 18 lbs. less than at admission or a 14.4% loss); 30 days after admission (03/29/2013): 102 lbs. (which is 23 lbs. less than at admission or an 18.4% loss.) A dietary note dated 3/8/13, completed by the dietary manager (DM) indicated R75 was on a regular diet and had been eating 68% of meals. It noted R75 weighed 107 pounds and ideal body weight was 108-132 pounds. The note further indicated R75 was independent in eating and needed help with tray set up and had been requesting to eat in room. R75 had no chewing or swallowing problems noted. Note continued to include dietary will continue to monitor weight, food/fluid intakes and labs and would follow	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 325	Continued From page 22 recommendations made by the doctor and the registered dietician (RD). However, the note had not identified R75 had weighed 125 pounds on admission date of 3/1/13 and now had a weight of 107 pounds a weight loss of 23 pounds in less than one month. R75's nutrition assessment dated 3/13/13, identified R75's admission weight was 125 pounds with ideal body weight of 108-132 pounds and usual body weight was left blank along with recent weight change was blank. The assessment noted R75 consumed 68% of meals and no meal supplement in place. No further documentation was provided from the dietitian regarding interventions to maintain weight or monitoring of current nutrition interventions. During review of interdisciplinary notes on 3/24/13, licensed practical nurse (LPN)-C wrote R75 ate poorly for breakfast meal but does eat 50-60% of noon meal. Note on 4/4/13, entitled Medicare indicated R75 had fair appetite to good. On 4/5/13, R75 was hospitalized and had not returned to the facility. Care conference note dated 3/20/13, had not identified the weight loss had been reviewed and discussed. R75's care plan original date 3/8/13 indicated regular diet, weigh weekly and monitor weekly by DM, supplements as ordered by physician or RD. There was no documentation indicated supplements had been ordered and no documentation was provided from the DM that weights were monitored weekly. During interview on 8/21/13, at 10:38 a.m. dietary manager indicated they were unaware of who	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 325	Continued From page 23 was responsible for looking at the resident weights to determine accuracy and whether a reweigh would have been indicated. DM indicated the reweigh policy directed staff if weekly weight showed a significant change the resident would be reweighed. The DM indicated the nursing assistants are now responsible for making sure weights are completed with the resident bath. DM indicated not sure how accurate weights are when documented due to having been hard to determine what actions need to be taken to ensure accuracy of weights. DM indicated R75 was not on a supplement or had any nutritional interventions to prevent the continued weight loss. During interview on 8/21/13, at 1:26 p.m. DON verified there was a system error now with not having the nursing assistant here that routinely completed the resident baths and documented the weights. At 1:30 p.m. the DM indicated they tried to look at resident weights before the resident ' s care conference. The DM verified they had not looked at weights weekly but would try to once a month to review the resident weights. The weight loss policy dated 8/3/13 read: Procedure: 1. The nursing staff will measure resident weights on admission and daily times three days. If there are no identified concerns eight will be measured monthly unless otherwise ordered by the primary physician. 2. Following admissions each resident will be weighed on their assigned bath day during the first week of each month. The bath aide will be responsible for obtaining the resident weight. 3. Each weight will be recorded in each unit's weight record chart (located in the whirlpool tub	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 325	Continued From page 24 room) and in the individual medical record. 4. Any weight change of greater than or less than 5 pounds within 30 days will require a re-weigh the following day for confirmation. 5. The RCC, DON and dietary supervisor will be immediately notified of any resident who demonstrates a 5 pound weight gain or loss. (Place an interdepartmental notice in the mailbox of those staff members who need to be notified of the weight change.) 6. The consultant dietitian will review the weight records each month to follow individual weight trends. Negative trends will be assessed and addressed by the dietician whether or not the definition of significant weight change has occurred. 7. Significant weight changes are defines as: More or less than 5% within 30 days. More or less than 7/5% in 90 days. More or less than 10% in 180 days. 9. If the weight loss meets the definition of significant the inter-disciplinary team should discuss if a significant change MDS is required. (In most cases this would occur during the risk management meeting.) 10. When unplanned weight loss is identified the dietary supervisor will complete the Identified Unplanned Weight Loss Review document and forward this document to the RCC. (This document is used to assist in identification of potential triggers/causes of weight loss.) 11. If an identified weight loss is identified the inter-departmental team will be directed to review the nutritional plan of care and implement individualized interventions to prevent further weight loss. 12. Interventions for undesirable weight loss should focus first on food. Nutritional supplement per facility guidelines may be implemented if the	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 325	Continued From page 25 resident intake remains inadequate despite changes in food offered. (The facility nutritional supplement is 2 cal HN 60 CC po tid) the physician may order tests, appetite stimulants, or medications as appropriate. 14. Unplanned weight changes will be reviewed at the risk management meeting each month.	F 325		
F 361 SS=E	483.35(a) QUALIFIED DIETITIAN - DIRECTOR OF FOOD SVCS The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure there was a registered dietitian (RD) available for frequently scheduled consultations to ensure resident nutritional problems were met. This had the potential to affect all 54 residents residing in the facility. Findings include:	F 361	F 361 It is the policy of the facility to employ a qualified dietitian on a consultant basis. An ad was placed in the local paper, Minnesota Workforce website and on the facility website indicating an open position for a qualified dietitian consultant on 8/22/13. The facility did hire a qualified dietitian on a consultant basis on 9/4/13. A meeting was held on 9/9/13 with the newly contracted dietitian to go over expectations/roles and responsibilities and a review of the State Survey which was conducted 8/19/13 thru 8/22/13. The dietary consultant will round at the facility monthly or more often as necessary to provide and ensure that resident's nutritional needs are met. The Director of Nursing will monitor for facility compliance to ensure that all residents are assessed by the dietary consultant to ensure that each resident's nutritional needs are met. Completion Date: 9/19/13	9-19-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 361	Continued From page 26 There was no RD available to consult with the dietary manager concerning residents at risk for and/or had significant weight loss for the past two months. See F-325: Based on observation, interview and document review the facility failed to monitor ongoing weight loss and develop appropriate interventions to prevent further weight loss for 2 of 3 residents (R76, R75) reviewed for nutrition who had unplanned and significant weight loss and continued to lose weight. There was no dietician available to assess R76's significant weight loss. The center for Medicare/Medicaid services (CMS) form 671 completed by the facility indicated there had been no dietician services currently employed at the facility nor contracted to provided nutritional services for the residents. During interview on 8/21/13, at 1:19 p.m. the director of nursing (DON) and dietary manager (DM) indicated the RD resigned the week after the fourth of July 2013. The DM indicated there had been no RD in the building since then to consult with in regards to monitoring weights and nutritional interventions for weight loss. The DM said they were not certified but have been enrolled in an online course to become a certified dietary manager. The DON verified she was the proctor for the DM. The DM said they had been completing the nutritional assessments since the RD was no longer employed and they would talk to the DON or to the resident care coordinators (RCC) if they had questions. During interview on 8/22/13, at 10:40 a.m. the DON stated the previous consultant RD had resigned, with her last visit to the facility the week	F 361		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 361	Continued From page 27 of July 4, 2013. DON stated the Worthington Hy-Vee store in which the previous RD was also employed had also resigned from Hy-Vee. The DON reported the pervious RD was, "Fairly confident that RD would be interested in consulting at the nursing home," and therefore the facility had not sought to hire a new RD. The DON added the previous RD was willing to be consulted until they found a new RD. Although the DON confirmed that to her knowledge the RCC's, nursing staff or the DM had not consulted with the previous RD since her resignation. The DON verified the facility did not have a process for determining what residents were at high risk for weight loss or nutritional issues, other than if the resident had a significant change in health status, or skin issues. The DON reported there was not a job description for consultant/contract employees. The DON added the previous consultant RD worked two to four hours a month and had been responsible for completed the quarterly, annual, significant change and new addition Minimum Data Set (MDS) as well as reviewing a list of people provided by the resident care coordinator (RCC) who had skin issues or other possible issues that involved their diet, swallowing difficulties and/or eating problems.	F 361		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 It is the policy and procedure of the facility to procure, store, prepare and serve food under sanitary conditions. On 8/19/13 Dietary Supervisor removed the thawing meat from the water and placed it on a tray in the cooler on a bottom shelf to finish thawing and separated the spaghetti sauce into three smaller containers and placed them back into the cooler. The DS re-educated the cook responsible for incorrectly thawing the meat about acceptable methods for thawing meats. On 8/30/13 the facility updated the policy on thawing frozen foods to ensure that food will be thawed properly. The DS also re-educated dietary staff that leftover food must be stored in a manner so as to cool to a safe temperature within 4 hours and that in order to accomplish this, large batches must be separated into smaller containers and leftover food temped to assure cooling to acceptable temperatures within 4 hours. An updated temperature log was placed in the kitchen on 9/1/2013 and cooks instructed to mark the temperatures down before serving the meals. The Dietary Supervisor will monitor to see that temperatures are appropriate and that each cook is writing them in the log.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 371	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to thaw frozen precooked meat, cool potentially hazardous leftover hot foods to below 40 degree according to the United States Food & Drug Administration (USFDA) Food Code to decrease the risk of food borne illness, complete food temperature logs to monitor potentially hazardous foods were cooked to the proper internal temperature and store an ice scoop in a sanitary manner. This had the potential to affect all 54 of 54 residents. THAWING: The facility did not thaw foods to minimize the risk for food borne illness. During the initial brief tour of the kitchen on 8/19/13, at 2:36 p.m. a fully cooked frozen pork roast, was thawing in the food prep sink in warm stagnant water. The dietary manager (DM) confirmed the roast was thawing in the warm water. The DM immediately took the roast and put it in the walk in refrigerator. The DM stated the day cook (C)-A, put the roast in the sink prior to leaving at approximately 1:45 p.m. DM added that she was not auditing the process to thaw foods to ensure all dietary staff were correctly thawing foods. On 8/21/13, at 12:10 p.m. C-A confirmed putting the roast in the sink to thaw in warm water. C-A the stated that frozen food should be thawed in the fridge or under continuously running cold water. C-A stated she forgot to pull the pork roast	F 371	The dietary department will be having an in-service on 9/23/2013 to retrain staff on how to prepare and store foods in a sanitary manner. An updated policy and procedure has be placed in the kitchen regarding how to prepare and store foods in a sanitary manner and when and on how to take food temperatures. The DM will monitor for compliance. Results of monitoring will be reviewed at quarterly Quality Assurance Committee meetings. A new container with a lid has been purchased and mounted on the wall to store the ice scoop. The policy and procedure for getting ice and storing the ice scoop will be addressed in an all staff in-service on 9-19-2013. The Activity Director, whose office is near the ice machine, will monitor daily for a period of 4 weeks to ensure compliance. Results of monitoring will be reviewed at quarterly Quality Assurance Committee meetings. Completion Date: 9/23/13	9-23-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 371	Continued From page 29 out of the freezer earlier in the day so she put it in warm water so it would thaw quicker. The facility's Food Thawing (undated) policy and procedure identified that any food that requires thawing prior to preparation or service must be thawed in a manner that avoids placing the food in the temperature danger zone of 40-140 degrees Fahrenheit (F). The procedure identified the preferred method of thawing was gradual under refrigeration with a temperature of less than 41 degrees F. Alternate methods included: I: Thaw food completely submerged under cold running water (70 degrees F or less) with water pressure sufficient to continuously agitate any loose particles of skin or dirt off product. Thawing time should be less than two hours or until food reaches 41 degrees F. COOLING: The facility did not have system in place to cool left over potentially hazardous foods properly to minimize the risk of food borne illness. During the initial brief tour of the kitchen on 8/19/13, at 2:37 p.m. the walk in cooler had a full six liter (L) container (tall round cylinder which does not allow rapid cooling) with left over spaghetti sauce from lunch that contained ground meat. The outside of the container was hot to the touch. At this time the DM confirmed the findings and stated lunch was over around 1 p.m. and staff had put the sauce in a container and into the refrigerator. The DM said that if there was a lot of leftover food from the meal then the staff was trained to put the food into several small containers so they cool quickly. The DM	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 371	Continued From page 30 confirmed the staff had not taken the temperature of the left overs to ensure potentially hazardous foods cooled from 135°F to 70°F within 2 hours; from 70°F to 41°F within 4 hours; the total time for cooling from 135°F to 41°F should not exceed six hours. The spaghetti sauce was temped at this time (2:37 p.m.) and found to be 158.5 degrees F. The DM separated the one large (six L) container into three smaller containers and placed them back into the refrigerator. During a follow-up visit of the kitchen on 8/21/13, at 12:13 p.m. leftover vegetable beef soup which was homemade by the facility staff had a date of 8/19/13. The soup was stored in a six L container and was filled to the top. There were also Barbeque ribs dated 8/19/13, stored in a two L container. The DM confirmed the left over soup should have been divided into small containers to cool rapidly. The DM stated she told her staff on 8/19/13, to make sure they put the left over soup in smaller containers but she had not been monitoring if they had followed her directions. The DM confirmed the facility did not have a monitoring/tracking system to ensure potentially hazardous foods were cooled from 135°F to 70°F within two hours; from 70°F to 41°F within four hours; with the total time for cooling from 135°F to 41°F not exceeding six hours. The DM reported she was responsible for infection control concerns which included monitoring the cooling of foods to minimize the risk of food borne illness. The DM also stated she was not involved with the infection control committee, but would be notified if there were any gastrointestinal resident illnesses. The DM verified the staff had not been in-serviced on how to properly cool foods within the last year.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 371	Continued From page 31 On 8/21/13, at 12:10 p.m. C-A reported she did know if left over potentially hazardous foods had been cooled from 135°F to 70°F within two hours; from 70°F to 41°F within four hours; with the total time for cooling from 135°F to 41°F did not exceed six hours, as she had not taken the food temperature when cooling down in the refrigerator. Cook-A then said that she had not been aware of the process to cool hot foods for safe storage. The facility's Storing and Freezing Leftovers Policy and Procedure (undated), identified any food that has been used for a meal must be cooled to 40 degrees or lower within four hours of use. The food item must be stored in a covered container with a label saying what it was and the date it was put in the cooler or freezer. The item must be discarded within 48 hours and one week if in the freezer. The procedure identified hot foods must be cooled to 40 degrees F or lower and if a big quantity separated into smaller containers so it cools faster. The infection control logs reviewed from 9/12, to 7/13, did not identify any food borne illness concerns with no resident or staff gastrointestinal illness reported. FOOD TEMPERATURE LOGS: The facility did not log or monitor the temperatures of potentially hazardous foods to minimize the risk of potentially hazardous foods. The Food Temp Charts reviewed for 6/13, 7/13 and 8/13, revealed the facility had not recorded any temperatures for ground or pureed meats with the exception of three times in the three month period.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 371	Continued From page 32 On 8/19/13, at 2:46 p.m. the DM confirmed the Food Temperature Charts had not been complete. The DM confirmed the facility served ground and pureed meat on every meal and currently had two residents who received pureed foods and four on mechanical soft foods. The DM stated she thought staff were taking the temperatures of these foods but had not been writing them down. The DM stated the Food Temperature Chart was what she used to determine foods had been cooked to their critical control points (combination of degrees and time) to minimize the risk of food borne illness. The DM stated she was hired about six months ago. On 8/21/13, at 12:10 p.m. C-A stated she always takes the temperatures of the purred and ground meat but was just not good at writing it down. C-A reported ground and pureed meats should be cooked to around 165-170 degrees F depending on the meat. C-A took the temperature of the ground and pureed pork which were at 175 degrees F at this time. During observation on 8/20/13, at 8:51 a.m. the ice scoop was stored directly touching the ice in the ice machine. During interview on 8/20/13, at 8:56 a.m. registered nurse (RN)-A indicated the ice machine was used for ice water pitchers on the dining room tables and also for filling ice water glasses for residents in their rooms every shift. RN-A indicated the activity department fills the water glasses in the morning and afternoon for water pass and the nursing assistants fill glasses during the night shift. RN-A verified the scoop was in with the ice.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 371	Continued From page 33 During interview on 8/20/13, at 9:02 a.m. maintenance supervisor indicated the original scoop broke, so now staff were leaving the scoop in with the ice. He also said the staff should have notified him that they needed to keep the ice scoop out of the ice storage area. During interview on 8/21//13, at 1:13 p.m. the director of nursing (DON) verified the ice scoop was not to be kept within the ice. The DON indicated maintenance had now fixed a holder to keep the ice scoop separate from the ice. During review of policy entitled infection control/ice machine cleaning and sanitizing dated 1/7/13, directed staff to keep scoop in receptacle marked for storage of scoop.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431	F 431 It is the policy and procedure of the facility to ensure that refrigerators used to store medications requiring refrigeration are properly maintained and monitored. All refrigerators used for medication storage were defrosted on 8/21/2013. On 9/12/13 a newly developed temperature log was placed at each location within the facility where medications are stored and maintained under proper storage perimeters. The facility replaced the refrigerator located on Unit A on 9/12/13 as current refrigerator was not working properly. The facility policy was reviewed and updated for defrosting and monitoring temperature logs to ensure that medications are stored within proper perimeters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 431	Continued From page 34 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure medication refrigerator temperatures were properly maintained, or monitored for proper storage of medications for 3 of 3 medication storage rooms. This had the potential to affect all residents who required emergency medication, pneumococcal vaccine and tuberculosis skin test. Findings include: During observation of D Wing medication storage room on 8/20/13, at 8:32 a.m. with registered nurse (RN)-C, a refrigerator was noted in the room that contained medication for resident use. Inside the refrigerator there was a small freezer section located on the top of the refrigerator which was surrounded by approximately 1 inch of thick ice on the top, side and bottom of the freezer's outer and inner shell. The thermometer in the refrigerator identified the temperature was	F 431	Education and training will be provided on 9/19/13 with regards to the policy/procedure for defrosting facility refrigerators used to store medications under proper perimeters. The facility temperature logs will also be reviewed with staff. The Resident Care Coordinators on each wing will be responsible to monitor for facility compliance. Results of monitoring will be reviewed at quarterly Quality Assurance Committee meetings. Completion Date: 9/19/13	9-19-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 431	Continued From page 35 49 degrees Fahrenheit (F.) The findings were verified by RN-C. Request was made to review the medication temperature logs. On 8/21/13, at 1:25 p.m. the director of nursing (DON) reported the facility had been unable to locate the logs. The following medications were stored in the refrigerator; medication used for treating diabetes which included one vial of Levemir insulin, and one vial of Lantus insulin. One vial of Latanoprost ophthalmic solution (used to control the progression of glaucoma.) Review of the manufacturer's guidelines indicated Novolog and Lantus insulin should be stored in the refrigerator at the temperature range of 36-46 degrees F before opening. Apisol had a manufacture's guideline that directed to store the medication in the refrigerator at a temperature range of 36-46 degrees F. Manufacturer's recommendation for storage of pneumovax was to keep refrigerated between 36-46 degrees. No further guidelines were provided. During observation of A/B Wing medication storage room on 8/20/13, at 8:45 a.m. with licensed practical nurse (LPN)-C, a refrigerator was noted in the room that contained medication for resident use. Inside the refrigerator there was a small freezer section on the top which was surrounded by approximately 2 inches of thick ice on the top, side and bottom of the freezer's outer and inner shell. The thermometer in the refrigerator identified the temperature was 48 degrees F. The findings were verified by LPN-C. Request was made to review the medication temperature logs. Again the resident medications stored in the refrigerator such as insulins, pneumococcal vaccine, etc. had manufacturer ' s recommendation for temperature range of 36 to 46 degrees.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 431	Continued From page 36 The DON was interviewed on 8/21/13, at 9:16 a.m. indicated the night shift nurse was responsible for logging the refrigerator temperatures on a daily basis, and for defrosting the refrigerator as needed. The DEFROSTING FACILITY REFRIGERATORS policy dated 8/24/12 indicated refrigerator temperatures are to be recorded daily.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441	F 441 It is the policy and procedure of the facility to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Effective 9/13/13 each refrigerator has its own thermometer to insure the prevention of cross-contamination. Effective 9/13/13 future infection control surveillance will include all comprehensive data (resident name, admit date, onset date, site, diagnosis, culture report it indicated, x-ray if obtained, organism, antibiotic therapy, whether isolation is necessary, whether facility acquired, re-culture report if indicated, and date of resolution). Accurate and comprehensive data collection is essential for the Infection Control Program to be successful. The infection control log will be reviewed weekly at the nurse management meeting and the infection summary/analysis will be reviewed for both residents/employees. Infection Summary will be reviewed at the facility Quality Assurance meeting quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 441	Continued From page 37 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program which at a minimum included surveillance, investigation of infections that occur in the facility, track employee infections, and maintain accurate and comprehensive records at the time the infection occurred. This had the potential to affect all 54 residents in the facility, staff and visitors. In addition, the facility failed to minimize the risk of cross contamination by failing to sanitize a thermometer used to track temperature in a bio hazard refrigerator before placing it into a medication refrigerator in 1 of 3 medication storage room observations potentially affecting 21 residents residing on the designated C wing. Findings include: During review of the facility's Infection Control monthly resident log(s) the following was noted: 7/1/13 to 7/31/13: The logs identified two residents had urinary tract infections (UTI's), and one resident had a respiratory infection. Resident's room numbers, and signs or	F 441	All staff will attend an in-service on 9/19/13 where the facility Infection Control Program will be explained. The importance of maintaining accurate and comprehensive records will be explained for not just our residents but to include our staff to avoid the potential spread of infection. The Director of Nursing will monitor to insure facility compliance with the Infection Control Program. Results of monitoring will be reviewed at quarterly Quality Assurance Committee meetings. Completion Date: 9/19/13	9-19-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 441	Continued From page 38 symptoms of infection had not been identified for these residents. On asking for a summary or analysis of the infections for July 2013, none was provided. 6/1/13 to 6/30/13: The log identified two residents had UTI's, one resident had a cellulitis infection, one resident had a yeast infection and one resident had been started on an antibiotic with no related infection signs or symptoms documented. Resident room numbers, site of infection, and signs or symptoms of infection had not been identified for any of these residents. The causative organism of infection had been identified for only one of the infections and effectiveness of treatment had been identified for only four of the infections. Again a summary or analysis was requested and none provided for June 2013. 5/1/13 to 6/31/13: The log identified three residents had UTI's, three residents had respiratory infections, and one resident had been treated on two occasions for a wound infection. Resident room numbers, site of infection, and signs or symptoms of infection had not been identified for any of these residents. The causative organism of infection had been identified for only four of the infections. No summary was provided for May 2013. 4/1/13 to 4/30/13: The log identified two residents had respiratory infections, one resident had been treated on two separate occasions for an ear infection, and one resident was identified with a gram positive infection not treated with an antibiotic. Resident room numbers, site of infection, and signs or symptoms of infection had not been identified for any of these residents. The	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 441	Continued From page 39 causative organism of infection had been identified for only one of the residents and effectiveness of treatment had been identified for only four of the infections. No summary was provided for April 2013. 1/1/13 to 3/31/13: The log again had missing resident room numbers, signs or symptoms and causative organism of infection had not been identified. No summary was provided for January, February and March 2013. During interview on 8/21/13, at 11:35 a.m. with the health information assistant, licensed practical nurse (LPN)-B, it was learned that LPN-B was responsible for filling out the infection control logs. LPN-B reported the practice was to gather the data each month for the previous month by reviewing infection report forms that had been filled out by nursing staff. LPN-B stated, " That form is given to [DON] or myself and kept until the end of the month." LPN-B further stated, "At the end of the month I fill out the log." When asked by surveyor how trends are identified as infections occurred LPN-B stated, "I would imagine [DON] does, she may, and I don't." LPN-B further reported only infections verified through lab testing would be included on the surveillance logs, as the facility did not collect data on residents who had been treated with an antibiotic without lab verification of an infection. LPN-B stated, "If the resident has not had labs we do not track them." During interview on 8/21/13, at 1:25 p.m. the DON reported she had tracked infections as they occurred by reviewing the infection forms and stated, "If I start seeing multiple infections of the same type then I track them." During review of	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 441	Continued From page 40 the infection control logs the DON verified she had not identified or tracked the multiple infections of the same type identified on the logs. During review of the facility's nursing employee illness tracking log with the DON on 8/21/13, at 1:25 p.m. it was noted the facility logs nursing employee absences each day regardless if it is an illness or other reason for absence. Although nursing employee illnesses were tracked by the facility, the facility did not utilize this information to identify infection or illness trends in the facility or relate them to any illness the residents may have had. The facility was unable to provide documentation of illness tracking for other staff departments other than nursing. During the review the DON verified employee infections are not tracked in departments other than nursing. On asking for an Infection control policy to identify resident and employee monitoring and surveillance it had not been provided by the facility. During observation of C Wing medication storage room on 8/20/13, at 8:58 a.m. with LPN-A, a refrigerator was noted in the room that contained medication for resident use. A small biohazard refrigerator was located on top of the medication refrigerator. LPN-A was observed to remove a thermometer from the biohazard refrigerator and place it in the medication refrigerator without sanitizing it. When surveyor asked LPN-A about sanitizing the thermometer she stated, "It should have been sanitized before placing it in the fridge." Then the LPN-A remove the thermometer from the medication refrigerator. During observation of the biohazard refrigerator it	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 441	Continued From page 41 was noted to have light brown streaks on the inner walls. LPN-A reported the discoloration as stains. The following medications were stored in the medication refrigerator; medication used for treating diabetes which included three vials of Lantus insulin, and one vial of Novolog insulin. One vial of Latanoprost ophthalmic solution (used to control the progression of glaucoma.) One vials of aplisol (used to test for tuberculosis,) and ceftriaxone IV (intravenous antibiotic solution.) During interview on 8/21/13, at 9:16 a.m. the DON stated, "[LPN] should have placed a new thermometer in the fridge." And not the one from the biohazard refrigerator. Request made for policy regarding cross contamination however none had been provided.	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520	F 520 It is the policy and procedure of the facility to maintain a quality assessment and assurance committee to identify issues with respect to QA & A activities and to develop and implement plans of action to correct identified deficiencies. A system error has been identified with regards to nutritional needs and assessment for residents who demonstrate a significant weight loss/nutritional concern. The facility has hired a qualified dietary consultant who will visit the facility bi-monthly to monitor and assess individual resident nutritional needs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 520	Continued From page 42 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Quality Assessment and Assurance committee (QAA) identified and assessed quality concerns related to nutritional concerns including significant weight loss as there had been a lack of following the facility policy that addressed nutritional needs, nutritional assessments had not been developed or developed comprehensively, reviewed for effectiveness, revisions if not effective for weight stabilization and ongoing weight monitoring. This had the potential to affect all 54 residents, which included 2 of 2 residents (R76 and R75) who had significant weight loss identified. Findings include: R76 and R75 were negatively impacted due to a nutritional system failure that had not been addressed by the QAA. Even though the facility was aware of the ongoing system failure in regards to resident weight changes. R76 was admitted on 3/11/2013, with diagnoses that included but not limited to dementia, hypertension, cardiomegaly, peripheral vascular	F 520	The Risk Management team addressed this issue on 9/18/13 and developed an action plan to insure that each resident receives their nutritional needs. The action plan and progress towards goals will be reviewed at each Risk Management meeting and at the next scheduled Quality Assurance Meeting in October. The action plan will be communicated to staff via general staff bulletins and staff meeting/in-services. Staff will be in-serviced on 9/19/13 regarding the development of a weight loss team and the development of an action plan to insure that each individual resident receives the necessary nutrition to maintain/prevent significant weight loss. Resident Care Coordinator #1 will be responsible to monitor for compliance. Results of monitoring will be reviewed at quarterly Quality Assurance Committee meetings. Completion Date: 9/19/13	9-19-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 520	Continued From page 43 disease and chronic kidney disease. During a six month timeframe R76 had a 24% weight loss and had not been monitored or new interventions put in place to prevent further significant weight loss. R75 was admitted to the facility on 3/1/13, with diagnoses of fracture of the neck of the femur and was discharged on 4/5/13 to the hospital. During the month timeframe R75 was at facility resident had a documented 18.4% weight loss that had not been monitored or interventions put in place to prevent further significant weight loss. See F-325 Based on observation, interview and document review, the facility failed to monitor ongoing weight loss and develop appropriate interventions to prevent further weight loss for 2 of 3 residents (R76, R75) reviewed for nutrition who had unplanned and significant weight loss and continued to lose weight. R76 lost 47 pounds in six months and R75 had lost 23 pound in one month. During interview on 8/21/13, at 1:26 p.m. the director of nursing (DON) indicated typically how system worked was the nursing assistant that completed the resident bath would document the weight and if a change in three or more pounds was noted a reweigh was expected to be done. DON verified there was a system error now with not having the nursing assistant here that routinely completed the resident baths and documented the weights. DON continued saying every nursing assistant was responsible for documenting the resident weight after completing the bath and indicated needed to find a back- up protocol for when baths were not documented. DON confirmed the resident care coordinator together with the dietary manager were	F 520	**Statement of Credible Allegation of Compliance:** South Shore Care Center objects to and disagrees with both the findings of non-compliance and the level of deficiencies cited. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statements of Deficiency were correctly cited, and is also not to be construed as an admission against interests of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies, sent by certified mail, as a condition to participate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by Facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 520	Continued From page 44 responsible for monitoring the weights. DON indicated they had not addressed weights not being completed by nursing assistants and had now been working on a policy in regards to unplanned weight loss. At 1:30 p.m. the dietary manager (DM) indicated they tried to look at weights for the care conference. The DM verified they had not looked at weights weekly but tried to at least once each month. The DON confirmed there was definitely a system error in place regarding resident weights and identifying weight loss timely. At 1:40 p.m. the DON printed off a form dated 8/3/2009, of the policy that the DON expected staff to follow. The DM indicated the form had not been completed for R76. During interview on 8/22/13, at 9:24 a.m. the director of nursing (DON) indicated the administrator was the chairperson of the QAA committee. The administrator was not available in the facility during survey. The DON indicated the QAA committee ' s role was to open up to all the staff and encourage the staff to bring areas of concerns and issues forward. The DON also indicated the facility had subcommittees that were also responsible to bring information forward to the QAA committee which in turn would discuss what needed to be worked on and the sequence of priority. The DON verified the concern of resident weight loss had not been completed nor had it been brought forward as a QAA project to work on and confirmed nursing and dietary department were aware of the concern with resident weights not being completed. The DON indicated the dietary manager was aware that concerns were to be brought forward to resident care coordinators and the director of nursing. The DON continued to say there was a system error in completing resident weights so residents with	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 520	Continued From page 45 weight loss could be identified timely. During review of the Quality Assurance and Assessment Policy and Procedures dated as reviewed on 7/1/09, identified the purpose of the committee was to keep systems functioning satisfactorily and consistently including maintaining current practice standards; preventing deviation from care processes from arising, to the extent possible; discerning issues and concerns with facility systems and determining if issues/concerns are identified and correcting inappropriate care processes.	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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
K 000	INITIAL COMMENTS	K 000		

DC: 10.01.2013

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on August 26, 2013. At the time of this survey, South Shore Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

EXIT: 08.22.2013

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
444 Cedar St., Suite 145
St Paul, MN 55101-5145, or

RECEIVED
SEP 23 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

POC ok
9.25-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Barbara Atchison	Administrator	9-20-13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/26/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	**1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187**

(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
K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and, Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. South Shore Care Center is a two-story building with partial basement. The original building was constructed in 1962, with building additions constructed in 1964 and 1968. All are fully sprinklered, and were determined to be of Type I (332) construction. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 62 beds and had a census of 54 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 020 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction	K 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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
K 020	Continued From page 2 having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the required fire resistance rating of a stairway, in accordance with NFPA 101 (2000) Chapter 19, Section 19.3.1 and Chapter 8, Section 8.2. In the event of a fire, this deficient practice could adversely affect 20 of 62 residents, staff and visitors. FINDINGS INCLUDE: On 08/26/2013 at 11:40 AM, while surveying on the D-Wing corridor, observation revealed the double doors leading into the stairway swung into the stairwell, the inactive door leaf was not positively locked into its frame, and the active door leaf did not fully close and failed to positively latch. This finding was verified with the chief building engineer at the time of discovery.	K 020	K 20 The double doors leading into the stairway have been repaired. Staff will be reminded at an all staff in-service on 9-19-13 that the inactive door leaf needs to be positively locked into the frame when not in use. The closer on the active door leave was adjusted so that is positively latches. The Maintenance Supervisor will be responsible for monitoring for compliance and has added this to his Preventative Maintenance List. Completion Date: 9-6-13	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed	K 029	K 29 The door to the Soiled Linen Room on D-wing has been repaired so as to self-close. The Maintenance Supervisor will be responsible for monitoring for compliance and has added this to his Preventative Maintenance List. Completion Date: 9-14-2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/26/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	**1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187**

(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
K 029	Continued From page 3 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain a hazardous area door in accordance with NFPA 101 (00), Chapter 19, Section 19.3.2.1 and 19.3.6.3.2, and Chapter 8, Section 8.2.3.2.3.2. In a fire emergency, this deficient practice could adversely affect 10 of 54 residents, staff and visitors. FINDINGS INCLUDE: On 08/26/2013 at 12:10 PM, observation revealed the corridor door to the Soiled Linen Room on the D-Wing egress corridor did not self-close, as the automatic door closing device was out of adjustment. This finding was confirmed with the chief building engineer.	K 029		