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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: IYQK

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/26/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Wendy Buckholz, HFE NE II — 10/26/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist 01/03/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245596 November 29, 2017

Mr. Scott Kessler, Administrator
South Shore Care Center
1307 South Shore Drive PO Box 69
Worthington, MN 56187

Dear Mr. Kessler:

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 October 26, 2017 the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
December 4, 2017

Mr. Scott Kessler, Administrator
South Shore Care Center
1307 South Shore Drive PO Box 69
Worthington, MN 56187

RE: Project Number S5596027

Dear Mr. Kessler:

On September 29, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective October 4, 2017. (42 CFR 488.422)

In addition, on September 29, 2017, as authorized by Centers for Medicare and Medicaid Services (CMS), we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 3, 2017. (42 CFR 488.417 (b))

Furthermore, in our letter of September 29, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 3, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on August 3, 2017, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on September 21, 2017. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On October 26, 2017, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on September 21, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 5, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on September 21, 2017, as of October 26, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 26, 2017.

In addition, this Department recommended to the CMS Region V Office the following action related to

the remedy outlined in our letter of September 29, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of this action:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 3, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 3, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 3, 2017, is to be rescinded.

In our letter of September 29, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 3, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 26, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: IYQK

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

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(L2) **201042900**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **9/21/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 10/02/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/4/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

September 29, 2017

Mr. Scott Kessler, Administrator
South Shore Care Center
1307 South Shore Drive PO Box 69
Worthington, MN 56187

RE: Project Number S5596027

Dear Mr. Kessler:

On August 15, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 3, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 21, 2017, the Minnesota Department of Health and on September 20, 2017, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 3, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 12, 2017. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our extended survey, completed on August 3, 2017. The deficiency not corrected is as follows:

F431 -- S/S: D -- 483.45(b)(2)(3)(g)(h) -- Drug Records, Label/Store Drugs & Biologicals

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D).

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective October 4, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 3, 2017. (42 CFR 488.417 (b))

Also, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 3, 2017.

The CMS Region V Office will notify you of their determination regarding our recommendations and appeal rights.

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.

A copy of the Statement of Deficiencies (CMS-2567) have been the electronically delivered.

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, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731 Fax: (507) 206-2711

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,

- Include electronic acknowledgement signature of provider and date.

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 remedy be imposed:

• 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 3, 2018 (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
Health Regulation Division
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 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	R 09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on September 21, 2017, to determine status of deficiencies issued as a result of the survey exited on August 3, 2017. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 431} SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	{F 431}		10/5/17

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

Electronically Signed | 10/02/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	R 09/21/2017

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

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{F 431}	Continued From page 1 (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	{F 431}	R10 and R42 have had their insulin	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	R 09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 2 review, the facility failed to correct and/or maintain labeled medications according to safe and acceptable standards of practice for 2 of 2 residents (R10 and R42) who received insulin after the documented end date of usage. Findings include: On 9/21/17, at 2:43 p.m. the C-wing medication cart was checked for outdated medications. Licensed practical nurse (LPN)-C and surveyor found R10's vial of Lantus insulin was dated with the date of expiration of 9/16/17 and a vial of Humalog insulin was dated with the expiration date of 9/16/17. Also R42's vial of Humalog insulin was dated with an expiration date of 9/16/17. On interview with LPN-C it was learned that both R10 and R42 received the outdated insulin as ordered by the doctor. R10 had physician orders for Lantus Solution 100 units/milliliters (ml) 10 units subcutaneously (SQ) two times a day (BID). This vial of Lantus insulin was dated with the date of expiration of 9/16/17, and according to the electronic medical record (EMR) was last administered on 9/21/17 at 7:00 a.m. The documentation indicated a total of nine doses of Lantus insulin were administered after the documented date of expiration. R10 also had a physician order for Humalog Solution 100 unit/ML six units before meals and an additional four units if blood glucose readings were greater than 500. The Humalog insulin was dated with the expiration date of 9/16/17, and the last date and time of administration was 9/21/17, at 11:00 a.m. The EMR documented a total of 14 doses as having been administered after the date of expiration.	{F 431}	reviewed and expired insulin replaced. They have been evaluated by a physician. Other resident potentially affected by this deficient practice have been evaluated, all insulin reviewed for expiration dates, and corrections made as necessary. Nurses have been in-serviced on 10-2-17 on the importance of verifying that insulin has not expired on checking notated expiration dates, and on the program explained below. A new program has been instituted by the Director of Nursing requiring (2) nurses to verify that any insulin being administered is double checked at the time of drawing it up to insure that it has not expired. All insulin is administered under this double-check practice and nurses will co-sign on a special form created for this purpose that they have reviewed the expiration date together and have verified that insulin is safe to administer and not expired. If expired, it will be replaced and the expired insulin destroyed. The Director of Nursing or her designee will audit this double-check process weekly x 4 weeks and then once monthly thereafter; each week, the DON or designee will review both the double -check process in action and the documentation for double-check process on a random day of the week (so nurses will not be aware which day the audit will occur). This same process of random dates selected will occur when the audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	R 09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 3 R42 had physician orders for Humalog solution 100 units/ML 10 units SQ at 5:00 p.m. and 8 units SQ BID at 7:00 a.m. and 11:30 a.m. This multidose vial of Humalog insulin was dated with an expiration date of 9/16/17, and the EMR listed the most recent dose as having been administered at 11:30 a.m. on 9/21/17, which was a total of 14 doses administered after the documented date of expiration. The director of nursing, (DON) was interviewed on 9/21/17, at 2:50 p.m. and confirmed the three multidose vials of insulin were being administered after the date of expiration. The DON futher indicated she would have expected the date of expiration to be checked prior to administration of each dose of the ordered insulin and the vials replaced after the noted date for expiration. The DON further indicated there was not a specific policy/procedure for insulin use once it was opened, but the facility followed the manufacture's guidelines which indicated: Lantus (insulin glargine injection) solution for subcutaneous injection, identified in-use (opened) had a expiration date of 28 days. Humalog insulin (Insulin Lispro -Human) solution for subcutaneous injection, (opened) had an expiration date of 30 days from the date of opening.	{F 431}	switches to monthly. The DON will report quarterly to the QA Committee on this process.	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: IYQK

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/03/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **54** (L18)
13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE-NE II 08/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 09/12/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 15, 2017

Ms. Linda Unger, Director of Nursing
South Shore Care Center
1307 South Shore Drive PO Box 69
Worthington, MN 56187

RE: Project Number S5596027

Dear Ms. Unger:

On August 3, 2017, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (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 September 12, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 November 3, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 3, 2018 (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
Health Regulation Division
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 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/03/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 312 SS=E	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide assistance with shaving as directed by the care plan for 3 of 3 residents (R17, R57, R38 assessed for activities of daily living (ADL). Findings include: R17's admitted to facility on 04/15/17, with primary diagnosis of Dementia. R17's quarterly Minimum Data Set (MDS) dated 7/11/17, indicated severe cognitive impairment and extensive assist with personal hygiene to include shaving.	F 312	It is the facility's policy that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. R-17 and R-57 were provided shave on 8/2/17. R-38 has been provided shave on her scheduled bath day. Other residents with the potential to be effected by this deficient practice were reviewed and shaving provided as needed and requested. Nursing staff were trained on 8/23/17 on the personal shave document stated below and on the handbook for men and	9/12/17

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

Electronically Signed | 08/23/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/03/2017

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F 312	Continued From page 1 The care plan dated 7/12/17, identified R17 with activity of daily living self-care performance deficit related to decreased function and decline in cognition. Indicating, that R17 requires extensive assistance from one staff with personal hygiene, including shaving. During observation 8/1/17, at 11:47 a.m., R17 was noted to have a unshaven white hairs on her chin R17 is non-verbal. During subsequent observations on 8/2/17, at 10:31 a.m. while sitting under hairdryer in hallway on wing C and again on 8/2/17 at 11:27 a.m. was noted to have chin hairs. On 8/2/17 at 1:53 p.m. R17 is lying in bed resting and continued to have unshaven white hairs on her chin. When interviewed on 8/2/17, at 2:01 p.m., nursing assistant (NA)-E stated that normally I would shave residents in the morning when a.m. cares are provided, but sometimes I will do it in the afternoon if I notice that it was not done. R57's quarterly Minimum Data Set (MDS) dated 5/2/17 indicated moderate cognitive impairment and extensive assist with personal hygiene to include shaving. The care plan dated 8/2/17, identified R57 with vascular dementia and required that with personal hygiene the resident requires assist of 1 staff to ensure adequate job is done. During observation on 8/1/17, at 8:55 a.m., R57 was noted to have unshaven hairs on her chin and her upper lip. R57 stated, "They usually help me shave those hairs, but I think they forgot this time." During subsequent observations on 8/2/17 at 7:59 a.m., and on 8/2/17 at 1:53 p.m., R57	F 312	women with regard to shaving also stated below and on the new program and updated policy that goes along with them. The facility procedure for personal grooming was revised on 8/18/17 to include that staff document completion of personal shave on the Skin Care Alert document which is completed on each residents bath day. The Unit Manager is responsible to review these documents to ensure that shaving has been done according to resident wishes (resident wishes are recorded in their care sheets and care plan with regard to shaving) The Resident Handbook was also updated to include that electric shaver for men and women who wish to shave is included in supplies provided by the facility. Unit charge nurses are responsible for monitoring for routine compliance. The Director of Nursing will randomly audit weekly x 4 and then monthly thereafter through rounding on nursing units to insure that necessary services to maintain good grooming are provided with resident cares. The results of monitoring will be provided to the Quality Assurance Committee at its next quarterly meeting. The Quality Assurance Committee will determine if further interventions or monitoring are necessary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 2 continued to have long unshaven hairs on her chin and upper lip. When interviewed on 8/2/17, at 1:53 p.m., nursing assistant (NA)-A stated that they shave residents every day with morning cares. NA-A verified R57 did need to have her chin and upper lip shaved. During interview on 8/2/17, at 1:55 p.m., licensed practical nurse (LPN)-A stated her expectation is that residents with facial hair should be shaved daily. "Especially women." When interviewed on 8/2/17, at 2:01 p.m., director of nursing (DON) stated her expectation is for every resident to be shaved daily if there is facial hair. R38's quarterly MDS dated 6/27/17, indicated moderate cognitive impairment and extensive assist with personal hygiene-shaving. R38's care plan dated 6/27/17, indicated an intervention of extensive assist of 1 staff with personal hygiene-shaving. On 8/1/17, at 9:42 a.m., R38 noted to have unshaved facial hairs on chin and upper lip. During subsequent observations on 8/2/17, at 7:33 a.m., and 8/2/17, and 1:40 p.m., R38 continues to have unshaven facial hairs on her chin and upper lip. When interviewed on 8/2/17, at 1:53 p.m., nursing assistant (NA)-A stated that they shave residents every day with morning cares. During interview on 8/2/17, at 1:55 p.m., licensed practical nurse (LPN)-A stated her expectation is	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 312	Continued From page 3 that residents with facial hair should be shaved daily. "Especially women." When interviewed on 8/2/17, at 2:01 p.m., director of nursing (DON) stated her expectation is for every resident to be shaved daily if there is facial hair. Received undated policy for "Care of Female Facial Hair" which indicates the purpose of this procedure are to provide appropriate care for female residents with facial hair.	F 312		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and	F 431		9/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/03/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 4 that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications used for 11 of 11 residents (R77, R79, R50, R89, R82, R26, R76, R75, R18, R24 and R100) had not outdated when given, also to remove outdated medications from access/use for residents who utilized pain medication and hepatitis vaccination, and failed to label medications such as eye drops and nasal sprays with open dates to determine when the	F 431	It is the facility's policy that drugs and biological used in the facility be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. On 8/18/17 all medication carts, and medication storage areas were audited by licensed staff, all drugs and biological	

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F 431	Continued From page 5 medications are outdated for 6 of 6 resident (R7, R54, R43, R23, R13 and R10), this had the potential to deliver expired medication. Findings include: On 8/2/17, at 11:30 a.m. the A/B wing medication storage room was reviewed with registered nurse (RN)-B. A single small refrigerator was opened and inspected which identified three boxes of multi-dose Aplisol solution. Inside each box contains a small bottle of the Aplisol solution. Two boxes/bottles were inspected and found opened with no information to identify when the boxes/bottles were opened, both delivered to the facility 4/4/17, the third box/bottle was inspected finding opened date of 4/3/17. Two bottles with lot numbers 602079 and 802079, the third box lot number 802078. Immediately following the observation, RN-B stated she would review the expiration date on the box as to when the solution should be used by. RN-B was asked who received the solution, RN-B stated it is given to new residents and new employees. A request of all residents who were admitted and received the Aplisol solution on and/or after 5/3/17 outdate was obtained and reviewed. Lot 802079 was administered once to R79, R26, R82, R100, R18 and R75 and three times to R76, two times to R77, lot 802078 was administer once to R26 and R76 and lot 602079 was administered once to R24, R89 and R76 and twice to R50. On 8/2/17 at 10:50 a.m. the C wing medication cart was reviewed with RN-A. A single/double	F 431	were checked to insure that open dates, expiration dates were applied in accordance with professional principles. Any medication which did not meet professional principles were destroyed according to facility procedures. Nurses will be in-serviced by 8/31/17 on the importance of making sure no outdated medications are on the med carts, that open dates and expiration dates are managed according to policy. They will also be trained to properly destroy outdated narcotics or those no longer in use as per policy. The elements of the policy will be taught upon at the meeting. All facility stock drugs and biological will be audited bi-monthly to insure prevention of expired medication on stock shelves. An audit form for this procedure has been developed by the DON. Licensed charge nurses will audit carts daily during medication pass to insure medications currently in the cart meet accepted professional principles. A full audit of medication carts and storage areas will be completed monthly during medication change over as a second check and balance. Unit charge nurses will be responsible to monitor facility compliance for medication labeling in accordance with currently accepted professional principles. Audits will be shared with the QA Committee. The Quality Assurance Committee will review concerns and determine the need for further interventions or monitoring.	

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F 431	Continued From page 6	F 431		

locked mediation cart was inspected which identified eye drops and nasal sprays were found open however, on open date was present. Two eye drops medication were for R7 and R54 and 7 nasal sprays medication for R54, R42, R23, R13 and R10 were identified.

In addition on cart C, there was a bottle of pain relief medication (generic Tylenol) with a cap that read stock with the date 7/8/17 upon further examination of the bottle found the manufacturers expiration date was 2/2017.

Additional finding on the C wing included the inspection of a single refrigerator with RN-A finding syringes of vaccination for Hepatitis B delivered from the pharmacy on 6/4/15, with an manufacturers expiration date of 1/24/17.

An interview on 8/2/17 at 1:38 p.m. with Director of Nursing (DON) stated the expectation is for staff to check for expiration dates and opened dates on medications before administering. DON stated the monitoring of the carts and medications room occur on a regular bases but was not able to provide audits of the monitoring, DON stated will be speaking with pharmacy to help with additional checks.

An interview on 8/2/17 at 2:23 p.m. with the consultant pharmacist stated the procedures and policies are supplied to the facility of the proper procedure on how to handle medications. The pharmacy also supplies "date open" stickers which are placed the medication before being dispensed to the facility. Pharmacist verified the Aplisol solution has an expiration of 30 days once opened. The manufacturer's expiration date will go in place unless opened. Pharmacist also

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F 431	Continued From page 7 verified the importance of the facilities to mark when opened. On 7/20/17 at 11:24 a.m. consulting pharmacist was contacted and verified the Tubersol once opened should be discarded after 30 days. Pharmacist stated the manufacturer box reads discard after 30 days once opened A policy reviewed Storage of Medications undated reads; the facility shall not use discontinued, outdated, or deteriorated drugs. A policy review Labeling of Medication undated reads; all mediations maintained in the facility shall be property labeled in accordance with the current state and federal regulations. Labels for individual drug containers shall include all necessary information, such as: the date that the medication was dispensed.	F 431		
F 456 SS=E	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain essential walk-in refrigeration equipment with cold food storage in safe operating condition with the potential to affect 38 of 39 residents.	F 456	It is the facility's policy to maintain all mechanical, electrical, and patient care equipment in safe operating condition. On 8/14/17 maintenance personal installed the plastic curtain inside the walk	9/12/17

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F 456	Continued From page 8 Findings include: During observation on 7/31/17, at 6:41 p.m., dietary service manager (DSM) was having a hard time opening the walk-in freezer. DSM states, "It gets stuck sometimes." The freezer door was opened and there was visible frost built up on the left side of the door jam, the metal shelves on the left hand side, and the left side of the floor. Further noted the plastic curtain was broken off inside and a portion of the top rubber seal around the door was noted to be missing. During interview on 7/31/17, at 7:32 p.m., DSM verified the frost build up inside the walk-in freezer. She stated last Tuesday freight (food) was delivered and there was not a frost build up of ice at that time. DSM further stated, "During the summer months the freezer likes to freeze shut." DSM stated she has not seen a plastic curtain on the freezer door in the twenty-two years of working at the facility. Review of monthly temperature logs of the walk in freezer for May, June, and July, 2017, there was no internal temperatures of the walk in freezer recorded. Interview on 8/2/17, at 8:32 p.m., DSM verified there were no internal temperatures recorded for the walk in freezer for the last 3 months. On 8/2/17, at 8:35 p.m., DSM could not get the door to the walk in freezer open and DSM asked the cook (C)-A to open the door. C-A took a long handled ice scraper and put it in between the frame and the left side of the freezer door and wedged it loose. Then the door was able to be	F 456	in freezer. A seal was ordered and shipped to the facility and installation of the replacement seal occurred on 8/19/17. Temperature (inside and outside) the walk in freezer is located in a notebook in the kitchen. Logging of temperatures is to be completed by the kitchen staff twice a day. The kitchen cook is assigned the responsibility to log temperatures and document any potential problems identified such as frost build-up, difficulty opening the freezer door, or evidence of condensation inside the walk in freezer. The dietary manager will conduct an in-service to dietary personal on 8/31/17 to review roles and responsibilities regarding their part in maintaining all mechanical, electrical, and patient care equipment in safe operating condition. The dietary manager will be responsible for monitoring facility compliance. The Quality Assurrance Committee will review concerns and determine the need for further interventions or monitoring	

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F 456	Continued From page 9 opened. There was a large amount of frost all alongside the rubber seal of the freezer door, the inside of the freezer door, and to the left side of the door on the floor. During interview on 8/2/17, at 8:48 a.m., maintenance supervisor (MS)-B stated he first heard about the problems with the walk in freezer about 3 weeks ago. MS-B further stated the air conditioning unit in the kitchen has not worked since last summer, so we had to put window air conditioning units in until we get approval from corporate to have it fixed. MS-B went on to state that the window air conditioners are not as affective to lower humidity levels so it build up in the kitchen. The "main culprit," with the walk-in freezer is the humidity in the basement. MS-B verified that staff have been using the long handled ice scraper to get the freezer door opened when it freezes shut. The moisture gets in between the seal in the door, the seal gets damp with condensation and it freezes the door shut. A policy on maintenance on refrigeration systems was requested and was not received.	F 456		

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	245596	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/01/2017**

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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. At the time of this survey, South Shore Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 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 By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/23/2017

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.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@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 54 beds and had a census of 39 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 346 SS=D	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of	K 346		9/12/17

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K 346	Continued From page 2 services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Alarm Out of Service Policy. This deficient practice could effect 39 of the 39 residents. Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 FINDINGS INCLUDE: On facility tour between 9:00 AM and 1:00 PM on 08/01/2017, documentation review revealed that the Out of Service Policy for the Fire Alarm System does not have current Staff/Fire Marshal contact information. This deficient practice was verified by the Facility Maintenance Director.	K 346	It is the facility's policy to ensure that residents, staff and visitors are protected and that a safe environment is maintained during periods in which the building fire alarm system and/or fire sprinkler system is out of service. On 8/21/17 the facility updated/revised the Fire Alarm System Out of Service policy and procedure. Revision included identification of the current Administrator and as well as the current Deputy State Fire Marshal. The facility will post the updated policy at each nurses station in the Emergency Preparedness Manuel. The updated policy will also be posted in the employee break room for staff review. The facility Administrator will monitor the facility compliance. The Quality Assurance Committee will review and determine the need for further interventions or monitoring.	
K 354 SS=D	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the	K 354		9/12/17

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K 354	Continued From page 3 extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Sprinkler Out of Service Policy. This deficient practice could effect 55 of the 55 residents. Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Findings include: On facility tour between 9:00 AM and 1:00 PM on	K 354	It is the facility's policy to ensure that residents, staff and visitors are protected and that a safe environment is maintained during periods in which the building fire alarm system and/or fire sprinkler system is out of service. On 8/21/17 the facility updated/revised the Fire Sprinkler System Out of Service policy and procedure. Revision included identification of the current Administrator and as well as the current Deputy State Fire Marshal. The facility will post the updated policy at each nurses station in the Emergency Preparedness Manuel. The updated policy will also be posted in the employee break room for staff review. The facility Administrator will monitor for facility compliance. The Quality Assurance Committee will review concerns and determine the need for further interventions or monitoring.	

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K 354	Continued From page 4 08/03/2017, documentation review revealed that the Out of Service Policy for the Fire Sprinkler System does not have current Staff/ Fire Marshal contact information and the 10 hour out of service time needs to be updated. This deficient practice was verified by the Facility Maintenance Director.	K 354		
K 911 SS=E	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This STANDARD is not met as evidenced by: Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Findings include: On facility tour between 9:00 AM and 1:00 PM on 08/01/2017, during the inspection, a surface mount electrical outlet in Resident Room 213 was observed pulled away from the wall. This deficient practice was verified by the Facility Maintenance Director.	K 911	It is the facility's policy to ensure that residents, staff and visitors are protected and that a continuous safe environment is maintained. On 8/1/17 it was observed that a surface mount electrical outlet in resident room 213 had been pulled away from the wall. Upon discovery the facility contacted the Worthington Electric Company who came to the facility and repaired the damaged outlet. The room arrangement was reviewed to determine if re-location of the resident bed would minimize potential repeat incident. Based on resident needs for bed mobility and transfers the bed was moved to promote ease with mobility/transfers as well as minimize potential for recurrence of outlet damage. The maintenance supervisor will be	9/12/17

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K 911	Continued From page 5	K 911	responsible to monitor facility compliance. The Quality Assurance Committee will review concerns and determine the need for further interventions or monitoring.	