DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: ID99

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY A	GENCY		Facility 1	ID: 00885
1. MEDICARE/MEDICAID PROVIDE (L1) 245596 2.STATE VENDOR OR MEDICAID No. (L2) 201042900		3. NAME AND AL (L3) SOUTH SHO (L4) 1307 SOUTH (L5) WORTHING	ORE CARE C H SHORE DR	ENTER	OX 69 (L6) 56	6187	4. TYPE OF 1. Initial 3. Termina 5. Validation	2. R tion 4. C on 6. C	<u>1 (</u> L8) Recertification CHOW Complaint
5. EFFECTIVE DATE CHANGE OF C		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site	Visit 9. Covey After Compla	Other
6. DATE OF SURVEY 7/28/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	14 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE		FISCAL YEAR	R ENDING DAT	TE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	64 (L18) 64 (L17)	Complianc1. A		gram	2. Techn 3. 24 Ho 4. 7-Day 5. Life S	ical Personnel ur RN RN (Rural SN) afety Code	7. Med	pe of Services Li lical Director ent Room Size	imit
14. LTC CERTIFIED BED BREAKDOV	VN				15. FACILITY ME	ETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1	861 (j) (1):	(L1	5)	
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION 1	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	EY AGENCY	APPROVAL	Da	nte:
Gary Nederhoff, Unit Sup	ervisor	0	07/29/2014	(L19)	K <u>amala Fiske-</u> l	Downing, I	Enforcement	<u>Specialis</u> t	07/29/2014 (L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR	SINGLE ST	TATE AGEN	CY	
19. DETERMINATION OF ELIGIBILE			IPLIANCE WITH HTS ACT:	H CIVIL	2. Ow	nership/Contro	cial Solvency (HO l Interest Disclosu		1513)
X 1. Facility is Eligible to Pa2. Facility is not Eligible	пистрате				3. Bo	th of the Above	:		
, ,	(L21)								
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINAT	ION ACTION:		(L30)	
OF PARTICIPATION 01/01/1992	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Closur		05	VOLUNTARY -Fail to Meet He	alth/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction 03-Risk of Involun			-Fail to Meet Ag	reement
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	7.10		04-Other Reason fo	•	<u>07</u> 07	<u>FHER</u> -Provider Status -Active	Change
(L27)	B. Rescind Su	uspension Date:	(L44)				00	-Active	
			(L45)						
28. TERMINATION DATE:	29	O. INTERMEDIARY/	CARRIER NO.		30. REMARKS				
		03001							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVAL	DATE					
	(L32)	07/25/2014		(L33)	DETERMINA	TION APPR	ROVAL		



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245596

July 29, 2014

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 July 22, 2014 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,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Kumalu Fiske Downing

Telephone: (651) 201-4112

Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered July 29, 2014

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

RE: Project Number S5596024

Dear Ms. Atchison:

On June 26, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 13, 2014. 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 July 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 22, 2014 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 June 13, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 22, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 13, 2014, effective July 22, 2014 and therefore remedies outlined in our letter to you dated June 26, 2014, 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Division of Compliance Monitoring

Minnesota Department of Health

Telephone: (651) 201-4112 Fax: (651) 215-9697

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245596	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/28/2014
Name of Facility		Street Address, City, State, Zip Code	
SOUTH SHORE CARE CENTER		1307 SOUTH SHORE DRIVE POWERTHINGTON MN 56187	O BOX 69

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	F0156		Correction Completed 07/10/2014	ID Prefix	F0244		Correction Completed 07/22/2014		ID Prefix	F0280		Correction Completed 07/10/2014
Reg. # LSC	483.10(b)(5) -	(10), 483.	10(k		483.15(c)(6)				Reg. # LSC	483.20(d)(3),	483.10(k	<u>)(</u> 2)
ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)	Correction Completed 07/10/2014	ID Prefix Reg. # LSC	F0312 483.25(a)(3)		Correction Completed 07/10/2014			F0325 483.25(i)		Correction Completed 07/10/2014
	F0329 483.25(l)		Correction Completed 07/10/2014		F0363 483.35(c)		Correction Completed 07/01/2014		Reg. #	F0428 483.60(c)		Correction Completed 07/10/2014
ID Prefix Reg. # LSC	483.60(b), (d)	, (e)	Correction Completed 07/10/2014	ID Prefix Reg. # LSC	F0441 483.65		Correction Completed 07/10/2014		ID Prefix Reg. # LSC	F0456 483.70(c)(2)		Correction Completed 06/13/2014
	F0465 483.70(h)		Correction Completed 07/22/2014	ID Prefix Reg. # LSC					_			
Reviewed I	Ву	Reviewed	-	Date:	Signature	e of Su	rveyor:				Date:	
State Agen Reviewed I CMS RO		GN/K Reviewed		07/29/201 Date:	Signature	e of Su	rveyor:	10	160		Date:	07/28/2014
Followup t	to Survey Com	•	1:							Summary of the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245596	(Y2) Multiple Con A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 7/22/2014
Name of Facility		Street Address, City, State, Zip Code	
SOUTH SHORE CARE CENTER		1307 SOUTH SHORE DRIVE PO	O BOX 69

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).

WORTHINGTON, MN 56187

(Y4) Item	(Y	'5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 07/01/2014	ID Prefix		Correction Completed	ID Prefix		Correction Completed
•	NFPA 101 K0021	<u> </u>	Reg. # LSC			Reg. # LSC		<u> </u>
Reg. #		Correction Completed	Reg. #		Correction Completed	Reg. #		Correction Completed —
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed	Reg. #		Correction Completed
Reg. #		Correction Completed	Reg. #		Correction Completed			Correction Completed
Reg. #			Reg. #			D #		
Reviewed E	By Review	ed By	Date:	Signature of Sur	veyor:		Date:	
State Agen	2 0,11		07/29/2014			251		07/22/2014
Reviewed E	By Review	ed By	Date:	Signature of Sur	veyor:		Date:	
Followup t	o Survey Completed 6/10/2014	on:	с	theck for any Uncor Uncorrected Defic				NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					TE SURVEY AGENCY		Facility ID: 00885
1. MEDICARE/MEDICAID PROVII (L1) 245596 2.STATE VENDOR OR MEDICAID (L2) 201042900		3. NAME AND ADDRESS OF FACILITY (L3) SOUTH SHORE CARE CENTER (L4) 1307 SOUTH SHORE DRIVE PO BO (L5) WORTHINGTON, MN			OX 69 (L6) 56187	4. TYPE OF AC 1. Initial 3. Termination 5. Validation	CTION: 2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OI (L9) 6. DATE OF SURVEY 06	FOWNERSHIP (13/2014 (L34)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual	PPLIER CATEG 05 HHA 06 PRTF	ORY 09 ESRD 10 NF	02 (L7) 13 PTIP 22 CLIA 14 CORF	7. On-Site Vision 8. Full Survey	t 9. Other After Complaint
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/III 12 RHC		FISCAL YEAR E	NDING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	64 (L18) 64 (L17)	Compliance1. Ac1. We B. Not in Com-	nce With equirements e Based On: cceptable POC	gram	And/Or Approved Waivers O 2. Technical Personne3. 24 Hour RN4. 7-Day RN (Rural S5. Life Safety Code * Code: B	6. Scope o	of Services Limit 1 Director Room Size
14. LTC CERTIFIED BED BREAKD	OOWN				15. FACILITY MEETS		
18 SNF 18/19 SNF	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REI	MARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENC	Y APPROVAL	Date:
Marietta Lee, HFE NE II	I	0	7/22/2014	(L19)	Kamala Fiske-Downing	, Enforcement S	pecialist 07/24/2014 (L20)
PA	ART II - TO BE	COMPLETED I	BY HCFA RE	EGIONA	L OFFICE OR SINGLE	STATE AGENCY	<i>Y</i>
DETERMINATION OF ELIGIB	Participate		PLIANCE WITH	H CIVIL	21. 1. Statement of Fin.2. Ownership/Contr3. Both of the Abox	rol Interest Disclosure S	
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	LTC AGREEN	MENT	26. TERMINATION ACTION	1:	(L30)
OF PARTICIPATION 01/01/1992	BEGINNING	DATE	ENDING DA	ГЕ	VOLUNTARY 01-Merger, Closure		LUNTARY il to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbur		il to Meet Agreement
25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS n of Admissions: uspension Date:	(L44)		03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	. <u>OTHI</u>	ovider Status Change
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			

(L33)

DETERMINATION APPROVAL

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered June 26, 2014

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

RE: Project Number S5596024

Dear Ms. Atchison:

On June 13, 2014, 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>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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) 206-2711

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 July 23, 2014, 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 July 22, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 September 13, 2014 (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

South Shore Care Center June 26, 2014 Page 5

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 December 13, 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 an ePoC 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 electronic 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 pat.sheehan@state.mn.us

Telephone: (651) 201-7205

Fax: (651) 215-0541

South Shore Care Center June 26, 2014 Page 6

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Kumalu Fish Downing

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 07/08/2014 FORM APPROVED OMB NO. 0938-0391

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED		
		245596	B. WING _		06	/13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	ER .		STREET ADDRESS, CITY, STATE, ZIP COD 1307 SOUTH SHORE DRIVE PO BOX 6 WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	гѕ	F 0	00		
	as your allegation of Department's acce enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.				
F 156 SS=D	on-site revisit of you validate that substate regulations has been your verification. 483.10(b)(5) - (10),	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with 483.10(b)(1) NOTICE OF SERVICES, CHARGES	F 1:	56		7/10/14
	and in writing in a la understands of his regulations governi responsibilities duri facility must also pr notice (if any) of the §1919(e)(6) of the made prior to or up resident's stay. Re	form the resident both orally anguage that the resident or her rights and all rules and ng resident conduct and ing the stay in the facility. The rovide the resident with the e State developed under Act. Such notification must be on admission and during the ceipt of such information, and o it, must be acknowledged in				
	entitled to Medicaic of admission to the resident becomes e items and services facility services und which the resident	form each resident who is I benefits, in writing, at the time nursing facility or, when the eligible for Medicaid of the that are included in nursing der the State plan and for may not be charged; those rvices that the facility offers				

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

Electronically Signed 07/04/2014

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			
		245596	B. WING _		06	13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CO 1307 SOUTH SHORE DRIVE PO BOX WORTHINGTON, MN 56187	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 156	the amount of char inform each resider the items and servi (i)(A) and (B) of this The facility must intat the time of admist the resident's stay, facility and of chargincluding any chargunder Medicare or The facility must fulegal rights which in A description of the funds, under paragunder Medicare or A description of the for establishing eligithe right to request 1924(c) which detenon-exempt resour institutionalization as spouse an equitable cannot be consider toward the cost of the medical care in his down to Medicaid exempts of all pertigroups such as the agency, the State ligombudsman program advocacy network, unit; and a statement.	esident may be charged, and ges for those services; and at when changes are made to ces specified in paragraphs (5) is section. Form each resident before, or esion, and periodically during of services available in the les for those services, les for services not covered by the facility's per diem rate. Formish a written description of includes: In manner of protecting personal raph (c) of this section; In requirements and procedures ibility for Medicaid, including an assessment under section rmines the extent of a couple's ces at the time of and attributes to the community e share of resources which ed available for payment the institutionalized spouse's or her process of spending	F 19	56		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245596	B. WING _		06/1	3/2014	
	PROVIDER OR SUPPLIER SHORE CARE CENTE			STREET ADDRESS, CITY, STATE, ZIP CO 1307 SOUTH SHORE DRIVE PO BOX WORTHINGTON, MN 56187	DE	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 156	Continued From pa	age 2	F 15	66			
	misappropriation o	resident abuse, neglect, and fresident property in the impliance with the advance nents.					
	name, specialty, ar	form each resident of the nd way of contacting the ble for his or her care.					
	written information applicants for adm information about hedicare and Med	rominently display in the facility, and provide to residents and ission oral and written now to apply for and use icaid benefits, and how to previous payments covered by					
	by: Based on interview facility failed to pro termination of all M for 3 of 3 residents	NT is not met as evidenced w and document review, the vide the required notices upon dedicare part A skilled services (R51, R11 and R3) who met receive Medicare services and om the facility.		It is the facility's policy to pro required notices to residents coverage and/or termination Part A skilled services. There negative outcomes related to termination notices.	related to of Medicare were no		
	NON-COVERAGE R51, R11, and R3 the Centers for Me (CMS) expedited d	lacked evidence of receiving dicare and Medicaid Services lecision, "Notice of Medicare erage" notice prior to discharge		The facility policy and proced providing appropriate notices and decisions have been revirevised. CMS approved form being used. Staff who is responding liability notices will be in-serviced on 7/10/14 to insurequirements are met. The Director of Nursing will be responsible for training and a	, instructions iewed and s are now onsible for oe ure that		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG			E SURVEY PLETED
		245596	B. WING			06/	13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R			ETY, STATE, ZIP CODE E DRIVE PO BOX 69 MN 56187	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 156	R51 was discharge due to electing hos document review of Determination on C Medicare days, accondice list provided in the facility. The faproviding R51 with Medicaid (CMS) ex Medicare Provider instructions on how Improvement Orgal reviewer authorized facility decision to c R11 was discharge due to lack of skille progress, according Skilled Nursing Factontinued Stay. R1 facility lacked evided Centers for Medica expedited decision, Non-Coverage " whow to contact the Organization (QIO) authorized by Medical decision to discharged due to lack of skilled progress, according Skilled Nursing Factontinued Stay. R3 was discharged due to lack of skilled progress, according Skilled Nursing Factontinued Stay. R3 according to reside by the facility. R3 r	d from Medicare on 4/10/14, pice benefits, according to f R51's Skilled Nursing Facility continued Stay. R51 used 10 cording to resident liability by the facility. R51 remained acility lacked evidence of the Centers for Medicare and pedited decision, "Notice of Non-Coverage" which included to contact the Quality nization (QIO), an independent by Medicare to review the lischarge from Medicare. If the Medicare on 10/29/13, d nursing or rehabilitation to document review of R11's cility Determination on 11 used 8 Medicare days, and liability notice list provided remained in the facility. The ence of providing R11 with the re and Medicaid (CMS) "Notice of Medicare Provider hich included instructions on Quality Improvement, an independent reviewer care to review the facility	F 1	compliance are audits at the recommittee months 7/28/14. The Committee	nd provide the results next Quality Assurance eeting scheduled for QA Committee will urther interventions of e necessary.	e	

PRINTED: 07/08/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245596	B. WING		Of	6/13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187	-	,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 156	Centers for Medica expedited decision, Non-Coverage" wh how to contact the Organization (QIO) authorized by Medidecision to dischard During interview on registered nurse (Revidence of providing Provider Non-Coverage Centers for Miservices Skiller Advanced Beneficial letter prior to services. The facility did not and Medicaid Serving Facility Advanced for the five denicenters for Medica website. The CMS would want their bill submitted for review by the facility titled Determination on Contact of the contact of	"Notice of Medicare Provider ich included instructions on Quality Improvement, an independent reviewer care to review the facility	F 1	56		
	represents our judg needed no longer n	not been made by Medicare. It pment that the services you net Medicare payment will be sent to Medicare for				

Facility ID: 00885

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY IPLETED
		245596	B. WING		06/	13/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 156	F 156 Continued From page 5 the services you received before (Date).		F 156			
	Normally, the bill s include services pr want to appeal this that the bill submitt services we determ Medicare will notify disagree with that appeal." R51 was discharge due to electing hos document review of Determination on Medicare days, accordice list provided in the facility. Althowith the Skilled Nu Continued Stay no	submitted to Medicare does not rovided after this date. If you is decision, you must request ted to Medicare include the nined to be noncovered. If you determination you may file an ed from Medicare on 4/10/14, spice benefits, according to of facility Skilled Nursing Facility Continued Stay. R51 used 10 cording to resident liability. By the facility. R51 remained ough the facility Determination on tice, the notice lacked emitting the facility bill to				
	due to lack of skilled progress, according Skilled Nursing Faccording Skilled Nursing Faccording to reside by the facility. R3 Although the facility Nursing Facility Denotice, the notice lasubmitting the facility During interview or verified these were R51 and R3. DENIAL LETTERS	d from Medicare on 5/29/14, ed nursing or rehabilitation g to document review of R3's cility Determination on the second				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245596	B. WING			06/	13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R		1	STREET ADDRESS, CITY, STATE, ZIP CODE 307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	due to electing hosp document review of Determination on C Medicare days, acc notice list provided in the facility. Altho Skilled Nursing Fac Continued Stay, the R51's decision to st Medicare. R11 was discharged due to lack of skilled progress, according Skilled Nursing Fac Continued Stay. R1 according to reside by the facility. R11 Although the facility Facility Determinating facility lacked evide or not submit the bill. During interview on accounts receivable the denial notice on to submit the bill. During interview on of nursing verified Facility Determination of nursing v	d from Medicare on 4/10/14, pice benefits, according to facility Skilled Nursing Facility Continued Stay. R51 used 10 cording to resident liability by the facility. R51 remained ough the facility provided the cility Determination on a facility lacked evidence of ubmit or not submit the bill to d from Medicare on 10/29/13, d nursing or rehabilitation g to document review of facility cility Determination on 11 used 8 Medicare days, nt liability notice list provided remained in the facility. It provided the Skilled Nursing on on Continued Stay, the ence of R11 decision to submit	F 1	156			
F 244 SS=E	483.15(c)(6) LISTE GRIEVANCE/RECO	N/ACT ON GROUP OMMENDATION	F 2	244			7/22/14

1 '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		245596	B. WING		06/ ⁻	13/2014	
	PROVIDER OR SUPPLIER SHORE CARE CENT			STREET ADDRESS, CITY, STATE, ZIP CO 1307 SOUTH SHORE DRIVE PO BOX WORTHINGTON, MN 56187	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 244	must listen to the grievances and re and families concoperational decisilife in the facility. This REQUIREMED by: Based on observe	or family group exists, the facility views and act upon the commendations of residents erning proposed policy and ons affecting resident care and ENT is not met as evidenced ation interview and document	F 2	It is the policy of the facility to			
	council concerns call lights were ad attempt to be reso and resident intern (R33 's family me R78, R4, R75, R6 facility. Findings include: Resident Council May, and June 20 minute 's had old not being answere the director of nur would do audits a minutes of 5/7/14 concerns related tin a timely manne indicated there we noted by the resid times they noted a During an intervie social worker (SW Council Minutes at	failed to ensure resident related to timely answering of dressed with a good faith olived. This also included family views for 12 of 42 residents imber [F-A], R27, R58, R1, R8, 6, R3, R34 and R28) in the Minutes were reviewed for April, 14. Each monthly meeting business related to call lights ed. The April minutes indicated sing (DON) stated that she and look for patterns. Meeting and 6/4/14 documented current to call lights not being answered in The 6/4/14 meeting minutes ere no specific times or patterns ents themselves but stated at a 40 minute wait for assistance, whom 6/13/14 at 11:00 a.m. the and stated that in February 2014 ll lights was noted under old		Resident Council concerns a in a timely manner with a good attempt to be resolved. There negative outcomes related to response to call lights. The Resident Council meets Minutes of the previous montare reviewed and residents a recommendations have been on. The next Resident Council scheduled for July 10, 2014. will include call light response the goal of agreeing to a mutacceptable expectation of call response time. The facility will review call light times weekly using the Arial of reporting system. Response than the goal established by Council will be investigated a addressed with staff and residence of Nurses. The Director of Nursing is respondent of the process of the process.	od faith e were no e extended monthly. th's meeting are asked if a followed up cil meeting is The agenda e time with ually Il light the response call light time greater the Resident and dents by the		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
		245596	B. WING		06/	13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	iR	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 244	business. R33's family memb 6/10/14 at 2:42 p.m half an hour for her answered and recequarterly minimum revealed R33 requiactivities of daily liv R27 was interviewed stated he would hasomeone to answere squarterly MDS dadiagnoses of demeand required extendaily living. R58 was interviewed stated sometimes had been an hour of were worse around bed. R1 was interviewed stated that she has minutes for someolight. R1 added if a bath, some nurses lights. Review of R3/25/14 revealed R required extensive daily living. R8 was interviewed stated that she has in the bathroom and to do that, but it half	ner (FM)-A was interviewed on a and stated that it could take mother to have the call light live help. Review of R33's data set (MDS) dated 4/8/14 red extensive assistance with	F 244	Nursing will audit call light resp 3 times a week for the next 30 determine the cause for extend response times and meet with residents to achieve a mutually acceptable solution. The result will be reviewed by the Quality Committee at its next quarterly scheduled for 7/28/14. The QA will determine if further interver monitoring are necessary.	days, ded staff and / ss of audits Assurance / meeting Committee	

NAME OF PROVIDER OR SUPPLIER SOUTH SHORE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 244 Continued From page 9 day. R8 added an hour was a long time to sit in	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER SOUTH SHORE CARE CENTER 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187	3/2014	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 244 Continued From page 9 F 244		
1 211	(X5) COMPLETION DATE	
there (referring to the sitting on the toilet for an hour.) Review of R8's 5 day MDS dated 4/18/14 revealed R8 had diagnoses of anxiety, depression, and history of urinary tract infections and required extensive assistance with activities of daily living. The facility provided the call light audit report for 6/11/14 and the report indicated a total of 232 call lights had been alarmed and cleared between 12:00 a.m. and 11:59 p.m. on 6/11/14. The report indicated an average answer time on 4 and ½ minutes; however, 13 or 5.6% of the time the alarm sounded greater than 20 minutes before responded to. The longer waits did not have a time of day patterns and occurred for residents in their rooms, in the bathroom, or on the patio. R33 was designated on the call light report indicated R33 waited 26 minutes on one occasion on 6/11/14. This occurred during the middle of the afternoon. Review of R33's quarterly minimum data set (MDS) dated 4/8/14 revealed R33 required extensive assistance with activities of daily living, 0n 6/12/14 from 7:55 a.m. to 10:10 a.m. R33 was observed sitting in a recliner, but would not respond when spoken too. At 10:10 a.m. she was noted to be sleeping in the chair. The care conference review dated 4/22/14 indicated R33 required assist of one for transfers and mobility. R78 was designated on the call light report which indicated that R78 waited 20 to 27 minutes on two occasions. The report indicated the alarms were turned on both in the morning and in the evening.		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	245596	B. WING		06	/13/2014	
NAME OF PROVIDER OR SUPPLIER SOUTH SHORE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187		DDE	,	
(X4) ID SUMMARY STATEMENT C PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTII	PRECEDED BY FULL	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
R78 required physical assis up in bed and assistance to 6/13/14 at 3:00 p.m. R78 st always answer the light" but takes a long time. R78 sta a director of nursing and had disease. R4 was designated on the dindicated R4 experienced a minutes on 6/11/14. R4's st dated 5/22/14 indicated R4 required extensive assistant daily living. R75 was designated on the also shared a companion report indicated R75 had a 27 minutes. R75 's significed dated 4/11/14 indicated R75 pulmonary disease and imprequired extensive assistant daily living. The call light autindicated the bathroom shath had a call light alarmed for the dated 6/14/14 indicated R66 minutes for the call light to had an admission MDS dated indicated R66 had diagnose cardiac issues, arthritis, and MDS also indicated R66 recassistance with activities of R3 was indicated on the call ndicated R3 had call light windicated R4 light	boost up in bed. On ated that "they that added sometimes it ted that she had been d Parkinson's call light report long wait of 21 ignificant change MDS had arthritis and ce with activities of call light report and born with R4. The call call light alarm on for eart change MDS experienced vaired vision and ce with activities of udit report also red by R75 and R4 30 minutes. call light audit report and had to wait 23 be answered. R66 ed 5/12/14 that es that included thip fracture. The quired extensive daily living.	F 2	44			

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		E SURVEY MPLETED
		245596	B. WING		06/	/13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	iR		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 244	5/9/14 indicated R3 with activities of dar that included stroke R34 was indicated 6/11/14 indicated R call light to be answ 6/10/14 at 9:50 a.m. The bed was in a lo lipped, and a fall ma.m. the nursing as needed to anticipat not speak English. 4/18/14 indicated R with activities of dar R28 was included of experienced call light from 23 to 34 minutes. She indicated R required extensive daily living. The director of nurse 6/13/14 at 9:15 a.m. light should be answinutes. She indicated resident concerns answered for long prome audits. The completed in April 2 longer answering reponsible production of the fact identify residents the light answering to a DON also stated the and then the supercall light alarmed all	ily living and had diagnoses e and hemiplegia. on the call light audit report of 34 waited 34 minutes for the vered. R34 was observed on a and 10:55 a.m. lying in bed. ow position, the mattress was at was on the floor. At 11:20 sistant (NA) - F stated staff e R34 's needs since R34 did The quarterly MDS dated 334 required extensive assist	F 2	44		

PRINTED: 07/08/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` ,	(X3) DATE SURVEY COMPLETED	
		245596	B. WING			06/13/2014	
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP COD 1307 SOUTH SHORE DRIVE PO BOX 6 WORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 244 F 280 SS=D	(RN)-C clinical mar receive an audible answered after 5 m audibly page a nurs answer the call ligh keep notifying RN-C answer. RN-C stat answer the call ligh. The social worker (6/13/14 at 11:00 a.r council complaint p department heads SW-A stated that in audit would need to members having as system. 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or othe incapacitated undeparticipate in plannichanges in care and A comprehensive assenterdisciplinary teaphysician, a register for the resident, and disciplines as deter and, to the extent p the resident, the resident is a subject to the resident in th	3/14 the registered nurse nager indicated that she would page for a call light not inutes. RN-C would then sing assistant of the need to t. The pager system would C until the call light was ed she would sometimes t if she was not busy. SW)-A was interviewed on m. She indicated the resident rocess would be for the to investigate and respond. In June 2014 a more in depth to be completed with more staff occess to the call light audit of (k)(2) RIGHT TO NNING CARE-REVISE CP the right, unless adjudged the erwise found to be the laws of the State, to ing care and treatment or	F2			7/10/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	X3) DATE SURVEY COMPLETED		
		245596	B. WING		06/13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	ER	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 307 SOUTH SHORE DRIVE PO BOX 69 VORTHINGTON, MN 56187	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 280	and revised by a te each assessment. This REQUIREME	age 13 eam of qualified persons after NT is not met as evidenced	F 280		
	review, the facility finclude current fall	tion, interview and document failed to revise the care plan to interventions and mobility sidents (R51) reviewed for		It is the policy and procedure of the facility to revise care plans to include current status and interventions.	
	mat had been on the 6/10/14, at 8:34 a.m. On 6/12/14, at 7:41 lying in bed and a fibeside the bed. On 6/12/14, at 9:52 (NA)-F and NA-A him wheelchair to bed a mechanical lift to trobservation a tab a	erved lying in bed and a floor ne floor beside the bed on m. I a.m., R51 had been observed floor mat had been on the floor 2 a.m., nursing assistant and transferred R51 from and had used a Hoyer ansfer R51. At time of alarm had laid on R51's night mattress had been on R51's		The Interdisciplinary Team (IDT) is responsible for periodic review and updating of the residents' plans of car when there is a change in condition, or a desired outcome is not reached, when the resident has been readmitted to the facility and at least quarterly. R-51. The comprehensive plan of car was revised on 6/17/14 to reflect interventions incorporated related to potential for falls associated with cognimpairment, weakness, and mobility of the facility will review the policy on comprehensive care plan developme and revision with staff at an in-service 7/10/14.	when nen he net ne net ne net ne
	physician orders dadiagnoses of but no hypertension and t of 3/5/14, Hoyer tra	nitted on 8/1/12. R51's ated 5/7/14, identified of limited to dementia, reatment order with order date ansfers for all mobility.		The Director of Nursing is responsible monitoring for compliance. The result monitoring will be provided to the Qua Assurance Committee at its next qua meeting scheduled for 7/28/14. The QACommittee will determine if further interventions or monitoring are neces	ts of ality rterly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245596	B. WING _		06/	13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP COL 1307 SOUTH SHORE DRIVE PO BOX WORTHINGTON, MN 56187	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 280	(MDS) dated 4/15/1 occurred in room /c two for transfers. Review of R51's medated 6/1/14 to 6/30 with A-Z for all mobnights, a.m. and p.r. Review of the facility provided by the facility provided by the facility provided by the facility provided by the facility provided in room. R51's current care problem self-care down and gait belt, rescheduled, assist in in wheelchair as ne continued safety was Problem potential for impairment, weakned interventions keep of respond promptly, the tabs to be proposed by the facility provided by the faci	4, identified ambulation: none orridor and extensive assist of edication administration record 0/14, identified Hoyer transfers ility, start date of 3/5/14 and in. shifts signing for treatment. y untitled page dated 4/22/14, lity identified subject; resident ember to always engage the onot leave resident in wheelchair. plan dated 11/19/13, identified eficit: walking evidenced by for all ambulation with with therapy with assist of emind resident when therapy is a transfer of resident to therapy eded and monitor for alking; two assist with gait belt. For falls related to cognitive ess, mobility deficit with call light/bell within easy reach, abs (no specification on where resident to request help if abulate per therapy incourage resident to wear ing hours and for all transfers esident as requested and as ter medications as ordered fects, night light in room at a litor location Arial alarm, ing seat alarm to wheelchair, is belt with instruction, 5/9/14	F 2	80		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245596	B. WING _		06	/13/2014	
	PROVIDER OR SUPPLIER SHORE CARE CENTI		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187		ODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280	had not identified in with A-Z for all mole no specification regalarm, mat on floor bed, lipped mattres bathroom and roor. During interview or registered nurse (is current plan of carregarding transfers transferred with a leassist. During interview or had stated when a were for R51, safe on bed, mat on floor mattress and cannot be mattress and cannot be mattress and cannot be mattred on 8/23/13 on 11/25/13 and do bathroom and roor started on 11/25/13. During interview or director of nursing be revised when mattress and cannot be revised on 11/25/13.	nt care plan dated 11/19/13, R51 required Hoyer transfers bility, R51 is non-ambulatory, garding placement of tab reside bed when R51 is in set, do not leave unattended in when in wheelchair. 16/11/14, at 2:56 p.m., RN)-C had verified R51's had no documentation and verified R51 is Hoyer mechanical lift and two and 6/12/14, at 9:56 a.m., NA-F sked what fall interventions ty belt on wheelchair, tab alarm for, bed low position, lipped ot leave alone in room. 16/13/14, at 8:34 a.m., RN-C antions of fall mat had been tab alarm for bed had started on not leave unattended in method when in wheelchair had a set of 13/14, at 12:07 p.m., stated would expect care plan take adjustments in care needs to be care planned.	F 28	30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	B) DATE SURVEY COMPLETED		
		245596	B. WING		06/13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R	1	TREET ADDRESS, CITY, STATE, ZIP CODE 307 SOUTH SHORE DRIVE PO BOX 69 VORTHINGTON, MN 56187	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 280 F 282 SS=D	individualized need 483.20(k)(3)(ii) SEF PERSONS/PER CATTHE SERVICES PROVIDED TO THE SERVICES PR	RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility y qualified persons in ach resident's written plan of a plan of the resident's written plan of the resident's written plan of a plan of the resident and document ailed to implement care plan erventions for 1 of 3 residents accidents. ag in wheelchair in room at the and R51' s self-release belt on the release belt on the release to the release the release the release the self-release the release the release the release to the release the releas	F 280 F 282	It is the policy and procedure of the facility to implement individualized car plans for each resident. The IDT is responsible for periodic revand updating of the residents' plans or care when there is a change in condition when a desired outcome is not reached when the resident has been readmitted the facility and at least quarterly. R-51 comprehensive plan of care was revised on 6/17/14 to reflect intervention.	view f ion, ed, d to s ons
	R51 was trying to s discontinued. Surve are communicated the communication nursing assistant dat the time nursing identified alarms, so 1:48 p.m., NA-A ha	n alarm so staff knows when tand, and had been eyor asked NA-A how changes and NA-A had replied through book, Kiosk in computer and aily worksheet. NA-A verified assistant daily worksheet elf-release belt for R51. At d stated the self-release belt blace and had not been used.		incorporated related to potential for fa associated with cognitive impairment, weakness, and mobility de Placement of the self-release seat bel while up in the wheelchair and release during supervised activities was implemented to alert staff to unsafe independent movements and avoid potential for recurrent falls associated this resident diminished cognition. The nursing assistant assignment sheets provide staff education as to the	eficit. It ed with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LTIPLE CONSTRUCTION (X		(X3) DATE SURVEY COMPLETED	
		245596	B. WING		06/	13/2014	
	PROVIDER OR SUPPLIER SHORE CARE CENTE	ER .		STREET ADDRESS, CITY, STATE, ZIP CO 1307 SOUTH SHORE DRIVE PO BOX WORTHINGTON, MN 56187	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE	HOULD BE	(X5) COMPLETION DATE	
F 282	During continuous 8:28 a.m., R51 sitti of C unit, 8:46 a.m. assisting R51 to ea end of C unit, 8:49 table in room end obeen removed. At same. At 9:20 a.m. 9:52 a.m., NA-F apif wanted to lie dow transferred R51 froused a Hoyer mechanged and the same of observations night stand. NA-F asked what fall into belt on wheelchair, floor, bed low positic cannot leave alone room after R51 had in place a product was dry. Nof R51, put be in loon floor beside bed on night stand and and walked out of I intervened at the time alarm was to be on stated if I had seen resident, NA-A che do not see an alarm and asked NA-A at R51's night stand at tab alarm should be R51's physician ordingnoses of but no hypertension. R51's	observation on 6/12/14, at ng in wheelchair in room end, staff person had been at breakfast at table in room a.m., R51 remains sitting at of C unit, breakfast tray had 2:09 a.m., R51 remains the , R51 remains the same. At proached R51 and asked R51 in in bed, NA-F and NA-A had in wheelchair to bed and had nanical lift to transfer R51. At a tab alarm had laid on R51 is had stated at the time when exventions were for R51, safety tab alarm on bed, mat on ion, lipped mattress and in room. NA-F had left R51's is been transferred into bed. In check incontinent product and stated the incontinent la-A placed call light in reach w position and placed fall mat la. Tab alarm remained placed NA-A had shut light off in room R51's room. Surveyor me and asked NA-A if the Tab and R51 when in bed. NA-A one I would have hooked it to cked R51's bed and stated I in for bed. Surveyor intervened bout the tab alarm sitting on and NA-A verified at the time e on R51 when in bed. ders dated 5/7/14, identified on limited to dementia and is significant change Minimum ted 4/15/14, identified toilet	F 2	self-release belt when up in vand may release during superactivities. The assignment shapeen coded that R-51 is a falt to be left alone in wheelchair. Care plan was updated 6/17/R-51 individualized toileting roward assistant assignment updated to reflect need to off before and after meals, upon pm to promote maximum uring continence. The facility will provide in-sere education to responsible staft to review the necessity of foll resident's comprehensive plan. Unit charge nurses are responsionationing for compliance. Tomonitoring will be provided to assurance Committee at its meeting scheduled for 7/10/11 Committee will determine if for interventions or monitoring and selections.	rvised eet also has I risk and not in room. 14 to reflect leeds. t sheets were er toileting rising, and hary vice f on 7/10/14 owing each in of care. Insible for the results of the Quality ext quarterly 4. The QA urther		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245596	B. WING			06/	13/2014
NAME OF PROVIDER OR SUPPLIER SOUTH SHORE CARE CENTER				13	TREET ADDRESS, CITY, STATE, ZIP CODE 307 SOUTH SHORE DRIVE PO BOX 69 ORTHINGTON, MN 56187	, 33	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 2	82			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
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F 282 F 312 SS=D	had stated interventions of tab alarm for bed had started on 11/25/13. During interview on 6/13/14, at 12:07 p.m., director of nursing had stated would expect to offer the toilet, tab alarm and self-release belt to be in place as that is part of R51's plan of care. Policy regarding following the care plan had been requested at the time and none had been provided. 483.25(a)(3) ADL CARE PROVIDED FOR			F 282		7/10/14	
	by: Based on observar review, the facility f provided for 2 of 3 reviewed for activiti remove facial hair f reviewed in the san Findings include: LACK OF NAIL CA R76 was observed R76 's finger nails on 6/12/14, at 8:20	tion, interview, and document ailed to ensure nail care was residents (R76, R51) es of daily living and failed to or 1 of 1 residents (R66) aple with facial hair. RE: on 6/10/14, at 8:57 a.m., and were long and soiled. Again 0 a.m., R76 finger nails were simmed and soiled under the		It is the facility's policy that residere unable to carry out activities living receive the necessary sermaintain good nutrition, grooming personal and oral hygiene. Resident #76 and #51 were procare immediately upon identificational care had not been provided. Resident #66 had her facial hair by staff as requested by the residenting interview by Director of North The facility procedure for persongrooming was reviewed and reviewed.	of daily vices to ag, and vided nail ation that removed dent ursing.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER SOUTH SHORE CARE CENTER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187		
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F 312	R76 's admission lassessment dated moderate cognitive extensive assistant hygiene. R76 's care plan d that R76 had self-or that included extenpersonal hygiene During interview or of nursing verified to finger nails. Direct expected staff to presure nails were dinterviewed at 6/12 they would like staff. During interview or nursing assistant-Band trimmed finger needed. Document review or nursing assistant-Band trimmed finger needed. Document review or nursing assistant-Band trimmed finger needed. R51 was observed on 6 on 6/11/14, at 1:35	Minimum Data Set (MDS), an 4/17/14, revealed R76 had a impairment and required be from one staff for personal atted 4/25/14, directed staff are deficit with interventions sive assist of 1-2 staff for a 6/12/14, at 1:58 p.m., director the untrimmed and soiled or of nursing stated she rovide nail care daily and to be clean. Also R76 was 1/14 at 2:00 p.m. and said that if to trim their finger nails. In 6/13/14, at 11:08 a.m., at (NA-B) stated she cleaned analls on bath day and as a policy dated revised 4/07, a purposes of this procedure ill bed, to keep nails trimmed, ctions." "General Guidelines 1. daily cleaning and regular on 6/10/14, at 10:22 a.m., and mmed fingernails. This was 1/11/14, at 9:04 a.m. and again	F 312	6/19/14. Staff will now document or skin care alert document that nail of (personal grooming) was provided. updated procedure for personal growill be reviewed with responsible stan in-service on 7/10/14. Unit charge nurses are responsible monitoring for compliance. The Dir. Nursing will randomly audit through rounding on nursing units to insure necessary services to maintain good grooming are provided with resider cares. The results of monitoring will provided to the Quality Assurance Committee at its next quarterly meascheduled for 7/28/14. The QA Corwill determine if further intervention monitoring are necessary.	are The coming raff at for ector of that od at I be etting mmittee	

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		245596	B. WING _		06/	13/2014	
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F 312	nursing assistant (I asked if R51 's fine R51 had been adm physician orders da diagnoses of but not hypertension. R51 Data Set (MDS) da hygiene extensive R51's current care problem self-care of to impaired mobility help from another with interventions of done each week by verbal cues as need Document review of 6/3/14, identified R1:30 p.m. and iden whirlpool bath on 60 During resident into a.m., R51 had statilength is o.k., but the I would like them to observed fingernaitedges. During interview or director of nursing be trimmed weekly needed, if resident come back, if refuscare. FACIAL HAIR:	NA)-B had stated no, when gernails appear trimmed. Initted on 8/1/12. R51 's ated 5/7/14, identified of limited to dementia and 's significant change Minimum ated 4/15/14 identified personal assist of one person. I plan dated 11/19/13, identified deficit personal hygiene related by, evidenced by needs daily person with personal hygiene of but not limited to: nail care by bath aide after 6, provide	F 3 ⁻				

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F 312	neatly dressed and room. During intershe was already dredone for the day. R66 's admission hassessment dated cognitive impairment assist of one staff for Document review of dated 5/22/14, directly self-care deficit and another person for During observation 2:00 p.m., director of chin hairs. Director expected staff to she was already dressed and the person for the	on to one inch long chin hairs, leating breakfast in the dining view at that time, R66 stated lessed and her cares were. Minimum Data Set (MDS), an 5/12/14, revealed R66 had no not and required extensive for personal hygiene. If the facility resident care planted staff that R66 had a needed daily help from personal hygiene. and interview on 6/12/14, at for nursing verified R66 's long of nursing stated she have female facial hair daily or	F 3	12			
F 325 SS=D	as needed. During p.m. R66 stated wo hairs. During interview on nursing assistant-B women with mornin 483.25(i) MAINTAIN UNLESS UNAVOID Based on a resident assessment, the faresident - (1) Maintains acceptatus, such as bootunless the resident demonstrates that the state of the	g interview on 6/12/14 at 2:02 buld like staff to remove chin 6/13/14, at 11:08 a.m., (NA-B) stated she shaved ag cares and on bath day. N NUTRITION STATUS DABLE at's comprehensive cility must ensure that a complete parameters of nutritional by weight and protein levels,	F3	.25		7/10/14	

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 325	Continued From panutritional problem.	_	F 325			
	by: Based on interview facility failed to reassignificant weight lodischarged resident. Findings include: R41 was admitted discharged on 6/10 plan printed 4/2/14 cancer, diabetes, however, however, diabetes, however, diabetes, however, diabetes, however, however, diabetes, however, however, however, however, however	gned 5/20/14 indicated the		It is the facility's policy to maintain acceptable parameters of nutritional status, such as body weight and prolevels; unless the resident's clinical condition demonstrates that this is nutritional assessment completed by dietary consultant on a at which time R-41's "weight was identified as stable. Continue to mor Resident condition was determined to declining on 5/20/14 during routine primary care physician (PCP)visit. O 5/30/14 weight loss was identified. A was sent to the PCP on 6/3/14 to communicate dietitian's recommend to implement glucerna 2oz. bid with pass. PCP approved recommendatic comprehensive weight loss assessment tool was completed for R-41 on 7/1/Correspondence to the PCP regarding explanation for significant weight loss received and noted on 7/1/14 to indicate indicate in the pollular to the pollular to indicate in the pollular to make th	tein ot t was 4/8/14 hitor." to be n fax ation med on. A hent 14. ng his s was cate ultiple	
	weight, intakes, and The admission Min	d labs. imum Data Set (MDS) dated		reviewed with staff at an in-service of 7/10/14. Focus will be on the important of maintaining acceptable parameter	ance	

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F 325	3/26/14 noted R41 mental status) of 12 On 3/31/14 the Carnutritional status no intake and non-comon dependent of the property	had a BIMS (brief interview of 2 or impaired cognitive status. e Area Assessment for sted: risk related to decreased apliance to diet. Idan consulting report noted no at this time. On 5/7/14 the obysician of an unstageable coccyx, but not that the pounds the previous month. Immended house supplement intake. Idan consulting report noted de, power potatoes and ed pass. The dietitian did not experienced a significant weight from 3/19/14 to 6/2/14) and of his ideal weight range nor d an open ulcer. There was no ght loss assessment mine the appropriate in the a		325	nutritional status such as body weight and protein levels unless the reside clinical condition demonstrates that not possible. The Resident Care Coordinators at members of the Risk Management Committee will be responsible to make for facility compliance with regards weight loss. Reports of resident we loss will be reviewed at the quarter meetings. The next QA meeting is scheduled for 7/28/14. "The QA Committee will determine if further interventions or monitoring are need to be a considerable of the	ent's t this is nd nonitor to eight ly QA		

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F 329 SS=D	sweets diet. The di R41 power potatoes powder, butter) eve R41 would also recessacks or a shake. R41 's weight loss weights in the compadded the resident notify the physician that usually an unpl would be completed causes of weight lost find it for R41. DM her documentation DM stated she thou of the significant we 483.25(I) DRUG RE UNNECESSARY DEACH TEACH TE	y with a low concentrated etary department would give is (cream cheese, protein ry day at noon. DM stated eive protein pudding for DM stated she was aware of because she monitored the outer system weekly. DM clinical care manager would of the weight loss. DM stated anned weight loss sheet in that included possible is and intakes, but could not stated that she was behind on related to resident changes. If the physician was notified eight loss. EGIMEN IS FREE FROM RUGS The gregimen must be free from an an unnecessary drug is any excessive dose (including or for excessive duration; or conitoring; or without adequate se; or in the presence of the swhich indicate the dose or discontinued; or any	F 32			7/10/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
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F 329	contraindicated, in drugs.	age 26 Intions, unless clinically Intions an effort to discontinue these ENT is not met as evidenced	F 329			
	by: Based on observareview, the facility dose reduction of reduction of psych residents (R40) remedication use; faindications (reside symptoms) for use for 2 of 5 residents unnecessary meditary medications include: R40 was admitted diagnosis that include diagnosis that include depression, accord 5/20/14. The facility identification behaviors, and recantianxiety, and are potential for side expotential for side expotential for side exposed for the facility identification of the facility identi	ation, interview and document failed to attempt a gradual antipsychotic medication and/or otropic medication for 1 of 5 viewed for unnecessary iled to clearly identify nt specific signs and of an antianxiety medication is (R8, R51) reviewed for		It is the facility's policy that each resident's drug regimen be free from unnecessary drugs. Those being drug used in excessive dose, excessive duration, without adequate monitoring without adequate indications, in the presence of adverse consequences, or any combination of these reasons. R-40 receives Lorazapam, Sertraline, Seroquel for diagnosis of obsessive compulsive disorder, major depressive disorder, psychosis and anxiety. These medicate are managed by the Veteran's Administration (VA) psychiatrist. On 4/16/14 the facility contacted the VA psychiatrist regarding the consulting pharmacist's recommendation for grad dose reduction (GDR) of psychotropic medications. The physician's response was that "patient needs to continue current medications, as reduction done the past made recurrence in his anxietinability to function, with decompensat The VA was contacted again on 6/13/1 and the psychiatrist indicated R-40 was stable	and ions dual e e in ty, ion."	

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	PROVIDER OR SUPPLIER SHORE CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH ACTION SHOUTH ACTION SHOUTH APPORT OF THE	OULD BE	(X5) COMPLETION DATE	
F 329	Continued From pashift and document 5/12/09, revealed palteration, with interaction, with interaction, with interaction, with interaction, with interaction, with interaction, with interaction alteration, with interaction and served. During observation R40 was observed a group activity. No observed. Observed. During resident interp.m., no moods or observed. Document review of dated 5/20/14, reveal (Ativan) 0.25 milligrams every maked of 11/16/10; and 450 milligrams every maked of 11/16/10; and 450 milligrams every maked of 11/16/10; and 450 milligrams every maked of 11/14/10; and 450 milligrams every maked of 11/14/14, revenue of 11/14	ge 27 Resident care plan dated roblem potential for mood eventions that included monitor ring increased behavior. s on 6/10/14, at 9:55 a.m., to wheel self independently to p moods or behaviors were ations on 6/10/14, at 12:30 pendently eating lunch in the cods or behaviors were erview on 6/10/14, at 12:45 behaviors were noted or f physician orders signed ealed orders for lorazepam ams every bedtime for of 3/25/11; zoloft 200 corning for depression, order and Seroquel (psychotropic) by bedtime for corder date of 11/15/11. If facility medication red for 5/1/14 to 5/31/14 and evealed R40 received Ativan, I as ordered. 6/11/14, at 2:22 p.m., social	F 32	change. "He needs to be on cu of medications, previous attem reduction resulted in severe de Patient and his family are fully a his condition and they "do not v changes in his meds, as he tole them well, and denies any side Based on documentation from GDR (gradual dose reduction) impair this individual's function or cause prinstability by exacerbating an umedical condition or psychiatric R-40 psychotropic medications managed by the VA psychiatris been monitoring this resident for time and has twice in the last to provided documentation that Golinically contraindicated. R-40' medication regimen helps promaintain the resident's highest mental, physical, and psychosomell-being, as identified by the and/or collaboration of physician R-8 had orders for Lorazepam pm. Resident had no specific be identified for use of Lorazepam Antianxiety medication was reversident's primary physician on with orders to discontinue this resident in the second continue this resident in the second continue this resident to discontinue this resident.	rrent dose pts of dose terioration. aware of want any erates effects." the VA, is likely to sychiatric nderlying a disorder. are t who has or a long wo months DR is s current note or practicable ocial resident ns. 1 mg tid ehaviors . iewed by 6/23/14 medication.		
	behavior monitoring managers and revieteam documentation identified the follow depression, anxiety stated R40 had no	ted she reviewed mood and g weekly with the clinical ewed facility risk management in with the team monthly. SS-A ing moods monitored included and sleep disturbance. SS-A target behaviors and no viors. SS-A stated if R40 had		Primary physician also reviewe antidepressant medications (Tr and Cymbalta) used for manag major depressive disorder and that GDR of these medications justified at this time due to likel recurrence of symptoms. R-8's diagnoses include depressive of the symptoms.	azadone ement of indicated is not ihood of medical		

PRINTED: 07/08/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245596	B. WING		06/13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	ER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 307 SOUTH SHORE DRIVE PO BOX 69 VORTHINGTON, MN 56187	
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 329	SS-A stated the monursing assistant of facility computer syshift mood monitor symptoms detail revealed there were revealed there were charting assessme identified the follow depression and sleand no behavioral Document review of mental status (BIMS score of 15/15-cog questionnaire (PHO) than minimal symphehaviors. Document review of mental status (BIMS score of 15/15-cog behavior assessme services mood assisted depression, anxiety incidents of these in (no depression). Document review of mental status (BIMS score of 13/15-cog behavior assessme services mood assisted depression, anxiety services depression, anxiety services depression, anxiety services depression, anxiety services depression, anxiety serv	ey would monitor the behaviors. In the position of moods included ocumentation every shift in the postern. SS-A verified every ing according to the mood export from 12/1/13 to 6/11/14, we no moods. In facility social services and annual dated 4/22/14 aring: no incidents of exp disturbance in past 14 days issues. In facility brief interview for sold and 10/22/13, revealed a mitton intact, patient health Q-9) identified score of 3, less toms of depression, and no of facility brief interview for sold ated 1/21/14, revealed a gnition intact, social services ent-no behaviors, social essment, monitored y, sleep disturbances with no moods, and PHQ-9 score of 0 of facility brief interview for sold dated 4/22/14, revealed a mitton intact, social services ent-no behaviors, social essment-monitored y, sleep disturbances with no essment-monitored y, sleep disturbances with no services ent-no behaviors, social essment-monitored y, sleep disturbances with no	F 329	The Director of Nursing interviewed on 6/30/14 regarding mood/depress and use of dual anti-depressant therapies. Resident indicated that she is willing to attem discontinuation of Citalopram and a was sent to her physician regarding discontinuation. R-51 had orders for Ativan 0.5mg popm anxiety/restlessness. R-51 had specific behaviors identified and upor review R-51 had not received Ativar over 90 days. Order was obtained to discontinue per facility policy due to nonuse. R-51 is also on an anti-depressant, however anti-depressant (Remeron) is being used for manag of weight loss and used as appetite enhancement. GDR is not recommental attempts to manage weight loss anti-depressant has been advised by physician. The facility does send a request to the primary care physicians to review psychotropic medications including using a document titled Psychopharmacological Medication Review. This document is completed by the Resident Care Coordinators on each asking for	pt fax pt q4hr no con n for corresponding to the c
	(no depression). Document review of	of Doctors Orders and ted 4/16/14, revealed		physician's response. This documer reviewed and revised to aid the prim care physicians to review residents' current treatment plans and determ adjustments in psychotropic medica	nary ine if

Facility ID: 00885

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245596	B. WING		06/1	3/2014	
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 307 SOUTH SHORE DRIVE PO BOX 69 VORTHINGTON, MN 56187		
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F 329	address psychophar review. Physician revealed R40 need medications as red recurrence in his ardecompensation. Psychopharmacolo were attached to the 4/16/14, each with Lorazepam 0.25 midiagnosis-anxiety, dose, resident does not advised by nurs. Zoloft 200 milligram diagnosis-depression well on this dose, renursing. Seroquel 450 milligram diagnosis-depression well on this dose, renursing. Seroquel 450 milligram diagnosis-depression well on this dose, renursing. Seroquel 450 milligram diagnosis-depression well on this dose, renursing. Seroquel 450 milligram diagnosis-depression well on this dose, renursing. Seroquel 450 milligram diagnosis-depression well on this dose, renursing. Seroquel 450 milligram diagnosis-depression well on this dose, renursing. Seroquel 450 milligram diagnosis-depression well on this dose, renursing. Seroquel 450 milligram diagnosis-depression well on this dose, renursing. Seroquel 450 milligram diagnosis-depression well on this dose, renursing.	cist request for physician to armacological medication response dated same day, ed to continue current rection done in the past made exiety instability with the following facility gical Medication Reviews e physician response dated review date of 2/6/14: Iligrams, order date-3/25/11, comments-This is minimal is well on this dose, reduction	F3	329	are justified. The Director of Nursin reviewed this assessment tool with Resident Care Coordinators on 6/2 insure compliance. The facility will I an in-service on 7/10/14 and staff will provided guidance on insuring that resident remain free from unnecess medication. Licensed staff will be re-educated on identifying specific behaviors for psychotropic medications prior to administration medications and requirements for documenting effectiveness after administration. Resident Care Coordinators in conjunction with the pharmacy consult be responsible for monitoring facompliance. The pharmacy consult be responsible for reporting compliance quarterly meeting. The next meetin scheduled for 7/28/14. The QA Corwill determine the need for further interventions or monitoring.	7/14 to nave will be each sary of PRN sultant acility ant will ance to at each g is	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245596	B. WING _		06/	13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187		
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F 329	Medication Review physician signed o Seroquel from 450 and to monitor respective facility was una information related and return to 450 r. During interview or of nursing stated signadual dose reduce medications or clin R8 received three and there was no puse of three antide used at the same to R8 had been admitorders dated 4/15/not limited to MDD anxiety, nervousne R8 's five day Mini 4/18/14, identified of depression mild scheduled and as received non medipain present occas activity, pain scale interview of mental out of 15 on the Mintact. During review of R dated 4/15/14, reveal to the mental out of 15 on the Mintact.	of Psychopharmacological with review date of "4/1/12," rder on "4/3/13, "to decrease milligrams to 400 milligrams ponse. Although requested, able to provide any further to dose reduction of Seroquel milligrams dosage. In 6/13/14, at 8:30 a.m., director he expected an attempt at ction of psychotropic dical justification for no attempt. antidepressant medicaations obysician justifications to be	F 32	29		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245596		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		COMPLETED 06/13/2014	
		245596	B. WING		06		
NAME OF PROVIDER OR SUPPLIER SOUTH SHORE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 1307 SOUTH SHORE DRIVE PO BOX WORTHINGTON, MN 56187	DDE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 329	citalopram (an antice every day for MDD, (an anti-anxiety me a day as needed for anxiety/nervousness and hydrocodone-amedication) 5/325 r hours as needed for R8's current care problem mood alternation, grief, loss of down at times, enterpoor appetite, anxiety, grief, loss of down at times, enterpoor appetite, anxiety concentration at time limited to give medifor side effects. Proof psychotropic medication in comfor pain, leg pain and profibut not limited to evaluate effective MAR (medication and interdisciplinary not review of physician identified current mativan (lorazepam) no documentation resouthwestern Mental Management progidentified diagnosis medications Cymba continue with Cymba and con	depressant medication) 20 mg start date 4/11/14, lorazepam dication) one mg three times r s/agitation, start date 10/4/13 cetaminophen (pain mg one to two tablets every six r osteoarthritis. Ian dated 1/8/14, identified ration related to depression, of role evidenced by feeling er long term care, feeling tired, bus, difficulty with nes with intervention of but not cation as ordered and monitor ablem potential for side effects dication with interventions of conitor behavior on each shift intervand document response hly. Problem potential for the pain related to lower back that all over with interventions assess episodes of pain and the so of interventions used, mess on PRN (as needed) dministration record) and/or in	F3	329			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(X	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER SHORE CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP COI 1307 SOUTH SHORE DRIVE PO BOX WORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE		
F 329	Cymbalta, trazodon start dates of 10/4/r physician justification antidepressant med Document review of administration reconstruction of 31/14 and from 6/2 had been receiving Cymbalta 20 mg every bedtime, loraday as needed and 5/325 mg one to two needed. Document review of sheets dated from sidentified R8 had receight times and real had been increased anxiousness/I amin been documented in lorazepam four out Hydrocodone-aceta been given 13 times no documentation of identified medical lorazepam and trazidate 4/17/14 had not lorazepam and citation identified medication identified medication identified identified medication identified	arding justification for use of e and lorazepam that had a and no documentation of on regarding starting third dication citalopram on 4/11/14. If R8's medication of dated from 5/1/14 to 6/30/14, identified R8 citalopram 20 mg every day, ery day and trazodone 50 mg zepam one mg three times a hydrocodone-acetaminophen of tablets every six hours as If R8's PRN Medication 6/1/14 through 6/12/14, ceived as needed lorazepam sons for giving documented anxiety/increased ervous and response had not egarding effectiveness of of the eight times. Iminophen medication had and six out of 13 doses had	F3	.29			

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	PROVIDER OR SUPPLIER SHORE CARE CENTE	ER .		STREET ADDRESS, CITY, STATE, ZIP C 1307 SOUTH SHORE DRIVE PO BO WORTHINGTON, MN 56187	ODE	
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F 329	not identified medic Cymbalta and citale Cymbalta and citale During interview or licensed practical reffectiveness of lor hydrocodone-aceta not been documented for givincreased anxiety/a specific anxiety syr when Ativan was giplan had no specific lorazepam medicate anxiety is documented. During interview or worker (SW)-A had care coordinator to management meet resident is receiving management team citalopram and lorarisk management tresident symptoms agitation related to SW-A reviewed R8 been no physician regarding use of Cyand citalopram in Form During interview or registered nurse (Form physician justificuse of Cymbalta, tresident symptoms agitation related to SW-A reviewed R8 been no physician in Form physician justificuse of Cymbalta, tresident symptoms agitation related to SW-A reviewed R8 been no physician justificuse of Cymbalta, tresident symptoms agitation related to SW-A reviewed R8 been no physician justificuse of Cymbalta, tresident symptoms agitation symptoms agitation related to SW-A reviewed R8 been no physician justificuse of Cymbalta, tresident symptoms agitation related to SW-A reviewed R8 been no physician justificuse of Cymbalta, tresident symptoms agitation related to SW-A reviewed R8 been no physician justificuse of Cymbalta, tresident symptoms agitation related to SW-A reviewed R8 been no physician justificuse of Cymbalta, tresident symptoms agitation related to SW-A reviewed R8 been no physician justificuse of Cymbalta, tresident symptoms agitation related to SW-A reviewed R8 been no physician justificuse of Cymbalta symptoms agitation related to SW-A reviewed R8 been no physician justificuse of Cymbalta symptoms agi	review date of 5/14/14, had cation use of lorazepam, opram medications. n 6/13/14, at 10:29 a.m., ourse (LPN)-D verified	F3	29		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	245596 B. WING			06/13/2014		
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187	,	
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F 329	director of nursing luse of citalopram a be reviewed and sp care planned. Director of nursing effectiveness of as given be documented being documented being documented being given as neer regarding what anx R51 received ativar there was no reside symptoms identified medication was affectiveness of but not depression, anxiety significant change I dated 4/15/14, identificant change I dated 5/7/14, reveal anti-anxiety medical anxiety medical anxie	6/13/14, at 12:21 p.m., nad stated she would expect and lorazepam medication to be discretic behaviors identified and ctor of nursing had stated cian justification to be ding use of Cymbalta, and why started citalopram. Stated would expect needed medications when ed and reason of anxiousness for lorazepam medication ded be more specific iousness is. In as needed (PRN) however, and specific anxiety signs and dot determine it the ective or not. Itted on 8/1/12. R51 's steed 5/7/14, identified to the limited to dementia, and the restriction of the states (MDS) tified mood: feeling down, less, feeling tired or having gor speaking slowly and cosis-delusional. R51 's brief status (BIMS) had been 3 out and indicated severe cognitive of the states of the	F 3.	29		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 329	identified problem prelated to loss of furweepy at times, par of interest, verbally disturbances and report in the problem pro	e plan dated 11/19/13, potential for mood alteration inction, feeling worthless, ranoid, resistive at times, lack elling, refusals, sleep estless with intervention of but its and monitor increased signs pression daily, document on its, review monthly at team inappropriate behavior: section related to cognitive, respit, hit, pinch, slap, throws yells, swears, refuses ADL ving), bath, medications, and cares. The plan had not identified of anxiety and restlessness edication use. The facility risk management on review dates 4/17/14 and cumentation regarding Ativan 16/13/14, at 10:50 a.m., social is stated she did not know R51 ivan, but I should of. SW-A of Ativan on R51 's current 11/19/13. SW-A verified risk had not reviewed the use of lentify specific behaviors	F 32	29		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER SHORE CARE CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 NORTHINGTON, MN 56187		
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F 363 SS=E	Review Tool dated assure that each remedications are as benefit/risk and graclinically contraindithat each resident from unnecessary reductions are improntraindicated. Possible to programme team Drug Review Tools that the facility is concerned as a proper team of the process	of the facility Psychotropic Drug 8/4/05, read, "PURPOSE To esident receiving psychotropic sessed routinely for adual dose reductions if not cated. It is the facilities policy so drug regimen remains free drugs and that gradual dose lemented unless clinically DLICY 3. The behavior will review all Psychotropic to assure their completion and compliant with state regulations. Residents who are started on a medication will have a tropic Drug Review Tool at the Transport of the interdisciplinary team assure that individualized approaches are contained ff care."	F 329			7/1/14

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER SHORE CARE CENTE	R	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 363	R34, R36, R58 and received mechanic Findings include: R3, R11, R13, R27 dished foods by the correct measured a menu. The meal m to be four ounces p R3's bowl was filled amount of Swiss st meal preparation for observations were preparing the dinner Cook-B had ground portions into a bown amount. Review of identified R3 as had national dysphagial meat. R11's bowl was filled amount of Swiss stobservation of the following the amount. The Stop Steak for R11. Coop steak and scooped the amount. The Stop Steak for R11 as had cardiac diet with put R13's bowl was fill amount of Swiss stobservation of the following steak stop Swiss Swis	I R75) in the sample who ally altered diets. R34, R36, R58 and R75 were a cook who did not use the amount according to the meal enu for the day had meat was per resident serving. With an undetermined eak during observation of the per R3 on 6/11/14 at 11:07 a.m. made of dietary cook-Ber meal of Swiss steak for R3. If the Swiss steak and scooped I without measuring the the resident 's medical recording a physician order for a diet II (NDD2) with ground eak which was noted during meal preparation for R11 on m. observations were made of paring the dinner meal of Swiss k-B had pureed the Swiss into a bowl without measuring wiss steak was then served to resident medical record aving a physician order for a	F 363	dietary allowances of the Food a Nutrition Board of the National F Council, NationalAcademy of So. The plan of correction for the 8 identified will be the same for all in the facility. Dietary staff have been re-educated the correct method to prepare a mechanically altered foods in approportions and to measure the using appropriate utensils so as appropriate nutritional servings a each resident's individualized plan of Education was provided by the O Dietitian on July 1, 2014. Hence training will be provided to all ne staff during orientation. The Dietary Supervisor is responsitoring for compliance. The monitor meal service 3 times perfour weeks and then once a week random shifts thereafter. The Co Dietitian will also monitor month next quarter and quarterly thereafter and quarterly thereafter and the next quarterly Q Assurance Meeting scheduled for 2014. The QA Committee will remake recommendations for ong monitoring.	Research ciences. Tesidents residents residents ated as to not serve propriate se foods to provide as per care. Consultant forth, this w dietary maible for DS will research to provide a serve propriate se foods to provide as per care. Consultant forth, this w dietary maible for DS will research to provide after. The will be uality or July 28, view and	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
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	245596 AME OF PROVIDER OR SUPPLIER SOUTH SHORE CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187		
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 363	dietary cook-B pre Swiss steak for R. steak and scooped the amount. Review	paring the dinner meal of Cook-B had pureed the Swiss I into a bowl without measuring w of the medical record	F3	63		
	R27's bowl was fill amount of Swiss sobservation of the 6/11/14 at 11:07 a. dietary cook-B presteak for R. Cookand scooped into a amount. Review of R27 as having a pl American Diabetes	ed with an undetermined teak which was noted during meal preparation for R27 on m. observations were made of paring the dinner meal of Swiss B had ground the Swiss steak a bowl without measuring the the medical record identified hysician order for an 1800 s Association (ADA) diabetic				
	amount of Swiss sobservation of the 6/11/14 at 11:07 a. dietary cook-B presums steak for R. steak and scooped the amount. Reviewidentified R34 as h	teak which was noted during meal preparation for R34 on m. observations were made of paring the dinner meal of Cook-B had ground the Swiss I into a bowl without measuring w of the medical record aving a physician order for a				
	amount of Swiss sobservation of the 6/11/14 at 11:07 a. dietary cook-B presums steak for R. steak and scooped the amount. Review	teak which was noted during meal preparation for R36 on m. observations were made of paring the dinner meal of Cook-B had ground the Swiss				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1307 SOUTH SHORE DRIVE PO BOX WORTHINGTON, MN 56187	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 363	amount of Swiss s observation of the 6/11/14 at 11:07 a. dietary cook-B presteak for R. Cookand scooped into a amount. Review on R58 as having a play purred meat diet. R75's bowl was fill amount of Swiss sobservation of the 6/11/14 at 11:07 a. dietary cook-B pressures steak for R. steak and scooped the amount. Review identified R75 as have a stated that she swiss steak for groof Swiss steak f	meat diet ed with an undetermined teak which was noted during meal preparation for R58 on m. observations were made of paring the dinner meal of Swiss B had pureed the Swiss steak a bowl without measuring the f the medical record identified hysician order for a NDD1 with ed with an undetermined teak which was noted during meal preparation for R75 on m. observations were made of paring the dinner meal of Cook-B had ground the Swiss I into a bowl without measuring w of the medical record aving a physician order for a lated sweets) with ground meat with cook-B on 6/11/14 11:10, a had placed 5 servings of bound diets and then 3 servings pureed diets into food en stated that the foods were ng to the consistency ordered, icated that once food was the	F 36	53			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		245596	B. WING		06/	13/2014	
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 363	Interview with dieta 11:12 a.m. verified mechanically altere time of serving. DM re-measure to ensucorrect. Observation had put the correct were observed to bowl vs. when the othey looked unequaserving vegetables spoon. DM went to	I that she did not measure the g into the bowls. ry manager (DM) on 6/11/14 at that she had also observed d foods were not measured at then proceeded to are amount served was on of bowls of meat after DM amount of food into the bowls e equal in amount in each cook put food into the bowls al. Cook-B was then observed onto plates using a slotted cabinet and obtained the spoon and told Cook-B she	F3	63			
	foods dated 3/24/14 the cook will put the food processor and get the numbers of processor so they k resident. 2) For the the number of servi is needed and will a cream to puree it. 3 cook will then meas how much the resid 483.60(c) DRUG R IRREGULAR, ACT The drug regimen of reviewed at least of pharmacist.	EGIMEN REVIEW, REPORT	F 4	28		7/10/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245596	B. WING		06/	13/2014	
	PROVIDER OR SUPPLIER SHORE CARE CENT			STREET ADDRESS, CITY, STATE, ZIP C 1307 SOUTH SHORE DRIVE PO BO WORTHINGTON, MN 56187	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 428	the attending phys nursing, and these	ician, and the director of reports must be acted upon.	F 4	28			
	by: Based on intervie consulting pharma to the physician ar monthly pharmacy	w and document review, the acist failed to report irregularities and director of nursing during the review for 2 of 5 residents (R8 d for unnecessary medication		It is the facility's policy that regimen of each resident be least once a month by a lice pharmacist and that any irre reported to the Director of N	e reviewed at ensed egularities be		
	diagnoses of but redepressive disorder agitation and oster Minimum Data Seridentified mood sordepression mild), scheduled and as received non med pain present occas activity, pain scale interview of mentate out of 15 on the Mintact. During review of Edated 4/15/14, revantidepressant medevery day for MDE Trazodone (an antidepressive disorder d	rs dated 4/15/14, identified not limited to MDD (major er), anxiety, nervousness, parthritis. R8's five day to (MDS) dated 4/18/14, ore of five (symptoms of no behaviors, had received needed pain medication, had ideation interventions for pain, sionally, pain limited day to day rate of eight. R8's brief I status (BIMS) had been 15 DS and indicated cognitively and indicated cognitively elected orders for Cymbalta (an edication) 20 mg (milligrams) of start date of 10/4/13, idepressant medication) 50 mg MDD, start date of 10/4/13,		The pharmacy consultant de each resident's drug regime and provide a report to the I Nursing and recommendation physicians. The pharmacy of provide correspondence to the physician and Director of Nurgards to R-8's need for resultant and Trazodone and Cymbalta and 5/28/14. On 6/23/14 the prinindicated that as R-8 just hard discontinuation of Lorazepa reduction of psychotropic manaly cause relapse of symposympharmacy consultant visited the facility on 6/30/14 and for R-8's use of Celexa since 4, was forwarded to the primare physician to consider discord Celexa due to multiple antibeing utilized and resident's attempt discontinuation of signs.	en each month Director of cons to consultant did the primary ursing with view of and GDR on mary physician ad a m, a further edications toms. The leading of the course of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245596	B. WING		06/	13/2014	
	PROVIDER OR SUPPLIER SHORE CARE CENTE	ER .		STREET ADDRESS, CITY, STATE, ZIP CO 1307 SOUTH SHORE DRIVE PO BOX WORTHINGTON, MN 56187	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 428	medication) 20 mg 4/11/14, lorazepam one mg three time anxiety/nervousnes and hydrocodone-a medication) 5/325 hours as needed for Review of Southwe Medication Managa 3/4/14, identified di medications Cymbocontinue with Cymbantidepressant Cel and there was not provided as to a ph three antidepressatime. Document review of administration reconstruction of the provided as to a ph three antidepressatime. Document review of administration reconstruction of the provided as to a ph three antidepressatime. Document review of administration reconstruction of the provided as needed and 5/325 mg one to two dated from 5/1/14 thad received as nead reasons for givin or eased anxiety/in nervous and respore garding effective the eight times. Hy) (an antidepressant every day for MDD, start date (an anti-anxiety medication) is a day as needed for es/agitation, start date 10/4/13 acetaminophen (paining one to two tablets every six or osteoarthritis. Estern Mental Health Center ement progress note dated agnosis depressive disorder, alta and Trazodone and calta and Trazodone. The third exa was started on 4/11/14 documentation nor was any physician 's justification to use int medications at the same	F 4.	prn pm anxiety/restlessness specific behaviors identified review R-51 had not receive over 90 days. Order was obt discontinue per facility policy nonuse. R-51 is also on an anti-depressant however and (Remeron) being used for m weight loss and used as appetite enhancement not recommended as reside demonstrated weight loss armanage weight loss with antihas been advised by the phy. The facility revised the policy procedure for pharmacy con and visits. The facility will review the pharmaconsultant's roles and responsan in-service on 7/10/14. Licu will be provided education or importance of reviewing and on the pharmacy consultant' recommendations in a timely Licensed nurses will be instructed the primary physician. The Director of Nursing will recipied the primary physician. The Director of Nursing will recipied for 7/28/14. The Owill determine the need for for interventions or monitoring.	and upon d Ativan for ained to v due to vi-depressant anagement of ent. GDR is not has not attempts to i-depressant vician. V and sultant role acy ensibilities at ensed staff on the following up so v manner. ucted to alert tor when ening acted on eneeting is QA Committee		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		TE SURVEY MPLETED
		245596	B. WING _		06	/13/2014
	245596 AME OF PROVIDER OR SUPPLIER OUTH SHORE CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	of 13 doses had not effectiveness. During interview or licensed practical reffectiveness of lor hydrocodone-aceta not been documented for givincreased anxiety/a resident specific si. During interview or director of nursing citalopram and lora reviewed and spectare planned. Director of nursing citalopram and lora reviewed and spectare planned. Director of nursing citalopram and lora reviewed and spectare planned. Director of nursing citalopram and lora reviewed and spectare planned. Director of nursing citalopram and lora reviewed and spectare planned. Director of nursing citalopram and lora reviewed and spectare planned. Director of nursing citalopram and lora reviewed and spectare planned. Director of nursing care planned. Director of nursing care planned. Director of nursing citalopram and lora reviewed and spectare planned. Director of nursing citalopram and lora reviewed and spectare planned. Director of nursing citalopram and lora reviewed and spectare planned. Director of nursing citalopram and lora reviewed and spectare planned. Director of nursing citalopram and lora reviewed and spectare planned. Director of nursing citalopram and lora reviewed and spectare planned. Director of nursing citalopram and lora reviewed and spectare planned. Director of nursing citalopram and lora reviewed and spectare planned. Director of nursing citalopram and lora reviewed and spectare planned. Director of nursing citalopram and lora reviewed and spectare planned.	o documentation of a documentation of a 6/13/14, at 10:29 a.m., nurse (LPN)-D verified azepam and aminophen medications had ted and verified the reason/s ving lorazepam had been anxiousness, which were not gns or symptoms for R8. In 6/13/14, at 12:21 p.m., had stated would expect use of azepam medication to be difficially be a ficial justification to be ding use of three dications being used for R8. effectiveness of as needed given are documented and less being documented for tion being given as needed be reding what anxiousness is. In 6/13/14, at 12:21 p.m., had stated would expect use of azepam medication to be directly be a stated and less being used for R8. effectiveness of as needed given are documented for tion being given as needed be reding what anxiousness is. In 6/13/14, at 12:21 p.m., had stated would expect use of and stated and stated and stated and less being used for R8. effectiveness of as needed be reding what anxiousness is. In 6/13/14, at 12:21 p.m., had stated would expect use of and stated and stated and stated and stated and less being documented for tion being given as needed be reding what anxiousness is. In 6/13/14, at 12:21 p.m., had stated would expect use of anxiousness of anxiousness of anxiousness of anxiousness of a stated and less being documented for tion being given as needed be reding what anxiousness is. In 6/13/14, at 12:21 p.m., had stated would expect use of anxiousness of anxio	F 42	28		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245596	B. WING		06/	13/2014	
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP C 1307 SOUTH SHORE DRIVE PO BO WORTHINGTON, MN 56187	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 428	interview of mental of 15 on the MDS a impairment. During review of R5 dated 5/7/14, revea anti-anxiety medica four hours as needs restlessness, start of the property of the	status (BIMS) had been 3 out nd indicated severe cognitive 61's current physician orders led an order for Ativan (an tion) 0.5 mg (milligrams) every ed, diagnoses of anxiety and date 4/17/14. 6/13/14, at 12:07 p.m., nad stated would expect use of the previewed and specific for use of medication. 6/13/14, at 1:37 p.m., cist (CP)-C had stated would extification for use of more than medication used at the same umented twice in the first year er and would expect specific fied for use of psychotropic	F4	128			
F 431 SS=D	Applicable Law." 483.60(b), (d), (e) D LABEL/STORE DR	DRUG RECORDS, UGS & BIOLOGICALS	F 4	131		7/10/14	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245596	B. WING			06/	13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENT			13	REET ADDRESS, CITY, STATE, ZIP CODE 807 SOUTH SHORE DRIVE PO BOX 69 ORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	a licensed pharma of records of recei controlled drugs in accurate reconcilia records are in orde controlled drugs is reconciled. Drugs and biologic labeled in accorda professional princi appropriate access instructions, and the applicable. In accordance with facility must store locked compartme controls, and perm have access to the The facility must ppermanently affixed controlled drugs list Comprehensive D Control Act of 197 abuse, except whe package drug distince.	mploy or obtain the services of a cist who establishes a system pt and disposition of all a sufficient detail to enable an ation; and determines that drug er and that an account of all a maintained and periodically cals used in the facility must be not ence with currently accepted ples, and include the sory and cautionary ne expiration date when all drugs and biologicals in ents under proper temperature nit only authorized personnel to be keys. Tovide separately locked, and compartments for storage of sted in Schedule II of the rug Abuse Prevention and and other drugs subject to the facility uses single unit ribution systems in which the minimal and a missing dose can	F 4	.31			
	by: Based on observa review, the facility	entrology in the service of the serv			It is the facility's policy that drugs a biologicals used in the facility be lal accordance with currently accepted	peled in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		OATE SURVEY OMPLETED	
		245596	B. WING _		06/	13/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1307 SOUTH SHORE DRIVE PO BO WORTHINGTON, MN 56187	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 431	during medication medications when carts reviewed, wh (R7, R19, R6) revistorage checks. Findings include: INACCURATE ME R40's medication of pharmacy label insolved he pass revealed R40 received the pass revealed received to the mather past 2 1/2 years. R40 was admitted diagnosis that incluphysician orders solved to the mather past 2 1/2 years. Document review signed dated 5/20/ saliva orally three day. Observations of that 12:38 p.m., reveals.	residents (R40, R8) observed pass; and failed to date opened for 1 of 3 medication nich affected 3 of 3 residents ewed during medication EDICATION LABELS: MouthKote artificial saliva) structed one spray to mouth, servations of the medication of took three sprays. Although obysician ordered correct nacy label had not been ost current physicians order for rs. to the facility 4/23/09, and had uded dry mouth, according to igned dated 5/20/14. of current physician orders /14, revealed orders for artificial sprays to mouth three times a re medication pass on 6/10/14, ealed licensed practical nurse louthKote to R40, who sprayed	F 43	,	cautionary tion date when lange between l'change in on container. e fallen off will be secured labels stay on ed. va spray ree sprays to ne facility tion" label to ty policy on lication cart on e in direction artificial saliva match the n label see lirrent Novalog ication vials ity open date ility placed ose vial in		
	revealed artificial s 9/29/13, and direct	of pharmacy medication label saliva; dispense date of tions to "Use 1 spray into times a day for dry mouth."		The facility reviewed and re policy on medication admin reflect State and Federal laws for storag	istration to		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245596	B. WING			06/1	13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	:R		1	TREET ADDRESS, CITY, STATE, ZIP CODE 307 SOUTH SHORE DRIVE PO BOX 69 VORTHINGTON, MN 56187	1 007	10,2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	During interview on verified the pharma dispense date of 9/spray three times a time, LPN-A verified signed and dated 5 order date of 11/15, three times a day. During interview on of nursing stated she medication labels with She stated she expedelivered to the factor medication labels with time. She stated with changed; she expedirection change should administration recovereceived artificial sathree times a day and Document review of Changing, and Discusted 1/1/13, page receives a new ordedose of a medication there is adequate should enter the new order with should enter the new Medication Record by Applicable Law, Pharmacy not to see	age 47 a 6/10/14, at 12:48 p.m., LPN-A acy medication label with 29/13, instructed one mouth day. During interview at that discurrent physician orders 3/20/14, for artificial saliva, /11, three sprays to mouth a 6/12/14, at 1:30 p.m., director the expected nurses checked with each medication pass. Dected when medications were stility, the nurse checked with physician orders at that when medication orders at the medication orders at the medication orders at the medication orders at the sticker on the medication orders at the medication orders at the medication orders at the sticker on the medication orders at the medication orders at the sticker on the medication orders at the sticker on the medication orders at the sticker on the medication orders. The sticker on the medication and facility policy Reordering, continuing Orders, revision 80, #3.5 "If Pharmacy er that changes the strength or on previously ordered, and supply on hand: 3.5.1 discontinue the original order; ician/Prescriber should write new directions and Facility are order on the appropriate Forms; and, 3.5.3 If permitted Facility should notify and the medication by the in Directions" sticker to the	F 4	31	guidelines for identification when a opened vial has expired and needs re-ordered. The revised policy and procedure f medication administration will be rewith nursing staff at an inservice or 7/10/14. The Resident Care Coordinators were sponsible for monitoring facility compliance for medication administration and report to the Director of Nursing concerns identified. The QA Commwill review concerns and determine need for further interventions or monitoring. The next QA meeting is scheduled for 7/28/14.	or eviewed ill be tration g any eittee e the	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245596	B. WING			06/ ⁻	13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CO 1307 SOUTH SHORE DRIVE PO BOX WORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 431	permanently affixes medication package order from Pharma Directions" stickers During telephone in p.m., consultant phethe label to be updastated the pharmac stickers for the faciliorder changes. R8's insulin vial label the physician order During observation on 6/12/14, at 11:02 (LPN)-B verified R8 had directions to aca a day and sliding scorders had changed scale now and I'll provider below units, 151 to 200 girunits, 151 to 200 girunits, 251 to 300 girunits and 351 to 40 Document review of administration reco 6/30/14, identified R Novolog insulin and 5/4/14.	medications until Pharmacy the new label to the e or container. Facility may cy bulk rolls of "Change in " terview on 6/13/14, at 1:37 armacist-C stated he expected atted with the current order. He y provided change of direction ity to use to alert their staff of el was not updated to reflect change. of medication administration a.m., licensed practical nurse 's Novolog insulin vial label liminister 30 units three times cale. LPN-B had stated the d, R8 only receives sliding at a sticker on bottle ange). It's physician telephone order fied order discontinue 30 units Moderate sliding scale only, 60, over 400, 60 to 150 give 0 are 4 units, 201 to 250 give 6 are 8 units, 301-350 give 10 are given and a container.	F 4	31			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245596		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING		06	06/13/2014	
	NAME OF PROVIDER OR SUPPLIER SOUTH SHORE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COI 1307 SOUTH SHORE DRIVE PO BOX WORTHINGTON, MN 56187	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	orders on label and on bottle to identify During interview or consultant pharmar incorrect directions would expect label home with stickers (medication admininew directions. During interview or of nursing had state directions on label expect flag (sticker physician orders as on bottle see MAR MEDICATIONS DAD During medication was noted: R7 's Roxanol 20 ro.25 ml po/sl [subliday.] The bottle was cabinet and no date opened. Twenty fix by RN-A and found R19 's medication was in drawer of mediate as to when op 6/11/14 at 2:40 p.m.	ovolog insulin vial had incorrect dono sticker had been placed order change. 1. 6/13/14, at 1:37 p.m., cist-C stated in regards to so no label of Novolog insulin he to be updated, we provide the to place over label see MAR istration record) or chart for a 6/13/14, 12:01 p.m., director ed in regards to incorrect of Novolog insulin she would to alert staff to check a change was done) to be put for order change. ATED WHEN OPENED: storage checks the following mg [milligram]/ml [milliliter] ngual] TID [three times per as stored in the locked narcotic e as to when bottle had been we ml left in bottle and verified a on 6/11/14 at 2:36 p.m. Humalog Observation Insulin ledication cart opened and no bened, this was noted on	F 4	31		

PRINTED: 07/08/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245596	B. WING	B. WING		/13/2014	
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED		PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 441 SS=D	Review of policy: 5 Dating of medication Needles revised 5/ #5. Once any med opened, Facility sho manufacturer/suppl expiration dates for staff should record medication contains shortened expiration Omnicare Pharmac Expiration Dates wi Insulin: 30 days aft temperature. Medion MEDICATIONS ON OPEN DATE PRES multi-dose vials sho when opened by lice 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and of to help prevent the of disease and infer (a) Infection Control The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what pr	d. The medication was found o.m. and verified by RN-A. 3 Storage and Expiration ns; Biological's, Syringes and 10/10; 01/01/13 page 2 of 3: ication or biological package is ould follow ier guidelines with respect to opened medications. Facility the date opened on the er when the medication has a n date once opened. by Services: Medication the effective date of 11/27/13: er opening at room cation Type: REMEMBER ALL THIS LIST MUST HAVE AN SENT. Multi-Dose Vials: All ould be dated and initialed ensed staff. I CONTROL, PREVENT tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control	F 4			7/10/14	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		245596	B. WING _		06/13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTI			STREET ADDRESS, CITY, STATE, ZIP COI 1307 SOUTH SHORE DRIVE PO BOX WORTHINGTON, MN 56187	DE .
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 441	(b) Preventing Spr (1) When the Infect determines that a prevent the spread isolate the residen (2) The facility must communicable disc from direct contact direct contact will t (3) The facility must hands after each of hand washing is in professional practic (c) Linens Personnel must ha	ead of Infection ead of Infection etion Control Program resident needs isolation to I of infection, the facility must t. est prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. est require staff to wash their lirect resident contact for which dicated by accepted	F 44	41	
	by: Based on observareview, the facility hand hygiene and spread of infection resident (R78) who Findings include: R78 was observed a wound dressing (RN)-E to the lacer RN-E washed her	NT is not met as evidenced ation, interview, and document failed to ensure appropriate glove use to prevent the during wound care for 1 of 1 or received a wound treatment. I on 6/12/14 at 8:43 a.m. during change by registered nurse ration on R78's right forearm. hands and donned examoved the foam dressing with		It is the facility's policy that stimplement hand hygiene (har washing)practices consistent accepted standards of practic the spread of infections and pcross-contamination. The nurse who provided wou R78 did indicate to the survey that she had made an error in The appropriate procedure for wound care has been reviewed nurse.	and with tee, to reduce prevent and care to for observing a procedure. r aseptic

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245596	B. WING		06/-	13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187		
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F 441	forearms, discarded the exam gloves but RN-E donned a cleathe area with wound laceration and surrous RN-E did not wash gloves before apply dressing. During an interview verified she had not the application of the applicat	the dressing from the right d the dressing and changed at did not wash her hands. an pair of gloves and sprayed d cleanser and dried the bunding area with clean gauze. her hands or change her ring the new sterile foam on 6/12/14 at 8:50 a.m. RN-E t changed her gloves before the new dressing. ician order for laceration right daily and dressing change pilex Border dressing. Change d. Observe for worsening On 6/13/14 the physician nged daily. Clear drainage. cian orders included: continue ge. Wash daily with saline. Do eroxide. Apply dressing daily ning. Intitled Non-Sterile Dressing was provided. The procedure 0) remove the dressing and g. The procedure then gloves, wash hands, and apply procedure (#12, #13, and #14) cleaning the wound with normal d cleanser and patting the area "remove gloves, wash hands,	F 441	The procedure for Aseptic Wour has been revised to include an ato monitor wound care practices an environment which maintains infection control program which recognizes, and controls, to the epossible, the onset and spread dinfections within the facility. The procedure for Aseptic Wour and importance of establishing a maintaining an infection control designed to provide a safe, sani comfortable environment and to prevent the development of tran of disease and infection will be rwith staff at an in-service on 7/10. The Infection Control Coordinate Director of Nursing will be respondent for compliance and to inwound care audits are complete randomly on licensed staff. The of Nursing will report on compliance Quality Assurance Committee. To Quality Assurance Committee with determine if further interventions monitoring are necessary. The meeting is scheduled for 7/28/14	audit tool to insure and prevents, extent of and Care and program tary, and help smission eviewed 0/14. or and nsible to sure that d Director nce to the The ill s or next QA	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER SHORE CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187		
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F 441 F 456 SS=F	The facility must may mechanical, electric equipment in safe of this REQUIREMENT by: Based on observat review, the facility facility facility facility facility facility facility for the facility facility facility for the facility facilit	NTIAL EQUIPMENT, SAFE DITION aintain all essential cal, and patient care operating condition. NT is not met as evidenced ion, interview, and document called to ensure the er dryers were in good and and fixed when temperature calter clothing color. a.m. the dryer was noted to eld opened upward. The dryer clothing visible in the dryer assistant (LA)-A was ime and stated this was a gas I was left open to cool the nore air. LA-A repeated the needed more air and therefore en. b.m. the laundry tour was ver (Huebsch Originator 75) out the upper shield was d the open shield helps with ryer. And LA-A added that if en the clothing would discolor. Checked on each dryer and ith a blanket of lint. LA-A said	F 45	It is the facility s policy to maintai essential equipment in safe operat condition and according to manufacturers specifications. The facility respectfully disagrees of statement in the third paragraph or 54, "The administrator and environ supervisor (ES) were interviewed 6/11/14 at 4:35 p.m. ES stated the Huebsch Originator was one of the dryers and that he knew the dryer get hot." According to the ES, the surveyor asked him the following do he had not done anything about the being too hot since he had stated to knew about it. The ES said he did recall making that statement. The surveyor replied "I wrote it down". administrator was at the meeting of 6/11/14 with the surveyor and ES at does not recall the ES stating that knew the dryer would get too hot. the administrator recalls the ES tel surveyor that he was not aware of overheating because no one had reconditional control of the surveyor that he was not aware of overheating because no one had reconditional control of the surveyor that he was not aware of overheating because no one had reconditional control of the surveyor that he was not aware of overheating because no one had reconditional control of the surveyor that he was not aware of overheating because no one had reconditional control of the surveyor that he was not aware of overheating because no one had reconditional control of the surveyor that he was not aware of overheating because no one had reconditional control of the surveyor that he was not aware of overheating because no one had reconditional control of the surveyor that he was not aware of overheating because no one had reconditional control of the surveyor and experience of the surveyor that he was not aware of overheating because no one had reconditional control of the surveyor and experience	with the n page mental on e e older would same lay why e dryer hat he not The n and he Rather, ling the the eported	4
	The lint traps were	checked on each dryer and ith a blanket of lint. LA-A said		surveyor that he was not aware of	the eported	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 456	The administrator at (ES) were interview ES stated the Huel older dryers and Ethot. The laundry was lot the elevator and phy was located under laundry contained at washers. The Huebsch Originanual was review had a schematic of in the open position combustion air. Do 12:10 P.M., ES indicated was to be open maintenance instruments as an insulator tumbler. " The facility's proced reviewed. The prowas to be removed daily. The Richard-Ewing invoice dated 6/12 overheating. Had to check limit thermost weak. The Richard-Ewing invoice was to be removed to the contained the	and environmental supervisor wed on 6/11/14 at 4:35 p.m. bsch Originator was one of the S knew the dryer would get too ocated on the lower level near hysical therapy. The laundry residential wing 200. The 3 gas dryers and 3 electric inator dryer manufacturer 's wed. Figure 36 in the manual of the dryer with the upper shield in indicating the flow of uring an interview on 6/12/14 at licated this meant the upper pen. The preventive uctions (pg 43) directed the lint of (no frequency) and "Failure in a buildup of lint in this area to and cause overheating in the dure dated 2002 was cedure directed that the lint of from the lint compartment of Equipment Co. Inc. service (14 read, "dryer was or replace thermostat. Also stat. Replaced it checked out	F 4	saw the surveyor write and during the interview on 6/surveyor was present at the interview and was holding computer, however it was did not make any entries interview. In the spirit of facility submits the following correction: The dryers were serviced qualified service technicial was overheating was repaired. Note: All dryers are equipated automatic shut off should excessive lint build up. Laundry staff has been reactly the correct procedure and cleaning lint filters and the reporting problems and concequipment to the ES or M Supervisor in a timely material than the procedure will be revised. Maintenance Supervisor of auditing to administrate with Quality Assurance Concequiped in the procedure will be revised. Maintenance Supervisor of auditing to administrate with Quality Assurance Concequiped for the QA Commischeduled for 7/28/14.	rining. The next many committee what is seen and content and conte	d she the the by a er that as to for e of out lit for eks. If desults eview hich	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	NAME OF PROVIDER OR SUPPLIER SOUTH SHORE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1307 SOUTH SHORE DRIVE PO BOX 6 WORTHINGTON, MN 56187	DE .	
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F 456	interviewed on 6/12 the thermostat " was observation, intervis facility failed to ens dryers were in good Findings include: On 6/11/14 at 8:40 have the upper shis was operating with drum. The laundry interviewed at that dryer and the shield dryer and provide in dryer was hot and in the vent was left op On 6/11/14 at 1:40 conducted. The Hu operating, but the u stated the open shi the dryer. And LA-A hot, then the clothir laundry tour all thre All three dryers had with lint also falling would clean out the	2/14 at 12:10 p.m. Tech stated as not working Based on ew, and document review the ure the clothing/linen tumbler d working order. a.m. the dryer was noted to eld opened upward. The dryer clothing visible in the dryer assistant (LA)-A was time and stated this was a gas d was left open to cool the nore air. LA-A repeated the needed more air and therefore ien. p.m. the laundry tour was uebsch Originator 75 was not upper shield was opened. LA-A eld helps with the ignition of added that if the dryer got added that if the dryer got a blanket of lint on the screen to the floor. LA-A stated she lint screen daily.	F4	,		
	(ES) were interview ES stated the Hueb older dryers and the hot. The laundry w	and environmental supervisor yed on 6/11/14 at 4:35 p.m. sech Originator was one of the at he knew the dryer would get was toured with ES on 6/12/14 yers were operating and each dual gas shut off.				
		cated on the lower level near ysical therapy. The laundry				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245596			PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 456	laundry contained washers. The Huebsch Orig manual was review had a schematic or in the open position combustion air. Dr. 12:10 P.M., ES indicated was to be open maintenance instruments of the second of the second was to be removed to do so will allow a act as an insulator tumbler. " The facility 's production of the second was to be removed daily. The Richard-Ewing invoice dated 6/12 overheating. Had to check limit thermore weak. The Richard-Ewing and environmental interviewed on 6/12 the thermostat "we replaced it. Both Tomanual allowed for the second washers.	residential wing 200. The 3 gas dryers and 3 electric inator dryer manufacturer 's wed. Figure 36 in the manual f the dryer with the upper shield in indicating the flow of uring an interview on 6/12/14 at licated this meant the upper pen. The preventive uctions (pg 43) directed the lint d (no frequency) and "Failure a buildup of lint in this area to and cause overheating in the redure dated 2002 was becedure directed that the lint d from the lint compartment d from the lint compartment d g Equipment Co. Inc. service (14 noted "dryer was o replace thermostat. Also stat. Replaced it checked out g Equipment technician (tech) supervisor (ES) were 2/14 at 12:10 p.m. Tech stated was not working " and he fech and ES stated the dryer in the dryer to run with the top		66		
	and environmental interviewed on 6/1: the thermostat " w replaced it. Both T manual allowed for shield door open to the towel discolorir because the therm	supervisor (ES) were 2/14 at 12:10 p.m. Tech stated vas not working " and he Tech and ES stated the dryer				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187	
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F 465 SS=F	not operating correct that without the the dryer won't shut of predetermined tempheating to hotter tempheating the state of the predetal tempheating to hotter tempheating the state of the dryer without the dryer without the state of the dryer without the dryer with the dryer without the dryer without the dryer with the dr	ctly. Tech stated the risk was rmostat working correctly, the ff when it reached a perature and would keep mperatures. y on 6/12/14 at 12:10 p.m. umulation was not a hazard, poor air flow and the dryer extricity and more gas with the first tech indicated the lint d be cleaned out 2 to 3 times y so many loads. AL/SANITARY/COMFORTABL ovide a safe, functional, ortable environment for	F 468		7/22/14
	by: Based on observate failed to ensure ceil were clear of dust in Also air vents, stove were not routinely of and sanitary environmental to received prepared for Unpleasant and post and not determined	cion and interview, the facility ling and mechanical air vents in 4 of 4 residential hallways; e hood, and steam table pans eleaned to maintain a clean nment in the kitchen and this affect all 42 residents who roods from the kitchen; esibly harmful odors detected if harmful to residents, the facility.		It is the facility 's policy to maintain to physical environment in a safe, clean sanitary condition, free of undesirable harmful odors. The ceiling grates on all identified with have been cleaned by the Maintenant Supervisor and will be re-painted by 7/22/14. The AC grates have also be cleaned. The Maintenance Man will a regular cleaning and maintenance to PM schedule. During the course of cleaning the grates.	, and e or ngs ce een add his

NAME OF PROVIDER OR SUPPLIER SOUTH SHORE CARE CENTER SOUTH SHORE CARE CENTER SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187	AND PLAN OF CORRECTION IDENTIFICATI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
SOUTH SHORE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG CONSTRUCTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)			245596					
F 465 Continued From page 58 A facility tour was conducted with environmental supervisor (ES) on 6/11/14 at 19:55 a.m. Hallways A & B were noted to have grates with a coat of dust and strands of dust also moving when air movement. The Trane air condition unit on Hallway C and mechanical unit not Hallway D also were noted to have grates with oating of dust and strands of dust also moving when air was moving. ES was interviewed during a tour on 6/12/14 at 12:30 p.m. ES stated the Trane air conditioner unit and mechanical unit had filters changed every 30 days and should have the intake vent cleaned. ES verified these were dusty. ES stated the 10 celling grates on hallways A & B were part of the old system and had original air duct system that could have a history of moisture exposure from humidifiers. ES did not know if the black areas were from rust stains or something else like mold. ES also stated the other ceiling vent grates were to be cleaned every 30 days, but that they were currently dusty. F 465 Continued From page 58 A facility four was conducted with environmental supervisor (ES) on 6/11/14 at 19:55 a.m. Hallways A & B were indeed to with environmental supervisor (ES) on 6/11/14 at 10 ceiling grates on the 400 wing the Maintenance Supervisor found that the motor in the unit was not working correctly. This could account for the musty odor identified by the surveyor. The unit has been repaired and no further unpleasant odors have been observed. The air handling/AC unit on the 100 wing was out of service at the time of the survey and the facility was in the process of seeking quotes to replace it. This is likely the cause for the unpleasant odors observed by the surveyors. A new unit was ordered on 6/30/14. Installation is scheduled for 7/10/14. The new air handling/AC unit is expected to remove any unpleasant odors. Once in place, the facility will assess for effectiveness. No other sources of odor have been identified. The Maintenance Supervisor for the unstreament the motor in the unit was not					1307 SOUTH SHORE DRIVE PO BOX 69			
A facility tour was conducted with environmental supervisor (ES) on 6/11/14 at 9:55 a.m. Hallways A & B were noted to have black areas on all 10 ceiling grates. Also noted on Hallways A, B, C were ceiling air grates with a coat of dust and strands of dust that was moving when air movement. The Trane air condition unit on Hallway C and mechanical unit on Hallway D also were noted to have grates with coating of dust and strands of dust also moving when air was moving. ES was interviewed during a tour on 6/12/14 at 12:30 p.m. ES stated the Trane air conditioner unit and mechanical unit had filters changed every 30 days and should have the intake vent cleaned. ES verified these were dusty. ES stated the 10 ceiling grates on hallways A & B were part of the old system and had original air duct system that could have a history of moisture exposure from humidifiers. ES did not know if the black areas were from rust stains or something else like mold. ES also stated the other ceiling vent grates were to be cleaned every 30 days, but that they were currently dusty.	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	N SHOULD BE COMPLÉTION		
Assurance Committee for review and further recommendations. The next QA Committee meeting is scheduled for 7/28/14. Assurance Committee for review and further recommendations. The next QA Committee meeting is scheduled for 7/28/14. It is the facility's policy to store, prepare, distribute, and serve food under sanitary conditions. An initial tour of the kitchen was conducted on 6/9/14 at 6:15 p.m. with the dietary aide (DA)-A. Assurance Committee for review and further recommendations. The next QA Committee meeting is scheduled for 7/28/14. It is the facility's policy to store, prepare, distribute, and serve food under sanitary conditions. The cooler fan was cleaned on 6/19/14 2014. The knobs on the oven and the	F 465	A facility tour was of supervisor (ES) on A & B were noted to ceiling grates. Also were ceiling air grastrands of dust that movement. The The Hallway C and medwere noted to have and strands of dust moving. ES was interviewed 12:30 p.m. ES stated that 10 ceilin were part of the old duct system that concerning the stated that they were curron on 6/13/14 at 8:50 past year, he had regrates either washe was not sure if that interview on 6/13/1 he used a ladder to first time. ES think grates could possible.	conducted with environmental 6/11/14 at 9:55 a.m. Hallways o have black areas on all 10 o noted on Hallways A, B, C tes with a coat of dust and t was moving when air rane air condition unit on chanical unit on Hallway D also grates with coating of dust t also moving when air was d during a tour on 6/12/14 at ted the Trane air conditioner all unit had filters changed should have the intake vent ed these were dusty. ES g grates on hallways A & B d system and had original air build have a history of moisture indifiers. ES did not know if the rom rust stains or something also stated the other ceiling also stated the other ceiling also be cleaned every 30 days, but ently dusty. a.m. ES stated that during the not had the 10 black marred ed or painted. ES stated he was ever done. During an 4 at 11:00 a.m. ES stated that o check out the vents for the sthe black marks on the 10 bly be rust.	F 465	on the air handling grates on the the Maintenance Supervisor for the motor in the unit was not we correctly. This could account for musty odor identified by the surface unit has been repaired and unpleasant odors have been obtained. The air handling/AC unit on the was out of service at the time of survey and the facility was in the of seeking quotes to replace it. likely the cause for the unplease observed by the surveyors. An was ordered on 6/30/14. Install scheduled for 7/10/14. The new handing/AC unit is expected to any unpleasant odors. Once in facility will assess for effectivene other sources of odor have been identified. The Maintenance Supervisor is responsible for monitoring for concept Results of monitoring will be for the Administrator and in turn the Assurance Committee for review further recommendations. The Committee meeting is schedule 7/28/14. It is the facility's policy to store, prepare, distribute, and serve for sanitary conditions. The cooler fan was cleaned on	and that orking or the veyor. In of urther served. 100 wing of the exprocess This is ant odors ew unit ation is a air remove place, the ess. No note that the expression of t		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245596	B. WING		06/	13/2014
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F 465	dietary manager (D Observations durin following: The vented lower so (directly above cood a brown, sticky subthe glass fixtures wellocated under the hasurrounding area of front surface of the the brown, sticky solecated in the refrigoed buildup of dust and surface and piping air around food sto observed to be underwise attached to the trunning along the the coated with deb. The storage room products and dished about 1 foot squares metal shelf on upper Interview of the DN verified that this opventilation system of transported person facility. This vent we without any grates observed that approved that approved that approved that approved that approved the composition of the opening and surrous a thick layer of dus. DM-A on 6/9/14 at	of the knobs located on the range were also coated with ubstance. The cooling fan gerated cooler showed a debris on both the frame of the unit. This fan circulates red in cooler. No food was covered. Insulated electrical ne back of tweerous the fan unit and op food shelf were observed to	F4	in the store room was cleaned. The exhaust vents above the grill in the kitchen were clean 6/17/14. The Dietary Supervithe policy for cleaning the hosto ensure that the vents stay. An in-service will be held on for all dietary staff to re-educt policies/procedures for clean documentation of the same. The Dietary Supervisor will be for monitoring cleaning 3 time the first month and then once every quarter on alternating a Consultant Dietitian will also monthly for the next quarter a thereafter. The results of more be reviewed at the next quarter Assurance Meeting scheduled for 7/28/14. The Civil review and make recommon for ongoing monitoring.	e ovens and led on sor reviewed od quarterly clean. July 8, 2014 ate staff on ing and e responsible es a week for e a week shifts. The monitor and quarterly nitoring will terly Quality A Committee	

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245596 NAME OF PROVIDER OR SUPPLIER SOUTH SHORE CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (FAUL DEFICIENCY AND THE PROPERTIES OF THE PROPERTIES OF THE PROPERTY OF THE PROPERTIES OF THE PROPERTY OF THE PROPE	2/2014
NAME OF PROVIDER OR SUPPLIER SOUTH SHORE CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187 ID PROVIDER'S PLAN OF CORRECTION	3/2014
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PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	(X5) COMPLETION DATE
F 465 Continued From page 60 grease buildup and that the range hood had been last cleaned professionally in January 2014. She also stated that maintenance was supposed to have been cleaning the range hood on a routine basis and that this had not been done. A second interview with the dietary manager on 6/11/14, at 11:07 a.m. was performed and she was in attendance during observation of the meal service. During observation it was noted that steam table pans (food containing surfaces) have white residue in corners that does scratch off. The coffee machine was observed to have white and brown buildup noted on the drain surface. Upon review of the dietary cleaning schedule which had been posted during the initial tour it was noted that there were multiple blanks present. This schedule included a weekly cleaning list for the day cook which included grill sides, back & drip tray; steam table; cooks counter; ovens wipe down daily, shelf below cook counter; ovens wipe down daily, shelf below cook counter; ovens wipe down daily, shelf below cook conter; etc. A copy of the policy titled: Exhaust Hood Semi Annual PM MT06:04SA dated 2002: stated: Maintenance Tasks 1.) Check and clean grease and foreign material from interior of duct at hood connections. 2.) Check and clean grease and foreign material from interior of duct at access panels. 4.) Check and clean grease and foreign material from interior of duct at access panels. 4.) Check and clean grease and foreign material from interior of duct at access panels. 4.) Check and clean grease and foreign material from all visible and accessible duct/hood seams and joints. 5.) Clean hood grills and filers. UNPLEASANT OR HARMFUL ODORS DETECTED On entrance to the building by way of the lower level entrance on the evening of 6/9/14 at 6:01 p.m. a strong sewer and musty odor was noted.	

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
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	PROVIDER OR SUPPLIER SHORE CARE CENTE	ER .	STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187		DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 465	lower level entrance weather the morning humid. The main of As the surveyor we the 100 room wing musty to sewer and room and hallway it was a strong sew between the end of entrance again a sewer and musty strong the nursing station. On 6/13/14 at 8:00 was interviewed. Resewer and musty stoileting needs of the At 8:01 a.m. RN-Desmell when the air on. At 8:03 a.m. he yes she was aware. The environmental interviewed on 6/12 there had been as lower residential ur required fixing pipe 90 days ago he had neutralizer/sanitize neutralize the toilet resident 's inconting the surveyor in the environmental interviewed on 6/12 there had been as lower residential ur required fixing pipe 90 days ago he had neutralize the toilet resident 's inconting the surveyor were the surveyor were the surveyor was a surveyor were and had been as lower residential ur required fixing pipe 90 days ago he had neutralize the toilet resident 's inconting the surveyor were the surveyor was a surveyor were the surveyor were the surveyor was a s	warm and humid. a.m. the front entrance and e had been entered. The ng of 6/13/14 was cool and not entrance again smelled musty. Ent from the main entrance to so the smell changed from a day you walked past the tub near rooms 106, 107, 108, 109 wer type smell and again of the hallway by the old house mell of sewer was noted. Atted on the lower level) was be lower level door on 6/13/14 at the entrance and dissipated by the stated and dissipated by the near rooms are lower level resident was noted and dissipated by the mell/s also other than when the resident were completed. Stated she noted a musty condition in her office turned ousekeeper (H) - A stated that the of a musty smell. Supervisor (ES) was 2/14 at 12:30 p.m. ES stated ewer odor in the past on the note and the wall. ES stated about	F 46	55		

PRINTED: 07/08/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245596	B. WING			06/1	3/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CO 1307 SOUTH SHORE DRIVE PO BOX WORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD E	3E	(X5) COMPLETION DATE
F 465	Continued From pa	_	F 4	265			

PRINTED: 07/16/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 06/10/2014 245596 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1307 SOUTH SHORE DRIVE PO BOX 69 SOUTH SHORE CARE CENTER **WORTHINGTON, MN 56187** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS 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 June 10, 2014. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or (X6) DATE

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

TITLE

07/04/2014

Electronically Signed

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.

Facility ID: 00885

PRINTED: 07/16/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 06/10/2014 245596 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1307 SOUTH SHORE DRIVE PO BOX 69 SOUTH SHORE CARE CENTER **WORTHINGTON, MN 56187** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 | Continued From page 1 K 000 By email to: 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 64 beds and had a census of 42 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: 7/1/14 K 021 NFPA 101 LIFE SAFETY CODE STANDARD K 021 SS=F Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such

(X2) MULTIPLE CONSTRUCTION

PRINTED: 07/16/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 06/10/2014 245596 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1307 SOUTH SHORE DRIVE PO BOX 69 SOUTH SHORE CARE CENTER WORTHINGTON, MN 56187 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 021 Continued From page 2 K 021 doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: It is the facility' □s policy that doors in exit Based on observation and interview, the facility passageways, stairway enclosures, failed to provide proper automatic smoke horizontal exits, smoke barriers, and detection within 5 feet of 2 hazardous area room hazardous areas can only be held open by doors in accordance with 1999 NFPA 72, section a device that automatically closes the 2-10.6.5.1.2. This deficient practice could affect door upon activation of the fire alarm the safety of all 42 residents. system, smoke detector or sprinkler system. Finding include: The smoke detectors in the basement On facility tour between 10:30 AM and 1:30 PM stairwell enclosure were installed by ABC on 6/10/2014, observation revealed, that the Automated Building Controls on 7/1/14. repair shop and the boiler room doors located in the basement stairwell enclosure are held in the open position with magnetic hold-openers The Maintenance Supervisor is responsible for monitoring for compliance. inter-connected to the buildings fire alarm system. There is no automatic smoke detectors with-in 5 feet of doors. This deficient practice was confirmed by the facility Maintenance Supervisor at the time of

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STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED	
		245596	B. WING			06/1	0/2014	
	NAME OF PROVIDER OR SUPPLIER SOUTH SHORE CARE CENTER			13	TREET ADDRESS, CITY, STATE, ZIP CODE 307 SOUTH SHORE DRIVE PO BOX 69 ORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 021	Continued From pa	ge 3	K)21				
		*						
							4	
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	**							



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted June 26, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5596024

Dear Ms. Atchison:

The above facility was surveyed on June 9, 2014 through June 13, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

South Shore Care Center June 26, 2014 Page 2

and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Kumalu Fiske Downing

Telephone: (651) 201-4112

Fax: (651) 215-9697

cc: Original - Facility

Licensing and Certification File

South Shore Care Center June 26, 2014 Page 3 South Shore Care Center June 26, 2014 Page 4

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00885	B. WING		06/1	3/2014
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE DRIVE PO BOX 69		
SOUTHS	SHORE CARE CENTE	· R	IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall	Minnesota Statute, section ction order has been issued by. If, upon reinspection, it is idency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.				
	corrected requires or requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all e rule provided at the tagule number indicated below. In several items, failure to the items will be considered a Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department wit	hearing on any assessments non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	participate in the electronic nsure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		00885	B. WING		06/	13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R 1307 SOL		STATE, ZIP CODE DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically, is necessary for Sta enter the word "context. You must then State licensure procompletion date, the corrected prior to el Minnesota Department's sand the following context in your and identify the date Minnesota Department's the State Licensing federal software. The assigned to Minnesota Department's sand the following context in your and identify the date Minnesota Department in the State Licensing federal software. The assigned to Minnesota Department is saigned to Minnesota Department in the State Licensing federal software. The assigned to Minnesota Department is saigned to Minnesota Department in the State Licensing federal software. The assigned tag is column entitled "ID statute/rule out of consummary Statement and replaces the "Torrection order. The findings which are in after the statement, evidence by." Follow	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 12 & 13, 2014, surveyors of taff, visited the above provider orrection orders are issued. Four electronic plan of have reviewed these orders, when they will be completed. The ent of Health is documenting and numbers have been noted state statutes/rules for the prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the niolation of the state statute. "This Rule is not met as wing the surveyors findings Method of Correction and	2 000			
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE I WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00005	B. WING		00/4	0/004.4
		00885	D. WINO		06/1	3/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SOUTH	SHORE CARE CENTE	R	JTH SHORE I NGTON, MN	DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
		omprehensive plan of care personnel involved in the .				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to implement care plan erventions for 1 of 3 residents accidents.				
	Findings include:					
	end of the C unit an R51 's wheelchair I back of R51 's wheelchair I back of R51 's wheelchair I surveyor informed so (NA)-A. NA-A at the belt was used for an R51 was trying to so discontinued. Surveyor are communicated the communication nursing assistant dat the time nursing	g in wheelchair in room at the d R51' s self-release belt on had been hanging behind the selchair unattached during /14, at 1:35 p.m. This staff person nursing assistant time stated the self-release halarm so staff knows when tand, and had been eyor asked NA-A how changes and NA-A had replied through book, Kiosk in computer and aily worksheet. NA-A verified assistant daily worksheet self-release belt for R51. At				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00885	B. WING		06/1	3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SOLITU 6	SHORE CARE CENTE	1307 SOU	TH SHORE	DRIVE PO BOX 69		
WORTHIN			IGTON, MN	56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 3	2 565			
	1:48 p.m., NA-A ha for R51 is to be in p stopped from being	d stated the self-release belt place and had not been used.				
	During continuous observation on 6/12/14, at 8:28 a.m., R51 sitting in wheelchair in room end of C unit, 8:46 a.m., staff person had been assisting R51 to eat breakfast at table in room end of C unit, 8:49 a.m., R51 remains sitting at table in room end of C unit, breakfast tray had been removed. At 9:09 a.m., R51 remains the same. At 9:20 a.m., R51 remains the same. At 9:52 a.m., NA-F approached R51 and asked R51 if wanted to lie down in bed, NA-F and NA-A had transferred R51 from wheelchair to bed and had					
	time of observation s night stand. NA-F asked what fall inte	nanical lift to transfer R51. At a tab alarm had laid on R51 had stated at the time when rventions were for R51, safety tab alarm on bed, mat on				
	cannot leave alone room after R51 had NA-A proceeded to	on, lipped mattress and in room. NA-F had left R51's been transferred into bed. check incontinent product and stated the incontinent				
	product was dry. Nof R51, put be in loon floor beside bed	A-A placed call light in reach w position and placed fall mat . Tab alarm remained placed NA-A had shut light off in room				
	intervened at the tir alarm was to be on	R51's room. Surveyor ne and asked NA-A if the Tab R51 when in bed. NA-A one I would have hooked it to				
	do not see an alarn and asked NA-A ab R51's night stand a	cked R51's bed and stated I in for bed. Surveyor intervened bout the tab alarm sitting on and NA-A verified at the time				
		e on R51 when in bed. Hers dated 5/7/14, identified				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLE	ETED
00885 B. WING 06/13/	/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
diagnoses of but not limited to dementia and hypertension. R51's significant change Minimum Data Set (MDS) dated 4/15/14, identified toilet extensive assist of two. R51's current care plan dated 11/19/13, identified problem potential for falls related to cognitive impairment, weakness, mobility deficit with interventions of but not limited to keep call light/bell within easy reach, tabs, toilet resident as requested and as scheduled, 1/30/14 self-releasing seat alarm to wheelchair, is able to open seat belt with instruction. Problem potential for alteration in urinary elimination, rft urinary retention and recent removal of long time indwelling catheter with interventions of but not limited to initiate voiding schedule to coordinate with intake: i.e. after meals. Problem incontinent of bowel related to cognitive impairment, loss of sphincter control, goal bowel management program: R51 will show improved bowel continence evidenced by fewer episode of bowel incontinence with interventions of but not limited to assist to commode or toilet after each meal and as needed. Document review of the facility untitled page dated 4/22/14, provided by the facility identified subject; resident profile for R51, remember to always engage the self-release belt. During interview on 6/11/14, at 2:23 p.m. licensed practical nurse (LPN)-C had stated R51 is supposed to have the self-release belt in place when R51 is in wheelchair. During interview on 6/12/14, at 10:12 a.m., NA-A had verified toilet had not been offered to R51 when NA-A had checked R51 is incontinent	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY LETED
		00885	B. WING		06/1	3/2014
	PROVIDER OR SUPPLIER	R 1307 SOU		STATE, ZIP CODE DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 5	2 565			
	had stated interven started on 11/25/13 During interview on	6/13/14, at 12:07 p.m.,				
	offer the toilet, tab a be in place as that i Policy regarding fol	nad stated would expect to alarm and self-release belt to is part of R51's plan of care. lowing the care plan had been ne and none had been				
	The administrator of policies and proceed plan interventions. educate staff to imp	administrator or designee				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 570	MN Rule 4658.0405 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal representative at least seven days of the revision of resident assessment required subpart 3, item B.				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		SURVEY PLETED
		00885	B. WING		06/	13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R 1307 SOU		STATE, ZIP CODE DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 6	2 570			
	by: Based on observati review, the facility fainclude current fall i status for 1 of 3 res accidents. Findings include:	ent is not met as evidenced on, interview and document ailed to revise the care plan to interventions and mobility idents (R51) reviewed for				
		e floor beside the bed on				
		a.m., R51 had been observed oor mat had been on the floor				
	(NA)-F and NA-A hawheelchair to bed a mechanical lift to traobservation a tab a	a.m., nursing assistant ad transferred R51 from and had used a Hoyer ansfer R51. At time of larm had laid on R51's night mattress had been on R51's				
	physician orders da diagnoses of but no hypertension and tr	itted on 8/1/12. R51's ted 5/7/14, identified of limited to dementia, eatment order with order date nsfers for all mobility.				
	(MDS) dated 4/15/1	change Minimum Data Set 4, identified ambulation: none corridor and extensive assist of				
	Review of R51's me	edication administration record				

Minnesota Department of Health

STATE FORM 6899 ID9911 If continuation sheet 7 of 61

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X				A. BUILDING:			
SOUTH SHORE CARE CENTER 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X			00885	B. WING		06/1	3/2014
WORTHINGTON, MN 56187 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	SOUTH	SHORE CARE CENTE	R				
	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETE DATE
2 570 Continued From page 7 dated 6/1/14 to 6/30/14, identified Hoyer transfers with A-Z for all mobility, start date of 3/5/14 and nights, a.m. and p.m. shifts signing for treatment. Review of the facility untitled page dated 4/22/14, provided by the facility identified subject; resident profile for R51, remember to always engage the self-release belt, do not leave resident unattended in room in wheelchair. R51's current care plan dated 11/19/13, identified problem self-care deficit: walking evidenced by needs assist of two for all ambulation with approaches of walk with therapy with assist of one and gait belt, remind resident when therapy is scheduled, assist in transfer of resident to therapy in wheelchair as needed and monitor for continued safety walking; two assist with gait belt. Problem potential for falls related to cognitive impairment, weakness, mobility deficit with interventions keep call light/bell within easy reach, respond promptly, tabs (no specification on where tabs to be), remind resident to request help if wants to get up, ambulate per therapy recommendation, encourage resident to wear glasses during waking hours and for all transfers and walking, toilet resident as requested and as scheduled, administer medications as ordered and monitor side effects, night light in room at night, 11/24/13 monitor location Arial alarm, 1/30/14 self- releasing seat alarm to wheelchair, is able to open seat belt with instruction, 5/9/14 toilet, check and change at 10:00 p.m. However the current care plan dated 11/19/13, had not identified R51 required Hoyer transfers with A-Z for all mobility, R51 is non-ambulatory, no specification regarding placement of tab alarm, mat on floor beside bed when R51 is in	2 570	dated 6/1/14 to 6/3 with A-Z for all mobnights, a.m. and p. Review of the facility provided by the factor profile for R51, remself-release belt, do unattended in room R51's current care problem self-care oneeds assist of two approaches of walk one and gait belt, rescheduled, assist in wheelchair as necontinued safety was Problem potential frimpairment, weakn interventions keep respond promptly, tabs to be), remind wants to get up, and recommendation, end glasses during wak and walking, toilet in scheduled, administ and monitor side en ight, 11/24/13 mon 1/30/14 self- released is able to open sear toilet, check and chec	0/14, identified Hoyer transfers bility, start date of 3/5/14 and m. shifts signing for treatment. Ity untitled page dated 4/22/14, illity identified subject; resident member to always engage the protect of the not leave resident in wheelchair. I plan dated 11/19/13, identified deficit: walking evidenced by for all ambulation with a with therapy with assist of emind resident when therapy is not transfer of resident to therapy edded and monitor for alking; two assist with gait belt. For falls related to cognitive ess, mobility deficit with call light/bell within easy reach, tabs (no specification on where resident to request help if anbulate per therapy encourage resident to wear ting hours and for all transfers resident as requested and as ster medications as ordered and as ster medications as ordered fects, night light in room at a nitor location Arial alarm, sing seat alarm to wheelchair, the belt with instruction, 5/9/14 anange at 10:00 p.m. Into care plan dated 11/19/13, 1851 required Hoyer transfers bility, R51 is non-ambulatory, garding placement of tab	2 570			

Minnesota Department of Health

STATE FORM 6899 ID9911 If continuation sheet 8 of 61

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00885	B. WING		06/1	3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
SOUTH	SHORE CARE CENTE	· R	TH SHORE IGTON, MN	DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 8	2 570			
	bathroom and room	n when in wheelchair.				
	registered nurse (R current plan of care regarding transfers	6/11/14, at 2:56 p.m., N)-C had verified R51's had no documentation and verified R51 is Hoyer mechanical lift and two				
	had stated when as were for R51, safet on bed, mat on floo	6/12/14, at 9:56 a.m., NA-F sked what fall interventions y belt on wheelchair, tab alarm or, bed low position, lipped ot leave alone in room.				
	During interview on 6/13/14, at 8:34 a.m., RN-C had stated interventions of fall mat had been started on 8/23/13, tab alarm for bed had started on 11/25/13 and do not leave unattended in bathroom and room when in wheelchair had started on 11/25/13.					
	director of nursing s be revised when m	6/13/14, at 12:07 p.m., stated would expect care plan ake adjustments in care needs to be care planned.				
	read "Procedure: 7 Coordinator will be	E CARE PLAN ND REVISION dated 9/13/13, '. The Unit Resident Care accountable to insure that of care accurately reflects the				
	The administrator of policies and proced The administrator of	THOD OF CORRECTION: could review and revise dures for care plan revisions. could educate nursing staff to The administrator or designee				

Minnesota Department of Health

STATE FORM 6899 ID9911 If continuation sheet 9 of 61

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00885	B. WING		06/1	3/2014
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SOUTH	SHORE CARE CENTE	·R	TH SHORE IGTON, MN	DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 570	Continued From pa	ige 9	2 570			
	could monitor staff	compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet		2 860			
	proper care. The cadequate and proper care and att	or determining adequate and criteria for determining er care include: tention to hands and feet. chails must be kept clean and				
	by: Based on observation review, the facility for provided for 2 of 3 reviewed for activition remove facial hair for the facility for the faci	ent is not met as evidenced ion, interview, and document ailed to ensure nail care was residents (R76, R51) es of daily living and failed to for 1 of 1 residents (R66) inple with facial hair.				
	Findings include:					
	LACK OF NAIL CA	RE:				
	R76 's finger nails on 6/12/14, at 8:20	on 6/10/14, at 8:57 a.m., and were long and soiled. Again 0 a.m., R76 finger nails were rimmed and soiled under the				
	assessment dated moderate cognitive	Minimum Data Set (MDS), an 4/17/14, revealed R76 had impairment and required be from one staff for personal				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00885	B. WING		06/	13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R 1307 SOU		STATE, ZIP CODE DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 860	hygiene. R76 's care plan da that R76 had self-cathat included extens personal hygiene During interview on of nursing verified the finger nails. Directed expected staff to prensure nails were conterviewed at 6/12/1 they would like staff. During interview on nursing assistant-B and trimmed finger needed. Document review on Fingernails/Toenails read, "Purpose The are to clean the nail and to prevent infect Nail care includes of trimming." R51 was observed on 6/11/14, at 1:35 During observation nursing assistant (Nasked if R51 's finger R51 had been admit physician orders date of the self-cathat in the self-cat	ated 4/25/14, directed staff are deficit with interventions sive assist of 1-2 staff for 6/12/14, at 1:58 p.m., director he untrimmed and soiled or of nursing stated she ovide nail care daily and to clean. Also R76 was (14 at 2:00 p.m. and said that if to trim their finger nails. 6/13/14, at 11:08 a.m., (NA-B) stated she cleaned nails on bath day and as If facility Care of a policy dated revised 4/07, a purposes of this procedure I bed, to keep nails trimmed, ctions." "General Guidelines 1. daily cleaning and regular on 6/10/14, at 10:22 a.m., and mmed fingernails. This was (11/14, at 9:04 a.m. and again	2 860			

Minnesota Department of Health

STATE FORM 6899 ID9911 If continuation sheet 11 of 61

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00885	B. WING		06/1	13/2014
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
SOUTH	SHORE CARE CENTE	R	TH SHORE I IGTON, MN	DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 860	hypertension. R51 hypertension. R51 hygiene extensive a R51's current care problem self-care d to impaired mobility help from another pwith interventions or done each week by verbal cues as need Document review of 6/3/14, identified R51:30 p.m. and ident whirlpool bath on 6/4 During resident intera.m., R51 had state length is o.k., but the I would like them tri observed fingernails edges. During interview on director of nursing help trimmed weekly needed, if resident come back, if refuse care. FACIAL HAIR: R66 was observed approximate ½ inch neatly dressed and room. During interview on director of nursing help trimmed weekly needed, if resident come back, if refuse care. FACIAL HAIR:	s significant change Minimum ted 4/15/14 identified personal assist of one person. plan dated 11/19/13, identified eficit personal hygiene related eficit personal hygiene related evidenced by needs daily person with personal hygiene fout not limited to: nail care to bath aide after 6, provide	2 860			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(3) DATE SURVEY COMPLETED	
		00885	B. WING		06/1	13/2014
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
SOUTH	SHORE CARE CENTE	R	ITH SHORE	DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 860	Continued From page 12		2 860			
	cognitive impairmer	5/12/14, revealed R66 had no not and required extensive or personal hygiene.				
	dated 5/22/14, direc	f the facility resident care plan cted staff that R66 had I needed daily help from personal hygiene.				
	2:00 p.m., director of chin hairs. Director expected staff to shas needed. During	and interview on 6/12/14, at of nursing verified R66 's long of nursing stated she have female facial hair daily or interview on 6/12/14 at 2:02 ould like staff to remove chin				
	nursing assistant-B	6/13/14, at 11:08 a.m., (NA-B) stated she shaved g cares and on bath day.				
	The director of nurs policies and proced of daily living, such nursing could educa	THOD OF CORRECTION: sing could review and revise lures for performing activities as nail care. The director of late all staff to provide nail of nursing could monitor staff				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21050	MN Rule 4658.0625 Planning	5 Subp. 1 Menus; Meal	21050			
	planned in advance changes in the mea	lanning. All menus must be a dated, and followed. Any als actually served must be of ue. The general menu for a				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00885	B. WING		06/1	3/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R 1307 SOU		STATE, ZIP CODE DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21050	seven-day period m start of that seven-accessible to reside general menu must menu. All menus a current and followin posted in the dietar and of foods purchamonths. A variety of file of tested recipes appropriate for the maintained. This MN Requirement by: Based on observation review the facility diportions for 8 of 8 m R34, R36, R58 and received mechanical Findings include: R3, R11, R13, R27, dished foods by the correct measured amenu. The meal meto be four ounces posservations were repreparing the dinner Cook-B had ground portions into a bowl amount. Review of identified R3 as have accessed to the start of the start o	nust be posted prior to the day period at a location readily ents, and any changes to the be noted on that posted and any changes for the g seven-day periods must be y area. Records of menus ased must be filed for six of foods must be provided. As adjusted to a yield size of the home must be ent is not met as evidenced on, interview and document d not provide adequate esidents (R3, R11, R13, R27, R75) in the sample who ally altered diets. R34, R36, R58 and R75 were a cook who did not use the amount according to the meal enu for the day had meat was	21050			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00885	B. WING		06/1	3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
SOUTH	SHORE CARE CENTE	R		DRIVE PO BOX 69		
0(0.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	IGTON, MN		ON	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21050	Continued From page 14		21050			
	amount of Swiss strobservation of the r 6/11/14 at 11:07 a.r dietary cook-B prep steak for R11. Cook steak and scooped the amount. The Sw R11. Review of the identified R11 as had cardiac diet with pure R13's bowl was filled amount of Swiss strobservation of the r 6/11/14 at 11:07 a.r dietary cook-B prep Swiss steak for R. G steak and scooped the amount. Review	ed with an undetermined eak which was noted during meal preparation for R13 on n. observations were made of earing the dinner meal of Cook-B had pureed the Swiss into a bowl without measuring of the medical record eaving a physician order for a				
	amount of Swiss strobservation of the r 6/11/14 at 11:07 a.r dietary cook-B prep steak for R. Cook-E and scooped into a amount. Review of R27 as having a ph	ed with an undetermined eak which was noted during meal preparation for R27 on m. observations were made of earing the dinner meal of Swiss 8 had ground the Swiss steak bowl without measuring the the medical record identified ysician order for an 1800 Association (ADA) diabetic eat diet.				
	amount of Swiss sto	ed with an undetermined eak which was noted during meal preparation for R34 on n. observations were made of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		E SURVEY PLETED	
		00885	B. WING		06/	13/2014
NAME OF PROVIDE		1307 SOU		STATE, ZIP CODE DRIVE PO BOX 69 56187		
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
dietary Swiss steak the an identif NDD2 R36's amount observed for the an identif NDD2 R58's amount observed for the an identif NDD2 R58's amount observed for the analysis and so amount R58 at purrect R75's amount observed for the analysis steak the analysis st	steak for R. and scooped nount. Review ied R34 as how with ground bowl was fillent of Swiss stration of the steak for R. and scooped nount. Review ied R36 as how with ground bowl was fillent of Swiss stration of the state of t	paring the dinner meal of Cook-B had ground the Swiss into a bowl without measuring w of the medical record aving a physician order for a meat diet ed with an undetermined reak which was noted during meal preparation for R36 on m. observations were made of cook-B had ground the Swiss into a bowl without measuring w of the medical record aving a physician order for a	21050			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00885	B. WING		06/1	3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
SOUTH	SHORE CARE CENTE	R	TH SHORE I	DRIVE PO BOX 69		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21050	During interview with she stated that she Swiss steak for groof Swiss steak for groof Swiss steak for grocessor. She the processed according Cook-B further indicappropriate consist unmeasured portion observation of food were observed to not prepared food. Whe portions were to be verified that the abounce servings and food prior to placing. Interview with dieta 11:12 a.m. verified mechanically altered time of serving. DM re-measure to ensure correct. Observation had put the correct were observed to bowl vs. when the context they looked unequals serving vegetables spoon. DM went to appropriate scoops	ch cook-B on 6/11/14 11:10, had placed 5 servings of und diets and then 3 servings of und diets and then 3 servings of und diets into food en stated that the foods were not the consistency ordered. Cated that once food was the ency she scooped ins into bowls. During being proportioned, the bowls of contain equal amounts of the surveyor asked if these equal amounts. Cook - Bowe residents were to receive 4 If that she did not measure the grinto the bowls. Try manager (DM) on 6/11/14 at that she had also observed do foods were not measured at then proceeded to the amount served was on of bowls of meat after DM amount of food into the bowls e equal in amount in each cook put food into the bowls al. Cook-B was then observed onto plates using a slotted cabinet and obtained the spoon and told Cook-B she	21050	DEFICIENCY)		
	appropriate scoop spoon and told Cook-B she must measure portions being served. Review of the facility policy for pureed and ground foods dated 3/24/14, included:1) for ground meat the cook will put the number of servings in the food processor and grind it up and measure to get the numbers of servings that was put in the processor so they know how much to give the resident. 2) For the pureed diet the cook will put					

Minnesota Department of Health

STATE FORM 6899 ID9911 If continuation sheet 17 of 61

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00885	B. WING		06/1	3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SOUTH	SHORE CARE CENTE	R		DRIVE PO BOX 69		
	0.11.41.45.7.4.67.4		IGTON, MN		011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21050	Continued From page 17		21050			
	is needed and will a cream to puree it. 3 cook will then meas how much the reside SUGGESTED MET. The registered dietipolicies and process of appropriate proportions with codietary manager codietary manager codietary.	ing in the food processor that add some half and half or by When the food is pureed the sure it out again so they know dent is to receive. THOD OF CORRECTION: Incident could review and revise dures related to serving foods ortions using appropriate. The registered dietician ary staff to serve appropriate rect utensils. The certified and monitor staff compliance. R CORRECTION: Twenty-one				
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and con E. a resident himmunization progradefined in part 465 procedures of residute prevention and	and procedures. The infection ust include policies and provide for the following: based on systematic data a nosocomial infections in detection, investigation, and so of infectious diseases; diprecautions systems to mission of infectious agents; ducation in infection trol; ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of	21390			

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00885	B. WING		06/1	3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SOUTH	SHORE CARE CENTE	R	ITH SHORE I	DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	practices, including defined in part 4656. G. a system for H. a system for products which affed disinfectants, antise incontinence products. In methods for current standards of the standards of	olicies and infection control a tuberculosis program as 3.0815; r reviewing antibiotic use; r review and evaluation of act infection control, such as applics, gloves, and	21390			
		t changed her gloves before				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
		00885	B. WING		06/	13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	1307 SOU	, ,	STATE, ZIP CODE DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21390	On 6/6/14 the physical forearm and wash of daily with 4 X 4 Mey if soiled or saturate signs of infection. On the direction of the signs of infection of the signs	ician order for laceration right daily and dressing change ollex Border dressing. Change d. Observe for worsening On 6/13/14 the physician nged daily. Clear drainage. cian orders included: continue ge. Wash daily with saline. Do eroxide. Apply dressing daily ning. Intitled Non-Sterile Dressing was provided. The procedure 0) remove the dressing and g. The procedure then gloves, wash hands, and apply procedure (#12, #13, and #14) eleaning the wound with normal dicleanser and patting the area "remove gloves, wash hands, es." Sing was interviewed on and stated gloves should dibefore touching the sterile THOD OF CORRECTION: could review and revise proper infection control ellowed for wound care. The could educate nursing staff on ocedures for wound care. The	21390			

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00885	B. WING		06/1	3/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SOUTH S	SHORE CARE CENTE	R	TH SHORE GTON, MN	DRIVE PO BOX 69		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
21426	(a) A nursing home maintain a compreh infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volus Health shall provide regarding implements	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of extechnical assistance intation of the guidelines.	21426			
	by: Based on interview facility failed to ense Tuberculosis (TB) I included a team/pe of the program, writ procedures, and he Findings include: Regulations for Tub Health Care Setting facilities to have a w infection control pro procedures were to	and document review, the ure the facility had a nfection Control Program that rson responsible for oversight ten TB infection control alth care worker education. Derculosis Control in Minnesota as dated July 2013 directed written tuberculosis (TB) ocedure. The written include: 1) early recognition oms of TB by staff and the				

Wilnneso	<u>ita Department of He</u>	alth				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
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NAIVIE OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SOUTH	SHORE CARE CENTE	R	ITH SHORE I	DRIVE PO BOX 69 56187		
(X4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
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				DEFICIENCY)		
21426	Continued From pa	ge 21	21426			
	staff role in the facil	lity 's TB infection control				
		on procedure for potentially				
		nts in an airborne infection				
		ailable or in a separate room				
		facility did not have an				
		oom. 3) referral and transfer				
		ng equipped to evaluate and				
	treat potentially infe					
		Center had policies dated				
		lated to procedure for				
	Tuberculosis Resid					
	Tuberculosis Emplo	yee Screening that directed				
	the use of symptom screening, 2-step tuberculin					
	skin test (TST), and	d chest x-rays as needed. The				
	facility also had a p	olicy related to Tuberculosis				
		ated 8/1/13 that directed the				
		t was to be done annually and				
		in 2013. The Tuberculosis				
		policy dated 9/4/12 provided				
		ignate responsibility for the TB				
		erculosis Resident Screening				
		provided 6/13/14 identified the				
		or her designated alternative nonitoring/surveillance for				
		nonitoring/surveillance for a have confirmed active TB.				
		d policies did not reveal an				
		culosis Control Program that				
		person responsible for the TB				
		ogram, staff recognition and				
		nagement of the program,				
		s for potentially infectious TB				
		rral system/setting equipment				
		at potentially infectious TB				
	patients.					
		erculosis Control in Minnesota				
		s dated July 2013 directed				
		all health care workers (HCW)				
		time of hire and annually or as				
		entation related to HCW				

education was provided.

	a Department of the					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
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						5,20
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SOUTH S	SHORE CARE CENTE	R		DRIVE PO BOX 69		
		WORTHIN	IGTON, MN	56187		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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				,		
21426	Continued From pa	ge 22	21426			
	The facility had des	ignated registered nurse				
		act person for infection control				
		/14 at 3:18 p.m. RN-B was				
		to the facility's TB program.				
		as not aware of the facility's				
		nd if they needed TST and				
		vare of the areas related to the				
		perculosis Control in Minnesota				
	Health Care Setting					
		sing (DON) was interviewed				
		o.m. DON stated the facility				
		parate policies related to				
		ad been provided and that she				
		y related to staff training.				
		not know the last education				
	held for HCW relate					
		HOD OF CORRECTION:				
		sing or her designee could				
		ons for Tuberculosis Control in				
		Care Settings dated July 2013				
		ions to revise/develop and				
		ulosis infection control				
		ctor of nursing or designee				
		opropriate staff on these				
		ures and staff role in the				
	•	TB infection control program.				
	The DON or her de	signee could provide in				
		ealth care workers related to				
	tuberculosis. The	DON or designee could				
	develop a monitorin	ng system to ensure ongoing				
	compliance with the	e regulations.				
	TIME PERIOD: Tw	renty-one (21) days.				
21530	MN Rule 4658.1310	A.B.C Drug Regimen Review	21530			
	A. The drug regim	en of each resident must be				
		onthly by a pharmacist				
		y the Board of Pharmacy.				

6899

	IT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		00885	B. WING		06/1	13/2014	
SOUTH SHORE CARE CENTER 1307 SOU			DDRESS, CITY, STATE, ZIP CODE JTH SHORE DRIVE PO BOX 69 NGTON, MN 56187				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
21530	This review must be Appendix N of the Surveyor Procedure Requirements in Lot the Department of I Health Care Finance This standard is in available through the system. It is not sure B. The pharma irregularities to the and the attending processing must be acted upon physician visit, or sure pharmacist. For purpon means the acreport and the signification of nursing services. C. If the attend with the pharmacist not provide adequate pharmacist believes being adversely affer fer the matter to the attending physician. If the medical direct physician does not must be referred for assessment and as by part 4658.0070, the medical direct must refer the mattassessment and as assessment and as sessment a	e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan bject to frequent change. It is ne Minitex interlibrary loan bject to frequent change. It is ne Minitex interlibrary loan bject to frequent change. It is ne Minitex interlibrary loan bject to frequent change. It is ne Minitex interlibrary loan bject to frequent change. It is new the interpret any director of nursing services hysician, and these reports in by the time of the next concer, if indicated by the imposes of this part, "acted coceptance or rejection of the ing or initialing by the director and the attending physician does not concur its recommendation, or does the justification, and the interpret is the resident's quality of life is extend, the pharmacist must the medical director for review to is not the attending edical director determines that can does not have adequate order and if the attending change the order, the matter is review to the quality securance committee required. If the attending physician is or, the consulting pharmacist er directly to the quality securance committee.	21530				
	by:	ent is not met as evidenced and document review, the					

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
SOUTH	SHORE CARE CENTE	R	TH SHORE I IGTON, MN	DRIVE PO BOX 69 56187		
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21530	Continued From pa	ge 24	21530			
	to the physician and monthly pharmacy	cist failed to report irregularities d director of nursing during the review for 2 of 5 residents (R8 for unnecessary medication				
	Findings include:					
	R8 physician orders dated 4/15/14, identified diagnoses of but not limited to MDD (major depressive disorder), anxiety, nervousness, agitation and osteoarthritis. R8's five day Minimum Data Set (MDS) dated 4/18/14, identified mood score of five (symptoms of depression mild), no behaviors, had received scheduled and as needed pain medication, had received non medication interventions for pain, pain present occasionally, pain limited day to day activity, pain scale rate of eight. R8's brief interview of mental status (BIMS) had been 15 out of 15 on the MDS and indicated cognitively intact.					
	dated 4/15/14, reversant depressant medevery day for MDD, Trazodone (an anticevery bedtime for Notialopram (Celexal medication) 20 mg 4/11/14, lorazepam one mg three times anxiety/nervousnessand hydrocodone-amedication) 5/325 reports as needed for Review of Southwestern day for MDD, and the series and hydrocodone-amedication (Celexal medication) 5/325 reports as needed for Review of Southwestern day for MDD, and the series and hydrocodone-amedication (Celexal MDD) for MDD, and the series and hydrocodone-amedication (Celexal MDD) for MDD, and the series are series and the series and th	B's current physician orders caled orders for Cymbalta (an dication) 20 mg (milligrams) start date of 10/4/13, depressant medication) 50 mg MDD, start date of 10/4/13, (an antidepressant every day for MDD, start date (an anti-anxiety medication) s a day as needed for sa/agitation, start date 10/4/13 acetaminophen (pain mg one to two tablets every six or osteoarthritis.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER SHORE CARE CENTE	R 1307 SOU		BTATE, ZIP CODE DRIVE PO BOX 69 56187		
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21530	3/4/14, identified dia medications Cymba continue with Cymba antidepressant Cele and there was not oprovided as to a phythree antidepressartime. Document review of administration records for a phythree antidepressartime. Document review of administration records for a phythree electric for a phythree electric for a phythree for a ph	agnosis depressive disorder, alta and Trazodone and valta and Trazodone. The third exa was started on 4/11/14 documentation nor was any sysician 's justification to use at medications at the same of R8's medication at the same of R8's medication at the same of R8's medication at the same of dated from 5/1/14 to of dated from 5/1/14, identified R8 of lorazepam eight times in documented had been documented had been documented from the dated from 13 times and six out documentation of of dated from 5/1/14 to of date of	21530			

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER	R STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
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director of nursing citalopram and lor reviewed and specare planned. Dire would expect physical documented regard antidepressant metalogue antidepressant metalogue antidepressant metalogue antidepressant metalogue antidepressant metalogue antidepressant metalogue antidepression antidepression antidepression, anxiet significant change dated 4/15/14, ide depressed or hope little energy, movin behaviors of psyclinterview of mentalogue antidepression antidepression antidepression antidepression antidepressed or hope little energy, movin behaviors of psyclinterview of mentalogue antidepression antidepres	n 6/13/14, at 12:21 p.m., had stated would expect use of azepam medication to be cific behaviors identified and ector of nursing had stated sician justification to be reding use of three edications being used for R8. The effectiveness of as needed given are documented and ness being documented for ation being given as needed be arding what anxiousness is. The eded antianxiety medication are no resident specific sign or ed to determine if the ation was affective or not. The orders dated 5/7/14, identified not limited to dementia, by, restlessness. R51's Minimum Data Set (MDS) Intified mood: feeling down, eless, feeling tired or having any or speaking slowly and hosis-delusional. R51's brief all status (BIMS) had been 3 out and indicated severe cognitive. R51's current physician orders alled an order for Ativan (an eation) 0.5 mg (milligrams) every ded, diagnoses of anxiety and	21530			

Minnesota Department of Health

STATE FORM 6899 ID9911 If continuation sheet 27 of 61

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00885	B. WING		06/1	13/2014
	PROVIDER OR SUPPLIER	1307 SOU		STATE, ZIP CODE DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21530	behaviors identified During interview on consultant pharmace expect physician just one antidepressant time and to be doct then yearly thereaft behaviors be identifications. Document review of Regimen Review of "Procedure: 2. Faci consultant pharmace Physician/Prescribe notes, and other do Consultant Pharma judgment as to whe in the medication renecessary information Applicable Law." SUGGESTED MET The director of nursipolicies and procedure pharmacist identified irregularities including monitoring effective could educate all nu procedures. The Quench could monitor compared to the procedure of	If for use of medication. 6/13/14, at 1:37 p.m., bist (CP)-C had stated would stification for use of more than medication used at the same umented twice in the first year er and would expect specific fied for use of psychotropic. If the facility policy Medication ated 12/1/07, read, lity should ensure that the bist has access to: 2.4 er progress notes, nurses' becuments which may assist the cist in making a professional either or not irregularities exist egimen; and, 2.5 Any other ion, in accordance with THOD OF CORRECTION: Sing could review and revise lures to ensure the consultant and and reported medication and indications for use and eness. The director of nursing ursing staff on the policies and enality Assurance Committee	21530			
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary	21535			

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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		00885	B. WING		06/1	3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
SOUTH	SHORE CARE CENTE	· R	TH SHORE I GTON, MN	DRIVE PO BOX 69 56187		
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21535	Continued From pa	ge 28	21535			
	must be free from a unnecessary drug in A. in excessive therapy; B. for excessive therapy; B. for excessive therapy; C. without adea D. in the prese which indicate the adiscontinued. In addition to the discontinued. In addition to the discontinued in the discontinued. In addition to the discontinued in the discontinued	quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in e nursing home must comply ne Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for acilities, published by the Ith and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan ite Law Library. It is not				
	by: Based on observati review, the facility f dose reduction of a reduction of psycho residents (R40) rev medication use; fail indications (resident symptoms) for use	ent is not met as evidenced ion, interview and document ailed to attempt a gradual ntipsychotic medication and/or otropic medication for 1 of 5 iewed for unnecessary led to clearly identify at specific signs and of an antianxiety medication (R8, R51) reviewed for cation use.				
	Findings include:					

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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SOUTH	SOUTH SHORE CARE CENTER WORTH			DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21535	Continued From page 29 R40 was admitted to the facility 4/23/09, and had diagnosis that included anxiety/psychosis and depression, according to physician orders signed 5/20/14.		21535			
	Data Set (MDS), and to have no cognitive behaviors, and received	d R40 on the annual Minimum assessment dated 4/22/14, e impairment, no moods, no eived antipsychotic, idepressant medications.				
	Document review of the resident care plan dated 5/12/09, directed staff R40 had problem of potential for side effects of psychotropic medications, with interventions that included monitor for side effects, monitor behavior each shift and document. Resident care plan dated 5/12/09, revealed problem potential for mood alteration, with interventions that included monitor key times for triggering increased behavior.					
	R40 was observed a group activity. No observed. Observa p.m., R40 was inde dining room. No mo observed. During resident inte	s on 6/10/14, at 9:55 a.m., to wheel self independently to moods or behaviors were ations on 6/10/14, at 12:30 pendently eating lunch in the cods or behaviors were erview on 6/10/14, at 12:45 pehaviors were noted or				
	Document review o dated 5/20/14, reve (Ativan) 0.25 milligr anxiety, order date milligrams every modate of 11/16/10; ar 450 milligrams ever	f physician orders signed aled orders for lorazepam ams every bedtime for of 3/25/11; zoloft 200 prning for depression, order and Seroquel (psychotropic) by bedtime for order date of 11/15/11.				

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00885		B. WING		06/1	3/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
SOUTH	SHORE CARE CENTE	R		DRIVE PO BOX 69			
		WORTHIN	IGTON, MN				
(X4) ID PREFIX TAG			ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE	
21535	Continued From page 30		21535				
	6/1/14 to 6/11/14, re Zoloft and Seroque During interview on services (SS)-A state behavior monitoring managers and revieteam documentation identified the follow depression, anxiety stated R40 had no monitoring of behaviors, then the SS-A stated the monursing assistant defacility computer syshift mood monitoring	rd for 5/1/14 to 5/31/14 and evealed R40 received Ativan, I as ordered. 6/11/14, at 2:22 p.m., social ted she reviewed mood and g weekly with the clinical ewed facility risk management in with the team monthly. SS-A ing moods monitored included and sleep disturbance. SS-A target behaviors and no viors. SS-A stated if R40 had y would monitor the behaviors. Initioring of moods included ocumentation every shift in the stem. SS-A verified everying according to the mood port from 12/1/13 to 6/11/14,					
	charting assessment identified the follow depression and slea and no behavioral in the depression and slea and no behavioral in the depression and slea and no behavioral in the depression and slean mental status (BIMS score of 15/15-cognic questionnaire (PHC than minimal symptobehaviors. Document review of the depression and slean status (BIMS score of 15/15-cognic questionnaire (PHC than minimal symptobehaviors.)	f facility brief interview for (5) dated 10/22/13, revealed a nition intact, patient health (2-9) identified score of 3, less froms of depression, and no					
	score of 15/15-cog	s) dated 1/21/14, revealed a nition intact, social services ent-no behaviors, social essment, monitored					

Minnesota Department of Health

STATE FORM 6899 ID9911 If continuation sheet 31 of 61

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00885	B. WING		06/	13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	1307 SOU		STATE, ZIP CODE DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21535	depression, anxiety incidents of these in (no depression). Document review of mental status (BIMS score of 13/15-cograte behavior assessments services mood assed depression, anxiety incidents of these in (no depression). Document review of Progress Notes date consultant pharmace address psychophare review. Physician in revealed R40 needing medications as redirecurrence in his and decompensation. Psychopharmacolo were attached to the 4/16/14, each with in Lorazepam 0.25 midiagnosis-anxiety, of dose, resident does not advised by nursing. Zoloft 200 milligram diagnosis-depression well on this dose, resident reduction not recommendate in the comments of the commen	r, sleep disturbances with no moods, and PHQ-9 score of 0 of facility brief interview for so dated 4/22/14, revealed a nition intact, social services ent-no behaviors, social essment-monitored r, sleep disturbances with no moods, and PHQ-9 score of 0 of Doctors Orders and ed 4/16/14, revealed cist request for physician to armacological medication esponse dated same day, ed to continue current auction done in the past made exist vinstability with the following facility gical Medication Reviews e physician response dated review date of 2/6/14: Iligrams, order date-3/25/11, comments-This is minimal is well on this dose, reduction	21535			

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NAME OF F	PROVIDER OR SUPPLIER		DRESS. CITY. S	STATE, ZIP CODE	1 00/1	0/2014
SOUTH S	SHORE CARE CENTE	R	TH SHORE I	DRIVE PO BOX 69 56187		
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21535	attempts at lowering or a gradual dose reverified psychophar reviews dated 2/6/1 the comment stater Zoloft, and Seroque dose reduction not by her. RN-C verifies the psychiatrist dated 4 medications, was become Document review of Medication Review physician signed or Seroquel from 450 and to monitor respect the facility was unainformation related and return to 450 medications or clinic R8 received three and there was no puse of three antidegused at the same times and the same times dated 4/15/1 not limited to MDD anxiety, nervousnes R8 's five day Minit 4/18/14, identified rof depression mild)	N)-C stated there had been no g the dose of Ativan and Zoloft eduction of Seroquel. RN-C macological medication 4, were written by RN-C with ment on each review-Ativan, el, does well on this dose and recommended, were written ed these reviews were sent to the statement from 1/16/14, to continue current ased on that review. If Psychopharmacological with review date of 4/1/12, der on 4/3/13, to decrease milligrams to 400 milligrams onse. Although requested, ble to provide any further to dose reduction of Seroquel hilligrams dosage. If Although requested, ble to provide any further to dose reduction of Seroquel hilligrams dosage. If Although requested, ble to provide any further to dose reduction of Seroquel hilligrams dosage. If Although requested, ble to provide any further to dose reduction of Seroquel hilligrams dosage.	21535			

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	PROVIDER OR SUPPLIER SHORE CARE CENTE	R 1307 SOL		TATE, ZIP CODE DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
21535	received non medicipain present occasi activity, pain scale in interview of mental out of 15 on the MD intact. During review of R8 dated 4/15/14, reveantidepressant medevery day for MDD, Trazodone (an anticevery bedtime for Motialopram (an anticevery day for MDD, (an anti-anxiety meadication) 5/325 rhours as needed for anxiety/nervousnessand hydrocodone-amedication) 5/325 rhours as needed for R8's current care personablem mood alternanxiety, grief, loss of down at times, enterpoor appetite, anxiety concentration at time limited to give medifor side effects. Proof psychotropic medication montal teration in comfor pain, leg pain and pof but not limited to evaluate effectives document effectives and course of the course of	cation interventions for pain, ionally, pain limited day to day rate of eight. R8 's brief status (BIMS) had been 15 DS and indicated cognitively B's current physician orders aled orders for Cymbalta (andication) 20 mg (milligrams) start date of 10/4/13, depressant medication) 50 mg MDD, start date of 10/4/13, depressant medication) 20 mg start date 4/11/14, lorazepam dication) one mg three times res/agitation, start date 10/4/13 cetaminophen (pain mg one to two tablets every six rosteoarthritis. Ian dated 1/8/14, identified ration related to depression, of role evidenced by feeling er long term care, feeling tired,	21535			

Minnesota Department of Health

STATE FORM 6899 ID9911 If continuation sheet 34 of 61

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00885		00885	B. WING		06/1	3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SOUTH	SHORE CARE CENTE	R	TH SHORE I	DRIVE PO BOX 69		
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	interdisciplinary not Review of physiciar identified current m Ativan (lorazepam) no documentation in Southwestern Ment Management progidentified diagnosis medications Cymba continue with Cymba above physician prodocumentation regard Cymbalta, trazodor start dates of 10/4/iphysician justification antidepressant medications and physician justification for the company of the compa	es. In progress note dated 2/25/14, edications of but not limited to cymbalta, trazodone, but had regarding mood. Review of tal Health Center Medication ress note dated 3/4/14, depressive disorder, alta and trazodone and balta and trazodone. The orgess notes had no arding justification for use of the end lorazepam that had 13 and no documentation of the end lorazepam that had 13 and no documentation of the end lorazepam on 4/11/14. If R8's medication regarding starting third dication citalopram on 4/11/14 to 6/30/14, identified R8 citalopram 20 mg every day, very day and trazodone 50 mg zepam one mg three times a hydrocodone-acetaminophen to tablets every six hours as If R8's PRN Medication for giving documented danxiety/increased dervous and response had not regarding effectiveness of of the eight times. In aminophen medication had and six out of 13 doses had	21535			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00885	B. WING		06/1	3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SOUTH	SHORE CARE CENTE	R	TH SHORE I	DRIVE PO BOX 69		
(VA) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SHOULD BE CON		(X5) COMPLETE DATE
21535	Continued From pa	ge 35	21535			
	team documentation of identified medic lorazepam and traz date 4/17/14 had not lorazepam and cita at 11:05 a.m., social medication identified 12/23/13 reviewed been documented if the facility risk mandated 4/17/14) and not identified medic Cymbalta and citalogaeth.					
	During interview on 6/13/14, at 10:29 a.m., licensed practical nurse (LPN)-D verified effectiveness of lorazepam and hydrocodone-acetaminophen medications had not been documented and verified reason documented for giving lorazeapm had been increased anxiety/anxiousness, however, resident specific anxiety symptoms not clearly identified when Ativan was given. LPN-D verified R8's care plan had no specific behaviors in regards to lorazepam medication use other than the word anxiety is documented on the care plan.					
	During interview on 6/13/14, at 11:05 a.m., social worker (SW)-A had stated it is up to the resident care coordinator to bring all information to risk management meetings regarding medications a resident is receiving. SW-A verified the risk management team had not reviewed the use of citalopram and lorazepam for R8 and verified the risk management team had not identified specific resident symptoms of anxiety, nervousness and agitation related to lorazepam medication use. SW-A reviewed R8's chart and verified there had been no physician justification documented					

Minnesota Department of Health

STATE FORM 6899 ID9911 If continuation sheet 36 of 61

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SOUTH SHORE CARE CENTER 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN ST6187 PREFIX FREET ADDRESS, CITY, STATE, ZIP CODE SOUTH SHORE CARE CENTER 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN ST6187 PREFIX FREED BY SHAND OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 21535 Continued From page 36 regarding use of Cymbalta, trazodone, lorazepam and citalopram in R8's physician progress notes. During interview on 6/13/14, at 11:23 a.m., registered nurse (RN)-C verified there had been no physician justification documented regarding use of Cymbalta, trazodone, lorazepam and citalopram and orizatepam medication to be reviewed and specific behaviors identified and care planned. Director of nursing had stated would expect use of citalopram and lorazepam medication to be documented regarding use of Cymbalta, trazodone, Altivan and why started citalopram. Director of nursing had stated would expect effectiveness of as needed medications when given be documented and reason of anxiousness being documented for lorazepam medication being given as needed be more specific regarding what anxiousness is. R51 received ativan as needed (PRN) however, there was no resident specific anxiety signs and symptoms identified to determine it the medication was affective or not. R51 had been admitted on 8/1/12, R51 's physician orders dated 5/7/14, identified diagnoses of but not limited to dementia, depression, anxiety, residensinesses. R51's significant change Minimum Data Set (MDS) dated 4/15/14, identified mood: feeling down, depressed or hopeless, feeling tried or having	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
SOUTH SHORE CARE CENTER 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187			00885	B. WING		06/	13/2014
CA1 ID PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION CASH	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE	-	
PRÉFIX TAG REGULATORY OR USC IDENTIFYING INFORMATION) 21535 Continued From page 36 regarding use of Cymbalta, trazodone, lorazepam and citalopram in R8's physician progress notes. During interview on 6/13/14, at 11:23 a.m., registered nurse (RN)-C verified there had been no physician justification documented regarding use of Cymbalta, trazodone, lorazepam and citalopram in R8's physician progress notes, just the diagnoses. During interview on 6/13/14, at 12:21 p.m., director of nursing had stated she would expect use of citalopram and lorazepam medication to be reviewed and specific behaviors identified and care planned. Director of nursing had stated would expect ypsician justification to be documented regarding use of Cymbalta, trazodone, Aitvan and why started citalopram. Director of nursing stated would expect physician justification to be documented regarding use of Cymbalta, trazodone, Aitvan and why started citalopram. Director of nursing stated would expect effectiveness of as needed medications when given be documented and reason of anxiousness being documented for lorazepam medication being given as needed be more specific regarding what anxiousness is. R51 received ativan as needed (PRN) however, there was no resident specific anxiety signs and symptoms identified to determine it the medication was affective or not. R51 had been admitted on 8/1/12. R51's physician orders dated 5/7/14, identified diagnoses of but not limited to dementia, depressed or hopeless, feeling down, depressed or hopeless, feeling down, depressed or hopeless, feeling thred or having	SOUTH	SHORE CARE CENTE	R				
regarding use of Cymbalta, trazodone, lorazepam and citalopram in R8's physician progress notes. During interview on 6/13/14, at 11:23 a.m., registered nurse (RN)-C verified there had been no physician justification documented regarding use of Cymbalta, trazodone, lorazepam and citalopram in R8's physician progress notes, just the diagnoses. During interview on 6/13/14, at 12:21 p.m., director of nursing had stated she would expect use of citalopram and lorazepam medication to be reviewed and specific behaviors identified and care planned. Director of nursing had stated would expect physician justification to be documented regarding use of Cymbalta, trazodone, Ativan and why started citalopram. Director of nursing stated would expect physician justification to be documented regarding use of Cymbalta, trazodone, Ativan and why started citalopram. Director of nursing stated would expect effectiveness of as needed medications when given be documented and reason of anxiousness being documented for lorazepam medication being given as needed be more specific regarding what anxiousness is. R51 received ativan as needed (PRN) however, there was no resident specific anxiety signs and symptoms identified to determine it the medication was affective or not. R51 had been admitted on 8/1/12. R51's physician orders dated 5/7/14, identified diagnoses of but not limited to dementia, depression, anxiety, restlessness. R51's significant change Minimum Data Set (MDS) dated 4/15/14, identified mood: feeling down, depressed or hopeless, feeling tired or having	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
little energy, moving or speaking slowly and behaviors of psychosis-delusional. R51 's brief interview of mental status (BIMS) had been 3 out	21535	regarding use of Cyand citalopram in R During interview on registered nurse (R no physician justification use of Cymbalta, tracitalopram in R8 's the diagnoses. During interview on director of nursing huse of citalopram a be reviewed and specare planned. Director of nursing huse of citalopram a be reviewed and specare planned. Director of nursing effectiveness of as given be documented being documented being documented being given as need regarding what anx R51 received ativar there was no reside symptoms identified medication was affer R51 had been adm physician orders day diagnoses of but not depression, anxiety significant change of dated 4/15/14, iden depressed or hopel little energy, moving behaviors of psychological citalogical contents.	mbalta, trazodone, lorazepam 8's physician progress notes. 6/13/14, at 11:23 a.m., N)-C verified there had been ation documented regarding azodone, lorazepam and physician progress notes, just 6/13/14, at 12:21 p.m., nad stated she would expect and lorazepam medication to recific behaviors identified and attor of nursing had stated cian justification to be ling use of Cymbalta, and why started citalopram. Stated would expect needed medications when red and reason of anxiousness for lorazepam medication ded be more specific iousness is. In as needed (PRN) however, and specific anxiety signs and determine it the rective or not. Sitted on 8/1/12. R51 's sted 5/7/14, identified to dementia, and the rective or not. Sitted mood: feeling down, ress, feeling tired or having gor speaking slowly and osis-delusional. R51 's brief	21535			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00885	B. WING		06/	13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	1307 SOU		TATE, ZIP CODE DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21535	of 15 on the MDS a impairment. During review of R5 dated 5/7/14, revea anti-anxiety medica four hours as neederestlessness, start of R51's current care identified problem prelated to loss of fur weepy at times, par of interest, verbal yedisturbances and renot limited to assess verbalization of depresentings. Problem physical, verbal, rejmood evidenced by objects, threatens,	nd indicated severe cognitive 51's current physician orders led an order for Ativan (an tion) 0.5 mg (milligrams) every ed, diagnoses of anxiety and date 4/17/14. e plan dated 11/19/13, potential for mood alteration nction, feeling worthless, ranoid, resistive at times, lack elling, refusals, sleep estless with intervention of but s and monitor increased signs ression daily, document on s, review monthly at team inappropriate behavior: ection related to cognitive, r spit, hit, pinch, slap, throws yells, swears, refuses ADL ring), bath, medications,	21535			
		re plan had not identified of anxiety and restlessness edication use.				
	team documentatio	f the facility risk management n review dates 4/17/14 and cumentation regarding Ativan				
	worker (SW)-A had had an order for Ati verified no mention plan of care dated	6/13/14, at 10:50 a.m., social stated she did not know R51 van, but I should of. SW-A of Ativan on R51 's current 11/19/13. SW-A verified risk had not reviewed the use of				

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		00885	B. WING		06/1	3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
SOUTH	SHORE CARE CENTE	R	TH SHORE	DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	Ativan for R51 to id related to medication director of nursing hativan medication to behaviors identified. Document review on Review Tool dated assure that each remedications are assuredirically contraindicated that each resident from unnecessary or reductions are implicontraindicated. Pomanagement team Drug Review Tools that the facility is contraindicated to PROCEDURE 4. Rememore properties of the process	entify specific behaviors on use. 6/13/14, at 12:07 p.m., nad stated would expect use of o be reviewed and specific	21535			
	Coordinator will be this tool. 5. Membe are responsible to a	responsible to completion of rs of the interdisciplinary team assure that individualized approaches are contained				
	The director of nurs policies and proced medications. Direct	THOD OF CORRECTION: sing could review and revise lures for unneccessary tor of nursing could educate ursing could monitor				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

6899

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER SHORE CARE CENTE	1307 SOU		STATE, ZIP CODE DRIVE PO BOX 69 56187			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
21620	in accordance with This MN Requirements: Based on observation review, the facility formedication labels for reviewed for 2 of 7 during medications when coarts reviewed, which (R7, R19, R6) reviewed storage checks. Findings include: INACCURATE MEDICAL RAO'S medication Maccuration	aursing home must be labeled part 6800.6300. ent is not met as evidenced on, interview, and document ailed to ensure accurate or 2 of 25 medication labels residents (R40, R8) observed bass; and failed to date opened for 1 of 3 medication och affected 3 of 3 residents wed during medication DICATION LABELS: IouthKote artificial saliva) ructed one spray to mouth, ervations of the medication took three sprays. Although mysician ordered correct acy label had not been ist current physicians order for	21620				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00885	B. WING		06/	13/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	1307 SOL	DDRESS, CITY, ST JTH SHORE D NGTON, MN 5	RIVE PO BOX 69		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
21620	Observations of the at 12:38 p.m., reveal (LPN)-A handed Mothree sprays into me prevealed artificial say 129/13, and direction mouth orally three to the pharma dispense date of 9/2 spray three times at time, LPN-A verified signed and dated 5 order date of 11/15, three times a day. During interview on of nursing stated she expedelivered to the factor medication labels with the stated with the st	e medication pass on 6/10/14, aled licensed practical nurse both Kote to R40, who sprayed outh. If pharmacy medication label aliva; dispense date of ons to "Use 1 spray into imes a day for dry mouth." 6/10/14, at 12:48 p.m., LPN-A cy medication label with 29/13, instructed one mouth day. During interview at that discurrent physician orders /20/14, for artificial saliva, /11, three sprays to mouth 6/12/14, at 1:30 p.m., director ne expected nurses checked with each medication pass. ected when medications were illity, the nurse checked with physician orders at that hen medication orders at that hen medication orders cted the nurse placed a sticker on the medication If facility medication rd 6/1/14-6/9/14, revealed R40 aliva three sprays to mouth s physician ordered. If facility policy Reordering, continuing Orders, revision				
	receives a new orde	80, #3.5 "If Pharmacy er that changes the strength or on previously ordered, and				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	(X3) DATE SURVEY COMPLETED	
00885 B. WING	6/13/2014	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
there is adequate supply on hand: 3.5.1 Pharmacy should discontinue the original order: 3.5.2 Facility Physician/Prescriber should write the new order with new directions and Facility should enter the new order on the appropriate Medication Record Forms; and, 3.5.3 if permitted by Applicable Law, Facility should notify Pharmacy not to send the medication by attaching a "Change in Directions" sticker to the existing quantity of medications until Pharmacy permanently affixes the new label to the medication package or container. Facility may order from Pharmacy bulk rolls of "Change in Directions" stickers." During telephone interview on 6/13/14, at 1:37 p.m., consultant pharmacist-C stated he expected the label to be updated with the current order. He stated the pharmacy provided change of direction stickers for the facility to use to alert their staff of order changes. R8's insulin vial label was not updated to reflect the physician order change. During observation of medication administration on 6/12/14, at 11:02 a.m., licensed practical nurse (LPN)-B verified R8's Novolog insulin vial label had directions to administer 30 units three times a day and sliding scale. LPN-B had stated the orders had changed, R8 only receives sliding scale now and I'll put a sticker on bottle (regarding order change). During review of R8's physician telephone order dated 5/4/14, identified order discontinue 30 units Novolog at meals. Moderate sliding scale only, call provider below 60, over 400, 60 to 150 give 0		

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	PROVIDER OR SUPPLIER SHORE CARE CENTE	R 1307 SOU		STATE, ZIP CODE DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21620	units and 351 to 40 Document review or administration records 6/30/14, identified Final Novolog insulin and 5/4/14. During interview on verified label on No orders on label and on bottle to identify. During interview on consultant pharmach incorrect directions would expect label home with stickers (medication administrated in the composition of nursing had stated directions on label of expect flag (sticker physician orders as on bottle see MAR MEDICATIONS DATE During medication is was noted: R7 's Roxanol 20 moders and polysician orders and no date opened. Twenty five the control of the composition of the comp	o give 12 units. f R8 's medication rd dated from 6/1/14 to R8 had received sliding scale I start date of order had been 6/12/14, at 11:28 a.m., LPN-B volog insulin vial had incorrect no sticker had been placed order change. 6/13/14, at 1:37 p.m., cist-C stated in regards to on label of Novolog insulin he to be updated, we provide the to place over label see MAR stration record) or chart for 6/13/14, 12:01 p.m., director ed in regards to incorrect of Novolog insulin she would to alert staff to check a change was done) to be put	21620			

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER SHORE CARE CENTE	R 1307 SOL		STATE, ZIP CODE DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21620	was in drawer of medate as to when ope 6/11/14 at 2:40 p.m. R6 has an order for [subcutaneous] TID to sliding scale. Bo medication cart ope when it was opened on 6/11/14 at 2:40 p. Review of policy: 5 Dating of medication Needles revised 5/1 #5. Once any mediopened, Facility sho manufacturer/suppl expiration dates for staff should record medication contains shortened expiration. Omnicare Pharmac Expiration Dates will Insulin: 30 days aft temperature. Mediom MEDICATIONS ON OPEN DATE PRES multi-dose vials showhen opened by lic. SUGGESTED MET The director of nursipolicies and proced medication labels, ropened, and destruthe director of nursipolicies and destruthe director of nursipolicies of nursipolicies and destruthe director of nursipolicies of nursipolicies and destruthe director of nursipo	Humalog Observation Insuling edication cart opened and not ened, this was noted on an ened, this was noted on a ened and no under the ened and no date found as to do an ened and no date found as to do an ened and reflect by RN-A. In a Storage and Expiration				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21620	Continued From pa	ge 44	21620			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21685	MN Rule 4658.1415 Housekeeping, Ope	5 Subp. 2 Plant eration, & Maintenance	21685			
	including walls, floo systems, and equip continuous state of with regard to the h well-being of the re	plant. The physical plant, rs, ceilings, all furnishings, ment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program.				
	by: Based on observatifailed to ensure ceil were clear of dust in Also air vents, stove were not routinely cand sanitary environ had the potential to received prepared funpleasant and posand not determined	on and interview, the facility ing and mechanical air vents a 4 of 4 residential hallways; a hood, and steam table pans leaned to maintain a clean ment in the kitchen and this affect all 42 residents who oods from the kitchen; asibly harmful odors detected if harmful to residents, the facility.				
	Findings include:					
	supervisor (ES) on A & B were noted to ceiling grates. Also were ceiling air grat	onducted with environmental 6/11/14 at 9:55 a.m. Hallways b have black areas on all 10 noted on Hallways A, B, C res with a coat of dust and was moving when air				

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00885	B. WING		06/1	3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
SOUTH	SHORE CARE CENTE	· K	TH SHORE I	DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21685	movement. The Tr Hallway C and med were noted to have and strands of dust moving. ES was interviewed 12:30 p.m. ES statunit and mechanical every 30 days and cleaned. ES verifical stated the 10 ceiling were part of the old duct system that concern the stated the 10 ceiling were part of the old duct system that concern the selike mold. ES vent grates were from humblack areas were from humblack areas were from the selike mold. ES vent grates were to that they were curred on 6/13/14 at 8:50 past year, he had not grates either washed was not sure if that interview on 6/13/14 he used a ladder to first time. ES think grates could possible An initial tour of the 6/9/14 at 6:15 p.m. The observations we dietary manager (DObservations durin following:	rane air condition unit on chanical unit on Hallway D also grates with coating of dust also moving when air was did during a tour on 6/12/14 at ted the Trane air conditioner al unit had filters changed should have the intake vent ed these were dusty. ES g grates on hallways A & B is system and had original air ould have a history of moisture hidifiers. ES did not know if the form rust stains or something also stated the other ceiling also stated the other ceiling also stated the other ceiling also stated the that during the forthad the 10 black marred ed or painted. ES stated he was ever done. During an 4 at 11:00 a.m. ES stated that of check out the vents for the sthe black marks on the 10 bly be rust. The kitchen was conducted on with the dietary aide (DA)-A. were reviewed and verified with pM)-A on 6/9/14 at 6:34 p.m. g the tour include the	21685			
	(directly above coo a brown, sticky sub	king surface); was coated with stance (grease) in addition to which covered the light bulbs				

Minnesota Department of Health

STATE FORM 6899 ID9911 If continuation sheet 46 of 61

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00885	B. WING		06/1	3/2014
NAME OF I				CTATE ZID CODE	00/1	3/2014
	PROVIDER OR SUPPLIER	1307 SOU		STATE, ZIP CODE DRIVE PO BOX 69		
SOUTH	SHORE CARE CENTE	· K	IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21685	located under the h surrounding area of front surface of the the brown, sticky surfocted in the refrigulation of dust and surface and piping air around food stored to be understand to the surface and piping air around food stored to be understand to the surface and piping air around food stored to be coated with debout 1 foot square metal shelf on upper linterview of the DN verified that this opventilation system for transported person facility. This vent without any grates observed that approvate observe	nood. The surfaces and f the knobs located on the range were also coated with ubstance. The cooling fan gerated cooler showed a debris on both the frame of the unit. This fan circulates red in cooler. No food was covered. Insulated electrical he back of the fan unit and op food shelf were observed to	21685			
		during observation of the meal				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00885	B. WING		06/1	3/2014
NAME OF PR	OVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SOUTH SH	IORE CARE CENTE	R	TH SHORE I	DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
S S V T a a L V V V V P C S C C C F A A A M a C C F P N S L L C K V P A t I C K V P A t I C K V P A t I C K V P A t I C K V P A T I C K V P A	steam table pans (fightite residue in corrections and brown buildup in the which had been post vas noted that there because the sides, back & drip to the sides, back & drip t	servation it was noted that ood containing surfaces) have mers that does scratch off. It was observed to have white noted on the drain surface. dietary cleaning schedule sted during the initial tour it we were multiple blanks dule included a weekly day cook which included grill ray; steam table; cooks we down daily, shelf below cook wittled: Exhaust Hood Semi 4SA dated 2002: stated: 1.) Check and clean grease and minterior of duct at hood neck and clean grease and minterior of duct at access and clean grease and foreign sible and accessible duct/hood 5.) Clean hood grills and filers. HARMFUL ODORS building by way of the lower ne evening of 6/9/14 at 6:01 er and musty odor was noted.	21685			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00885	B. WING		06/1	3/2014
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
SOUTH	SHORE CARE CENTE	· R	TH SHORE I IGTON, MN	DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21685	it was a strong sew between the end of entrance again a si. The 400 wing (local entered through the 7:55 a.m. On entered through the 10:55 a.m. On entered through the nursing station. On 6/13/14 at 8:00 was interviewed. R sewer and musty stoileting needs of the At 8:01 a.m. RN-D smell when the air on. At 8:03 a.m. however end the air on. At 8:03 a.m. however end the air on. At 8:03 a.m. however end the air on the environmental interviewed on 6/12 there had been a slower residential urrequired fixing pipe 90 days ago he had neutralizer/sanitize neutralize the toilet resident 's incontinuity did not smell the moder because he had grown the environmental nursing could review procedures to ensure environment and	rer type smell and again if the hallway by the old house mell of sewer was noted. Ited on the lower level) was be lower level door on 6/13/14 at the ring the lower level resident was noted and dissipated by a.m. registered nurse (RN)-EN-E stated she had noted the mell/s also other than when he resident were completed. Stated she noted a musty condition in her office turned busekeeper (H) - A stated that it of a musty smell. Supervisor (ES) was 2/14 at 12:30 p.m. ES stated ewer odor in the past on the nit about 3 years ago and is in the wall. ES stated about dispurchased an air in to be used in the building to ing odors created by the nence episodes. ES stated he usty or sewer type odor	21685			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00885	B. WING		06/1	3/2014
	PROVIDER OR SUPPLIER	1307 SOL		STATE, ZIP CODE DRIVE PO BOX 69		
SOUTHS	SHORE CARE CENTE	K	IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21685	Continued From page 49		21685			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21800	Residents of HC Farsula Subd. 4. Informar residents shall, at a are legal rights for stay at the facility of treatment and main that these are described written statement of responsibilities set to case of patients address as defined in section statement shall also person 16 years old provided in section shall list the names individuals and organ advocacy and legal residential program accommodations strong and communication impospeak a language of facility policies, insplocal health authorit the written statements.	tion about rights. Patients and dmission, be told that there their protection during their rethroughout their course of tenance in the community and ribed in an accompanying of the applicable rights and forth in this section. In the mitted to residential programs in 253C.01, the written of describe the right of a learn or older to request release as 253B.04, subdivision 2, and and telephone numbers of anizations that provide services for patients in				
	to the administrator person, consistent	ives upon reasonable request or other designated staff with chapter 13, the Data section 626.557, relating to				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00885	B. WING		06/1	3/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SOUTH	SHORE CARE CENTE	R	TH SHORE	DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21800	Continued From pa	ge 50	21800			
	by: Based on interview facility failed to prove termination of all M for 3 of 3 residents	ent is not met as evidenced and document review, the vide the required notices upon edicare part A skilled services (R51, R11 and R3) who met receive Medicare services and om the facility.				
	Findings include:					
	NOTICE OF MEDIONON-COVERAGE:					
	R51, R11, and R3 lacked evidence of receiving the Centers for Medicare and Medicaid Services (CMS) expedited decision, "Notice of Medicare Provider Non-Coverage" notice prior to discharge from Medicare services.					
	due to electing hos document review of Determination on C Medicare days, accondice list provided in the facility. The faproviding R51 with Medicaid (CMS) ex Medicare Provider instructions on how Improvement Organ reviewer authorized	d from Medicare on 4/10/14, pice benefits, according to f R51's Skilled Nursing Facility continued Stay. R51 used 10 cording to resident liability by the facility. R51 remained acility lacked evidence of the Centers for Medicare and pedited decision, "Notice of Non-Coverage" which included to contact the Quality nization (QIO), an independent by Medicare to review the lischarge from Medicare.				
	due to lack of skille progress, according	d from Medicare on 10/29/13, d nursing or rehabilitation g to document review of R11's cility Determination on				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			D WINC		20/12/22/	
		00885	B. WING		06/1	3/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SOUTH	SHORE CARE CENTE	R	IGTON, MN	DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21800	Continued Stay. R according to reside by the facility. R11 facility lacked evide Centers for Medica expedited decision. Non-Coverage " whow to contact the Organization (QIO) authorized by Medidecision to discharged due to lack of skille progress, according Skilled Nursing Fac Continued Stay. R according to reside by the facility. R3 r facility lacked evide Centers for Medica expedited decision. Non-Coverage" whhow to contact the Organization (QIO) authorized by Medidecision to discharge. During interview on registered nurse (R evidence of providing Provider Non-Cover SKILLE ADVANCED BENE LETTERS:	11 used 8 Medicare days, and liability notice list provided remained in the facility. The ence of providing R11 with the are and Medicaid (CMS), "Notice of Medicare Provider hich included instructions on Quality Improvement, an independent reviewer care to review the facility ge from Medicare on 5/29/14, and nursing or rehabilitation go to document review of R3's cility Determination on 3 used 29 Medicare days, and liability notice list provided remained in the facility. The ence of providing R3 with the are and Medicaid (CMS), "Notice of Medicare Provider ich included instructions on Quality Improvement, an independent reviewer care to review the facility				

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			* *	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00885	B. WING		06/1	3/2014
NAME OF PROVIDER OR SUP	.IER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SOUTH SHORE CARE C	NTE	₹	TH SHORE	DRIVE PO BOX 69 56187		
PREFIX (EACH DEFIC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
and Medicaid Nursing Facilit one of the five Centers for Me website. The would want the submitted for by the facility to Determination following requirements. This decision represents ou needed no lon requirements. The services ye Normally, the include service want to appeat that the bill su services we de Medicare will in disagree with appeal." R51 was disch due to electing document revirate Determination Medicare days notice list provint the facility. with the Skiller Continued Sta	not uservice Advokument MS r bill wiew led "no Control of the cont	use the Centers for Medicare ces (CMS) approved Skilled anced Beneficiary Notice or al letters available on the e and Medicaid (CMS) notice asked residents if they submitted to Medicare or not a. The denial letter provided Skilled Nursing Facility ontinued Stay " lacked the formation according to the formation according to the ment that the services you set Medicare payment will be sent to Medicare for seived before (Date). It because the ment that the services you decision, you must request a do Medicare include the med to be noncovered. You of its determination. If you determination you may file an a deform Medicare on 4/10/14, since benefits, according to facility Skilled Nursing Facility on the facility. R51 remained ugh the facility Determination on ce, the notice lacked nitting the facility bill to	21800			

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00885	B. WING		06/1	3/2014
				TATE, ZIP CODE DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ORRECTIVE ACTION SHOULD BE COMPI FERENCED TO THE APPROPRIATE DAT	
21800	R3 was discharged due to lack of skilled progress, according Skilled Nursing Factor Continued Stay. R3 according to reside by the facility. R3 r Although the facility Nursing Facility Denotice, the notice las submitting the facility During interview on verified these were R51 and R3. DENIAL LETTERS SUBMIT OR NOT SR51 was discharge due to electing hose document review of Determination on C Medicare days, according to reside in the facility. Although the facility. R11 was discharge due to lack of skilled progress, according Skilled Nursing Factor Continued Stay. R11 was discharge due to lack of skilled progress, according Skilled Nursing Factor Continued Stay. R12 according to reside by the facility. R11 Although the facility. R11 Although the facility Facility Determinati	from Medicare on 5/29/14, d nursing or rehabilitation of to document review of R3's cility Determination on 3 used 29 Medicare days, and liability notice list provided emained in the facility. The provided R3 with the Skilled termination on Continued Stay coked instructions on the bill to Medicare for review. 6/13/14, at 1:59 p.m., RN-C, the denial letters provided to LACKED DECISION TO SUBMIT BILL TO MEDICARE: d from Medicare on 4/10/14, pice benefits, according to a facility Skilled Nursing Facility continued Stay. R51 used 10 cording to resident liability by the facility. R51 remained augh the facility provided the colity Determination on a facility lacked evidence of a dubmit or not submit the bill to d from Medicare on 10/29/13, d nursing or rehabilitation on the facility Determination on the facility Determination on the facility notice list provided remained in the facility. The provided of the Skilled Nursing on on Continued Stay, the ence of R11 decision to submit the content of the submit of the skilled Nursing on on Continued Stay, the ence of R11 decision to submit the content of R11 decision to submit t	21800			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00885	B. WING		06/1	3/2014
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SOUTHS	SHORE CARE CENTE	R	GTON, MN	DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21800	Continued From page 54		21800			
	During interview on 6/13/14, at 1:45 p.m., accounts receivable (AR)-G stated she received the denial notice only if the decision was marked to submit the bill.					
	of nursing verified F Nursing Facility Det lacked decision to s Medicare for review RN-C was responsi During interview at	6/13/14, at 1:59 p.m., director R51 and R11, facility Skilled termination on Continued Stay submit or not submit the bill to a. Director of nursing identified ble for the denial letters. that time, RN-C verified the submit or not submit the bill.				
	The administrator of policies and proced the appropriate liab Medicare services a are acted upon. The all appropriate staff	HOD OF CORRECTION: ould review and revise ures to ensure staff provide ility notices at the end of and to ensure resident rights a eadministrator could educate to provide the liability notices. ould monitor staff compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21870	MN St. Statute 144. Residents of HC Fa	.651 Subd. 18 Patients & ac.Bill of Rights	21870			
	residents shall have	nsive service. Patients and e the right to a prompt and se to their questions and				
	by:	ent is not met as evidenced on interview and document				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SOUTH	SHORE CARE CENTE	R	ITH SHORE I IGTON, MN	DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21870	Continued From pa	ge 55	21870			
	council concerns re call lights were add attempt to be resolvand resident intervi (R33 's family men	ailed to ensure resident elated to timely answering of ressed with a good faith wed. This also included family ews for 12 of 42 residents of the resident of the resi				
	Findings include:					
	Resident Council Minutes were reviewed for April, May, and June 2014. Each monthly meeting minute 's had old business related to call lights not being answered. The April minutes indicated the director of nursing (DON) stated that she would do audits and look for patterns. Meeting minutes of 5/7/14 and 6/4/14 documented current concerns related to call lights not being answered in a timely manner. The 6/4/14 meeting minutes indicated there were no specific times or patterns noted by the residents themselves but stated at times they noted a 40 minute wait for assistance. During an interview on 6/13/14 at 11:00 a.m. the social worker (SW)-A reviewed previous Resident Council Minutes and stated that in February 2014 a discussion of call lights was noted under old business.					
	6/10/14 at 2:42 p.m half an hour for her answered and rece quarterly minimum	er (FM)-A was interviewed on a and stated that it could take mother to have the call light ive help. Review of R33's data set (MDS) dated 4/8/14 red extensive assistance with ing.				
	stated he would ha	ed on 6/10/14 at 2:41 p.m. and ve to wait up to 20 minutes for r the call light. Review of R27				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00005	B. WING			
		00885			06/1	3/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SOUTH	SHORE CARE CENTE	· K	IGTON, MN	DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21870	Continued From page 56		21870			
	s quarterly MDS dated 5/27/14 revealed R27 had diagnoses of dementia, anxiety, and depression and required extensive assist with activities of daily living.					
	stated sometimes had been an hour of	ed on 6/10/14 at 9:18 a.m. and had to wait a while and that it or so. R58 felt the evenings I the time R58 wanted to go to				
	R1 was interviewed on 6/10/14 at 8:46 a.m. and stated that she has had to wait for up to 30 minutes for someone to come to answer the call light. R1 added if a nursing assistant was giving a bath, some nurses would not answer the call lights. Review of R1's quarterly MDS dated 3/25/14 revealed R1 had heart failure and required extensive assistance with activities of daily living.					
	stated that she has in the bathroom an to do that, but it had the morning when a day. R8 added an there (referring to thour.) Review of R revealed R8 had didepression, and his	d on 6/10/14 at 8:50 a.m. R8 had to wait as long as an hour d knew that staff didn't mean ppened. Usually happened in getting up and dressed for the hour was a long time to sit in he sitting on the toilet for an 88's 5 day MDS dated 4/18/14 agnoses of anxiety, story of urinary tract infections sive assistance with activities				
	6/11/14 and the replights had been ala 12:00 a.m. and 11: report indicated an	d the call light audit report for cort indicated a total of 232 call rmed and cleared between 59 p.m. on 6/11/14. The average answer time on 4 and er, 13 or 5.6% of the time the				

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NAME 05		00885	B. WING		06/1	3/2014
	PROVIDER OR SUPPLIER	1307 SQU		STATE, ZIP CODE DRIVE PO BOX 69		
SOUTH	SHORE CARE CENTE	WORTHIN	GTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21870	Continued From pa	ge 57	21870			
	alarm sounded greater than 20 minutes before responded to. The longer waits did not have a time of day patterns and occurred for residents in their rooms, in the bathroom, or on the patio.					
	R33 was designated on the call light report indicated R33 waited 26 minutes on one occasion on 6/11/14. This occurred during the middle of the afternoon. Review of R33's quarterly minimum data set (MDS) dated 4/8/14 revealed R33 required extensive assistance with activities of daily living. On 6/12/14 from 7:55 a.m. to					
	of daily living. On 6/12/14 from 7:55 a.m. to 10:10 a.m. R33 was observed sitting in a recliner, but would not respond when spoken too. At 10:10 a.m. she was noted to be sleeping in the chair. The care conference review dated 4/22/14 indicated R33 required assist of one for transfers and mobility.					
	indicated that R78 occasions. The rep turned on both in th R78 was observed in bed. The care pl R78 required physic up in bed and assis 6/13/14 at 3:00 p.m always answer the takes a long time.	d on the call light report which waited 20 to 27 minutes on two ort indicated the alarms were the morning and in the evening. On 6/12/14 at 8:00 a.m. lying an dated 5/31/14 indicated cal assistance from staff to sit stance to boost up in bed. On a. R78 stated that "they light" but added sometimes it R78 stated that she had been g and had Parkinson's				
	indicated R4 experi minutes on 6/11/14 dated 5/22/14 indic	on the call light report enced a long wait of 21 . R4's significant change MDS ated R4 had arthritis and assistance with activities of				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00885	B. WING		06/1	3/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
SOUTH S	HORE CARE CENTE	R	TH SHORE I	DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	also shared a compreport indicated R7 27 minutes. R75 's dated 4/11/14 indicated 4/11/14 indicated 4/11/14 indicated extensive daily living. The caindicated the bathrohad a call light alarman R66 was designated dated 6/14/14 indicated 6/14/14 indicated R66 had cardiac issues, arth MDS also indicated assistance with activities of daily and 32 minutes. R3 was indicated R3 with activities of daily and 32 minutes. R5/9/14 indicated R3 with activities of daily that included stroke R34 was indicated R6/11/14 indicated R call light to be answ 6/10/14 at 9:50 a.m. The bed was in a lo lipped, and a fall man. the nursing as needed to anticipat not speak English.	d on the call light report and banion room with R4. The call 5 had a call light alarm on for a significant change MDS ated R75 experienced and impaired vision and assistance with activities of all light audit report also born shared by R75 and R4 med for 30 minutes. If on the call light audit report ated R66 had to wait 23 light to be answered. R66 MDS dated 5/12/14 that diagnoses that included writis, and hip fracture. The R66 required extensive divities of daily living. In the call light audit report all light waits of 28 and 33 athroom call light waits of 19 athroom call light waits of 19 athroom call light waits of 19 are and hemiplegia. In the call light audit report and hemiplegia. In the call light audit report of 34 waited 34 minutes for the vered. R34 was observed on and 10:55 a.m. lying in bed. In the was on the floor. At 11:20 sistant (NA) - F stated staff are R34's needs since R34 did are quired extensive assist and 34 required extensive assist	21870			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00885	B. WING		06/1	3/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R 1307 SOU	DRESS, CITY, ST JTH SHORE D IGTON, MN 5	RIVE PO BOX 69		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21870	R28 was included of experienced call light from 23 to 34 minuted 4/29/14 indicated Required extensive daily living. The director of nurse 6/13/14 at 9:15 a.m. light should be answindered for long passive audits. The completed in April 2 longer answering reduction points and the fact identify residents the light answering to a DON also stated the and then the superscall light alarmed are responsible to answered after 5 maudibly page a nurse answer the call light keep notifying RN-C answer. RN-C stat answer the call light The social worker (6/13/14 at 11:00 a.m. council complaint propagation of the call sight stated that in department heads a SW-A stated that in the call stated in the call stated that in the call stat	ge 59 on the call light report and had hts wait times that ranged tes. The quarterly MDS dated 28 had anxiety disorder and assistance with activities of sing (DON) was interviewed on. DON stated she felt the call wered within the first 10 cated she was aware of the elated to call lights not being periods of time and had done only audit she could locate was 2014 and that audit identified esponse in the evening. The ility had a system in place to at had complained about call lert staff of the problem. The at after 5 minutes the nurse visor would be alerted to the not they should then be wer the resident's call light. 3/14 the registered nurse hager indicated that she would page for a call light not inutes. RN-C would then sing assistant of the need to the not. The pager system would contil the call light was ed she would sometimes to if she was not busy. SW)-A was interviewed on m. She indicated the resident rocess would be for the to investigate and respond. June 2014 a more in depth to be completed with more staff				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00885	B. WING		06/1	3/2014
	PROVIDER OR SUPPLIER SHORE CARE CENTE	R 1307 SOU		STATE, ZIP CODE DRIVE PO BOX 69 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21870	members having ac system. SUGGESTED MET The administrator of policies and proced resolution of grieval educate all staff on Assurance Commit compliance.	ge 60 ccess to the call light audit THOD OF CORRECTION: could review and revise lures related to grievances and nces. The administrator could the process. The Quality tee could monitor staff R CORRECTION: Twenty-one	21870			

6899