Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 17, 2023

Administrator
South Shore Care Center
1307 South Shore Drive
Worthington, MN 56187

RE: CCN: 245596
Cycle Start Date: March 29, 2023

Dear Administrator:

On March 29, 2023, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 June 29, 2023 (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).

In addition, if substantial compliance with the regulations is not verified by September 29, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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 ______	C 03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	**1307 SOUTH SHORE DRIVE 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
E 000	Initial Comments On 3/27/23 through 3/29/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/27/23 through 3/29/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H5596041C (MN82202) and H5596042C(MN80797). The facility is enrolled in ePOC, therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/24/2023

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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F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures.	F 636		4/24/23

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F 636	Continued From page 2 (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed complete a comprehensive and/or quarterly nutritional assessment for 4 of 4 residents (R5, R10, and R25). Findings include: R5 had a significant change Minimum Data Set (MDS) scheduled with an assessment reference	F 636	F 636 R5 quarterly nutritional assessment was completed on 3/27/2023. R5 MDS dated 1/6/2023 will be modified. R5 oral assessment will be created in a nurse progress report. R10 MDS's for 12/19/22 and 1/12/2023 were modified and a nutritional assessment was completed on	

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F 636	Continued From page 3 date (ARD) of 1/6/23. R5 had no nutritional data assessment completed that identified if food intake had declined, weight loss had occurred, mobility status identified, if resident suffered psychological stress, and neuropsychological problems were identified, or the current Body Mass Index (BMI) had been determined to identified malnutrition or risk of malnutrition. There had been no documented assessment to answer section K swallowing/national status and section L oral/dental status of the MDS. R10 had the following MDS's scheduled: significant change MDS with ARD of 5/12/22. A quarterly MDS with ARD of 11/23/22. A significant change MDS with ARD of 12/19/22. A significant change MDS with ARD of 1/12/23. There were no national data assessments completed for the scheduled MDS's that identified if food intake had declined, weight loss had occurred, mobility status identified, if resident suffered psychological stress, if neuropsychological problems were identified, or the current Body Mass Index (BMI) had been determined to identified malnutrition or risk of malnutrition. There had been no documented assessment to answer section K swallowing/national status and section L oral/dental status of the MDS. Further identified was a quarterly MDS with ARD of 2/3/23 however, the national data assessment had been completed after the assessment reference date (ARD) on 2/8/23. R25 had the following MDS's scheduled: Annual MDS with ARD of 12/18/22. Significant change MDS with ARD of 12/20/22. Significant change MDS with ARD of 1/10/22. There were no national data assessments completed for the scheduled MDS's that identified if food intake had declined,	F 636	2/8/23 and will be completed again during the next ARD date. R10 will have an oral assessment completed in a nurse progress note. R25 MDS's dated for 12/18/22, 12/20/22 and 1/10/23 will be modified. R25 will have an oral assessment completed in a nurse progress note. All current residents were reviewed for nutritional assessment completion and the Resident Quarterly Review, and any missing assessments will be completed. Future residents who admit to the facility will have a nutritional assessment completed along with an oral assessment that is incorporated in the nursing admission processes. The nutritional assessment will be completed quarterly along with the Resident Quarterly Review which includes the oral assessment per RAI timeframe guidelines and facility policy. Dietary Manager was in-serviced on the Documenting in the Medical Record policy with emphasis on item #'s 1 & 2 that all pertinent information related to the resident nutritional status must be documented as changes occur and that the documentation must be timely. The MDS Coordinator was also in-serviced on the MDS Submission Timeframe Policy with emphasis on item #2 ensuring that assessments are completed and submitted timely. Director of Nursing and/or designee will be responsible for compliance. Audits on nutritional assessment timely	

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F 636	Continued From page 4 weight loss had occurred, mobility status identified, if resident suffered psychological stress, if neuropsychological problems were identified, or the current Body Mass Index (BMI) had been determined to identified malnutrition or risk of malnutrition. There had been no documented assessment to answer section K swallowing/national status and section L oral/dental status of the MDS. Interview on 3/29/23 at 10:39 a.m., with assistant director of nursing (ADON) identified she was responsible for scheduling the MDS's and once she had a schedule, she would email that schedule out to all departments. She reported if there was a change and a significant change MDS was scheduled, she would send out an email with the updated information. She reported all department managers had the MDS schedule so they are aware of when the assessments were due and the MDS had to be completed. She confirmed that the dietary department manager was included in email with the MDS schedule. Interview on 3/29/23 at 12:27 p.m., with certified dietary manager (CDM) confirmed that there was an email that notified all departments of the MDS schedule for the month and when assessments are due. She reported she tries to complete on the day they are due or the next day. She revealed she worked at both facilities and had been "short staffed" and needed to work in the kitchen so she was be behind. She confirmed she should have completed an assessment for the above-mentioned residents with each scheduled MDS and was unaware she had missed "that many". She identified when completing an assessment for a significant change MDS she does a more detailed assessment and reviews	F 636	completion and oral assessment completion will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 5/1/2023	

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F 636	Continued From page 5 more information than she does on a quarterly assessment but the national data assessment questions on the form were the same. She confirmed that the information that she entered was obtained from the assessment she completed. Interview on 3/29/23 at 2:16 p.m., with director of nursing (DON) identified that the ADON sends out the MDS schedule every month to all the department managers. The ADON updates the MDS schedule and re-sends with any changes such as scheduling a significant change MDS. The expectation was that each department manager completes their required assessments in order to complete the MDS. She further identified that the schedule was emailed each month to ensure that all departments know the ARD and when their assessments are due to ensure timely completion of the MDS. She confirmed that dietary department had been behind with working both buildings and covering the cook position for a while. Interview on 3/29/23 at 2:27 p.m., with administrator who agreed that assessments should be completed and completed timely in order to complete the MDS. He reported that the CDM worked both facilities and as a cook which "pushed some things to the back burner". The CDM had recently hired a cook which he felt should help. He further, revealed the facility was in between dieticians with a consulting dietician covering until the new dietician was able to start in May. He revealed he suspected things had been missed during this transition and was not surprised that assessments had been missed. Review undated, Resident Assessment policy	F 636		

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F 636	Continued From page 6 identified that comprehensive assessments of each residents needs are made at intervals designated by OBRA and PPS requirements. The interdisciplinary team conducts timely and appropriate resident assessments and reviews. Review of undated, Medicare Reimbursement Resource Manual Team Processes and Documention policy identified each discipline completes assessments prior to or on ARD of the MDS. Each quarter or as needed the care plan should be updated to be consistent with the assessments to ensure the development of a resident specific care plan.	F 636		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:	F 676		4/24/23

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F 676	Continued From page 7 §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a method to communicate effectively with a non-English speaking resident, and educate staff on identified communication needs for 1 of 1 resident (R27) reviewed for communication. Findings include: R27's 1/10/23 Significant Change Minimum Data Set (MDS) identified that R27 needed or wanted an interpreter to enable communication with her doctor or health care staff. She required supervision with oversight or cueing for bed mobility, transfers, and toileting, and required extensive assist of 1 staff for dressing. R27's undated care plan, identified a communication problem related to a language barrier as the resident spoke Laotian. The care plan identified staff were to communicate with R27 by use of the language line, her daughter, or	F 676	F 676 R27 communication care plan was reviewed and updated to include use of the language app on facility iPad for communication purposes. All other residents were reviewed for communication language barriers and their care plans were reviewed and updated as needed. For future residents who admit with a language barrier, the facility staff will utilize the language line and/or facility provided language translator app. Facility staff will be in-serviced on the Translation and/or Interpretation of Facility Services policy with emphasis on item #13 asking if family members can interpret and utilizing the language line and/or facility provided language translator app. Director of Nursing and/or designee will	

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F 676	Continued From page 8 by using a picture board located in R27's room. Interview on 3/27/23 at 5:40 p.m., with family member (FM)-A reported R27 neither spoke or understood the English language. Her primary language was Laotion and that made it difficult for her to communicate her needs or preferences to staff. FM-A reported R27 had expressed that she did not want male caregivers and that she would like to take more frequent baths. Due to her communication barrier she had not been able to communicate these preferences with staff. Interview on 3/29/23 at 7:46 a.m., with R27 using the assistance of the Language Line she communicated she was neither able to understand staff nor were they able to understand her. R27 reported she would prefer staff to use an interpreter to clarify communication. R27 also repeated that she preferred to not have a male caregiver. Interview on 3/29/23 at 10:33 a.m., with NA-C reported that she communicated with R27 by pointing and using hand gestures. NA-A also reported a communication binder was located in R27's room but she had not used it and or been trained on how she should communicate with R27. Interview on 3/29/23 at 10:39 a.m., NA-B reported that she communicated with R27 by pointing and making hand gestures and agreed it would have been helpful to have an interpreter. She further reported R27 would ask a second Laotian speaking resident to relay information for her when staff had not been able to understand her. Interview on 3/29/23 at 2:56 p.m., with the	F 676	be responsible for compliance. Audits on communication care plans and staff competency of utilizing the language line and facility provided language translator app will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 5/1/2023	

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F 676	Continued From page 9 administrator reported the facility had an interpreter available through a language line and it was his expectation for staff to utilize the language line for communication with non-English speaking residents. Review of the undated facility policy Translation and/or Interpretation of Facility Services identified neither family members or friends were to be relied on for interpretation services of residents that are non-English speaking. The facility policy further identified that providing meaningful access to services provided by the facility required the individual with limited English proficiency (LEP) resident's needs and questions are accurately communicated. Oral interpretation services therefore include interpretation from the LEP resident's primary language back to English. It is understood that in order to provide meaningful access to services provided by this facility, translation and/or interpretation must be provided in a way that is culturally relevant and appropriate to the LEP individual.	F 676		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		4/24/23

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	245596	A. BUILDING ______ B. WING ______	C 03/29/2023

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F 812	Continued From page 10 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure food products with an expiration date or "use by" date were disposed of after expiration date. This had the potential to affect all 32 residents who consumed food products from the kitchen. Findings include: Observation and interview on 3/27/23 at 11:00 a.m., with dietary cook-A during initial tour of the kitchen identified in the walk- in cooler: 1) a box with receive date of 2/7/23, that contained 2 packages of beef patties with the label of the box damaged so no identified expiration date. 2) a box with receive date of 3/2/23 that contained two 5 pound packages of hamburger that identified a use date or freeze date of 3/22/23. 3) a box with a receive date of 2/7/23., that contained 3 packages of sliced corn beef that identified use date or freeze date of 2/26/23. 4) 1 package of sliced ham sitting on shelf with expiration date of 11/30/22, that contained a white milky substance within the package. 5) a box with a receive date of 3/7/23, that contained 1 package of roast beef sandwich meat with a use by or freeze by date of 3/19/23. 6) 3 gallons of chocolate milk with expiration date	F 812	F 812 All outdated food was removed from the facility dietary department. A new order for replacement items was created and items were delivered. Facility resident documentation was reviewed from survey exit through 3/31/2023 and there was no adverse reaction to this deficient practice. For future food storage, food items will be dated and stored per facility policy. Dietary department staff were in-serviced on the Food Storage Policy with emphasis on item #7 that stock must be rotated with each new order received, old stock used first and food must be dated when placed on the shelves. Dietary Manager and/or designee will be responsible for compliance. Audits on food storage will begin 2x week for 2 weeks, weekly x 4 weeks, then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and recommendation.	

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F 812	Continued From page 11 of 3/1/23. 7) Also observed in the walk-in cooler was a 5 gallon bucket catching water leaking from the sprinkler head located on ceiling when you first enter the walk-in cooler with water standing on the floor around the bucket. Towards the back of the walk-in cooler was more standing water on the floor with a second sprinkler leaking water from the ceiling. Interview with dietary cook-A revealed that the product came in, it was dated when received, and was placed in the walk-in cooler. She revealed that the meat should have been frozen when delivered and that staff should only be taking out what was needed for the menu to thaw for use. She confirmed the expired ham sandwich meat contained a white milky substance and was not editable. She confirmed the products were expired and should not be used since all identified products had pasted there "use by" date and had not previously been frozen. She reported that the Maintenance director and administrator were aware of the leaking sprinklers in the walk-in cooler. Interview on 3/28/23 at 10:12 a.m., with certified dietary manager (CDM) confirmed that the meat should have been frozen when delivered and not been left in the cooler. She further confirmed that only what was needed for the menu should have been thawing in the cooler. She revealed there was no process or policy to monitor for expired foods but would be creating a process. Interview on 3/28/23 at 2:43 p.m., with consulting dietician identified staff should be checking for expired products each time and using first in products first. He confirmed any item that was found to be expired should be eliminated. He	F 812	Compliance: 5/1/2023	

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F 812	Continued From page 12 revealed staff should be able to see by the menu what is needed and have that in the cooler thawing. He confirmed products that are able to be frozen and come in bulk supply should be frozen and staff should only be thawing what is needed for the menu. Interview on 3/29/23 at 2:16 p.m., with director of nursing (DON) revealed her expectation would be that there was a process for monitoring for for expired foods to ensure no expired foods were served. Interview on 3/29/23 at 2:27 p.m., with administrator agreed that there should be a process for monitoring for expired foods. He revealed that the dietary manager should be providing oversight to ensure no expired foods were served. Review of 8/3/22, Food Storage policy identified perishable food such as meat, must be frozen or stored in refrigerator immediately after receipt. Safe thawing for frozen meat should be defrosted in a refrigerator for 24 to 48 hours and should be used immediately after thawing.	F 812		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/27/2023. 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/18/2023

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. This 2-story facility with partial basement was built 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 facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 51 beds and had a census of 32 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________ b) Who provided system test _________________ c) Water system supply source ________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.7, 9.7.8, and NFPA 25 (2011edition), sections 5.2.1.1.1 and 5.2.1.1.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K 353	1. Facility maintenance man contacted Midwest Mechanical on 3/27. 2. Midwest Mechanical technician arrived on 4/3 and inspected the sprinkler system and the two sprinkler heads in the the kitchen cooler. The technician did not detect a leak in the system and determined the leak was coming in from the outside through the roof of the cooler.	4/18/23

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K 353	Continued From page 3 On 03/27/2023 at 11:30AM, it was revealed by observation that the two fire sprinkler heads inside of the kitchen cooler were leaking water from above the actual sprinkler head. There was heavy rust build up on one of the protective covers giving the appearance that it may be rusted to the point that it would not open to allow water to flow from the sprinkler head. An interview with the Facility Maintenance Director verified this deficient finding at the time of discovery.	K 353	The technician also installed a new protective cover on each sprinkler head. 3. Facility maintenance man replaced and caulked around the seals of the sprinkler system pipes on the roof of the cooler on 4/11. 4. Facility maintenance man will periodically inspect and monitor the condition of the seals and caulk to ensure there is no leakage. 5. Date of compliance 4/11/2023.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire dampers per NFPA 101 (2012 edition), Life Safety Code, sections 19.5.2.1 and 9.2.1, and NFPA 90A (2012 edition), Standard for the Installation of Air-Conditioning and Ventilating Systems, section 5.4.8.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives 19.4.1.1. This deficient finding could have a widespread impact on the	K 521	1. Facility maintenance man contacted Johnson Controls on 3/27. 2. The Johnson Controls technician arrived on 4/11 and performed a visual and manual inspection of the HVAC fire damper. 3. Facility maintenance man told the technician to put the facility on their calendar for inspection of the HVAC fire damper every 4 years per code	4/18/23

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K 521	Continued From page 4 residents within the facility. Findings include: On 03/27/2023 at 12:00PM, it was revealed that a HVAC fire damper inspection had not occurred within the required 4 year time period. The last fire damper inspection took place on August 28, 2018. An interview with the Maintenance Director verified this finding at the time of dsicovery.	K 521	requirement. Next inspection will be no later than 4/11/2027. 4. Facility maintenance man will monitor for compliance. 5. Compliance date 4/11/2023.	