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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QM88

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 **11/5/2016** (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:

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

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 :
Gary Nederhoff, Unit Supervisor 11/9/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/09/2016 (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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245596

November 9, 2016

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

Dear Mr. Buchanan:

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 November 1, 2016 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
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 9, 2016

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

RE: Project Number S5596026

Dear Mr. Buchanan:

On October 7, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 22, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 5, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 7, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 22, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 1, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 22, 2016, effective November 1, 2016 and therefore remedies outlined in our letter to you dated October 7, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245596 (Y1)	A. Building B. Wing (Y2)	11/5/2016 (Y3)

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156 Reg. # 483.10(b)(5) - (10), 483.10(b)(1) LSC	Correction Completed 11/01/2016	ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 11/01/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 11/01/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	11/09/2016	10160	11/5/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/22/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245596 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/7/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0029	11/01/2016	LSC K0034	11/01/2016	LSC K0038	11/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0050	11/01/2016	LSC K0072	11/01/2016	LSC K0104	11/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0147	11/01/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	11/9/2016	35482	11/7/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/23/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QM88

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 **09/22/2016** (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 :
Christina Smith, HFE NE II 10/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/08/2016 (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)

Posted 11/10/2016 Co.

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 7, 2016

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

RE: Project Number S5596026

Dear Mr. Buchanan:

On September 22, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the September 22, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5596019 that was found to be unsubstantiated.

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
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 1, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 1, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 22, 2016 (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 March 22, 2017 (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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. 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,

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

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 _____	09/22/2016

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. "A recertification survey was conducted and complaint investigation had been completed at the time of the standard survey." An investigation of complaint H5596019 was completed and found not to be substantiated.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is	F 156		11/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/12/2016

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 _____	09/22/2016

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 156	Continued From page 1 entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone	F 156		

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F 156	Continued From page 2 numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident received the required liability notice (CMS 100123) two days before ending services and the appeals notice for 1 of 3 residents (R11) reviewed for liability and beneficiary rights. Findings include: R11's entry tracking record Minimum Data Set completed same day of admission which was	F 156	1. Resident 11 is capable of being his or her own decision maker. On 10/11/16 the resident care coordinator (MDS Nurse) and social worker explained to resident that we had failed to have her sign the CMS liability and appeals notice two days prior to the resident's services ending. The resident care coordinator and social worker did have resident sign a Medicare liability and appeals notice on 10/11/16 for services ending 7/14/16.	

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F 156	Continued From page 3 6/2/16. Progress Note dated 7/10/16 indicated R11 plateaued with physical therapy/occupational therapy, a Medicare denial was completed (CMS 100123), and R11's family (F)-A was informed via voicemail with instructions to come into the facility to sign the Medicare denial paperwork. On 9/20/16 at 2:28 p.m. when asked for R11's liability forms, the administrator reported R11's Medicare denial (CMS 100123) paperwork was unable to be located. Administrator said R11 had not met the 100 days maximum allowed by CMS. Facility policy, Medicare Policy dated 7/1/16, read; "4. The appropriate denial letter is also initiated on or before the last covered day when medicare skilled level of care is no longer needed and on or before the 100th day of coverage when benefits are exhausted. 5. The resident or the responsible party is notified of last covered day and the right to have bills submitted to Medicare and signs the response to verify notification. 6. If the responsible party is unavailable, attempt is made to notify by phone and documented on the denial letter that an attempt was made with the time attempt was made. 7. A completed denial letter is given to medical records and accounts receivable."	F 156	2. All residents have the potential to be affected. 3. Policy and procedure for providing Medicare Liability and Appeals Notices was reviewed by the administrator and director of nursing by 11/1/16. Education was provided to Resident Care Coordinators (MDS Nurses) as well as the Director of Nursing by Administrator on 9/20/16. A new process was immediately put in place to provide liability and appeals notices to all residents two days prior to resident's Medicare Part A services ending. 4. The Administrator or designee will audit up to 5 random residents weekly for 4 weeks and monthly for 3 months to ensure liability and appeals notices were given and signed two days prior to resident's Medicare services ending. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's	F 157		11/1/16

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F 157	Continued From page 4 physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview facility failed to ensure the medical provider was notified timely of a significant change in health status for 1 of 2 residents (R72) reviewed for a death record. Findings include: R72 was admitted to the facility on 5/6/16, following a hospital stay from 5/1/16 and with a diagnosis found on discharge summary of a stroke, sepsis and pneumonia. R72 had an indwelling bladder catheter placed at the hospital. Discharge summary dated 5/6/16	F 157	1. Resident 72 is deceased. 2. All residents have the potential to be affected. 3. Policy and procedure for notifying medical provider of significant changes in resident condition was reviewed and updated by administrator and director of nursing on 10/10/16. Education was provided to all nurses by the administrator and director of nursing by 11/1/16	

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F 157	Continued From page 5 from the hospital identifies R72's urine was clear and yellow in color. R72 upon admission to the facility had an order for Amoxicillin-Clauvulanate Potassium 875-125 mg tablet by mouth two times daily for a total of nine tablets. R72 was receiving this for pneumonia. Medication administration record (MAR) indicates R72 received all nine tablets as ordered. Progress note dated 5/16/16, at 1:00 p.m. identifies R72 to have blood tinged urine present in the catheter. Progress note also identifies R72 to be refusing to eat more than bites at meals. Fax dated 5/16/16, from facility to the medical provider identifies,"today and over this past weekend resident has only ate bites of meals and drank sips of liquids. Have been offering liquids and supplements in between meals, but often resident refuses or only takes a sip." Fax did not address the presence of blood in the urine. Also there was no response from the medical provider regarding the fax that was sent. Facility unable to provide any further documentation of follow up with medical provider to determine if he received the fax and wanted to make changes to current orders. The doctor was faxed again on 5/17/16, regarding, "resident seized [sic] breathing and no vital signs present at 7:15am [a.m.]." Interview on 9/21/16, at 3:15 p.m. with the director of nursing (DON) stated the physician should have been notified immediately with the change in condition when it first began in regards to not eating/drinking well and blood in urine. DON stated a fax is sent first. If a response is not received another fax can be sent. DON stated the expectation is if staff do not get a response from the medical provider by fax a phone call should be placed.	F 157	regarding timely notification of medical provider in the case of a significant change in a resident's condition. This training included a review of our process of notifying the medical provider, and procedure for what to do if the medical provider is unavailable or does not respond timely to the notification from us. 4. Audits will be completed by the director of nursing or designee on 5 random residents weekly for 4 weeks and monthly for 3 months to ensure that any significant change within the past 30 days was reported timely to the medical provider and to ensure proper procedure was followed. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting.	

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F 157	Continued From page 6 Policy titled Clinical Monitoring/Condition charting policy/procedure, dated 7/1/16, identifies residents who demonstrate failure to respond to treatment will require staff to promptly notify the primary physician of change in condition via fax to insure that each resident is receiving the necessary care and treatment to promote the highest practical level of well-being.	F 157		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the monitoring and documentation of a decline in condition was completed for 1 of 2 residents (R72) reviewed for a death record. Findings include: R72 was admitted to the facility on 5/6/16, following a hospital stay from 5/1/16 to 5/6/16 with a diagnosis found on discharge summary of a stroke, sepsis and pneumonia. R72 had an indwelling bladder catheter placed at the hospital. History and Physical identifies R72's urine was clear and yellow in color during hospital stay. R72 admission to the facility had an order for Amoxicillin-Clauvulanate Potassium 875-125	F 309	1. Resident 72 is deceased. 2. All residents have the potential to be affected. 3. Medicare Charting Guidelines/Change in condition charting guidelines policy was reviewed and updated by the administrator and director of nursing on 10/10/16. Education was provided to all nurses by 11/1/16 regarding the policy, specifically expectations regarding charting for change in condition, monitoring of antibiotic use, changes in urine (odor, color, etc.), and monitoring lung sounds. Education included process	11/1/16

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F 309	Continued From page 7 milligrams (MG) tablet by mouth two times daily for a total of nine tablets. R72 was receiving this for pneumonia. Medication administration record (MAR) indicates R72 received all nine tablets as ordered. R72 received antibiotic from 5/7/16 to 5/11/16. Review of progress notes indicates a nurse to nurse report was completed on 5/6/16, at 5:49 p.m. Progress note identifies, Foley catheter was inserted on 5/6/16 related to high residual greater than 500 cubic centimeter and lungs are diminished in lower fields with crackles in the right lower lobe. Admission note dated 5/6/16, at 9:54 p.m. indicates blood tinged urine in catheter. Note indicates vitals were completed with temperature of 98.6, pulse of 88/minute, respirations of 22/minute and blood pressure of 130/74. Note does not indicate lung sounds were assessed on admission and does not identify the blood tinged urine which was seen earlier. Admission Evaluation and Interim Care Plan dated 5/6/16 indicates vital signs were assessed. Under section B of the evaluation for assessments of level of consciousness, cognitive/emotional factors, behavioral factors, sensory/communication, neurological, skin, Respiration (including lung sounds), Cardiovascular, and Pedal pulses were not completed and left blank. Progress note dated 5/7/16, at 3:15 a.m. identifies R72's vital signs were completed and R72 was "squirmy in bed." Progress note dated 5/7/16, at 2:57 p.m. indicates vitals were taken. Review of progress notes from 5/7/16 to 5/17/16 indicates only three nursing notes identifying vital signs or assessment of physical condition. The next nursing progress note was dated 5/16/16, at 1:00 p.m., indicating R72 had blood	F 309	nurses should use for identifying responsibility for daily charting by using the charting assignment sheet tool. Education also included procedure and expectation for completion of assessment of residents upon their admission to the facility. 4. Audits of charting for the past 30 days for 5 random residents will be completed by director of nursing or designee weekly for 4 weeks and then monthly for 3 months to ensure proper documentation procedures are being followed for change in condition, monitoring of antibiotic use, changes in urine, and monitoring lung sounds as well as any other significant changes, and to ensure daily charting procedures are being followed. Audits of up to 5 new admissions will be audited weekly for 4 weeks and monthly for 3 months by the director of nursing or designee to ensure proper admission assessments were completed.	

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F 309	Continued From page 8 tinged urine in catheter and was refusing to eat more than bites at meals. Progress note dated 5/16/16, at 2:09 p.m. identifies R72 not eating well or drinking well today or over the weekend. Fax sent to the doctor to inform but no comment about blood tinged urine. Discharge summary dated 5/17/16, at 9:12 a.m. identifies R72 found at 7:15 a.m. with absence of vital signs. R72 was pronounced deceased. Interview on 9/21/16, at 12:50 p.m. with registered nurse (RN)-B stated on admission vital signs are completed. RN-B stated the admission evaluation and interim care plan worksheet is to be filled out which would include lung sounds being assessed on admission. RN-B stated the night nurse completes a full head to toe assessment the evening of admission to include lung sounds and assessment of urine condition. Interview on 9/21/16, at 12:57 p.m. with licensed practical nurse (LPN)-B stated when a resident comes in on an antibiotic they are flagged for condition charting which should be completed on all three shifts. LPN-B stated the charting should include specific symptoms related to why the resident is on the antibiotic including vital signs. LPN-B stated a note should be added for any change in status as well as notifying the physician. Interview on 9/21/16, at 1:25 p.m. with RN-A stated R72 was on Medicare and condition charting. RN-A stated charting should have been completed at least daily to include how R72 was tolerating treatment, vital signs and lung sounds. RN-A stated her expectation would be while R72 was on an antibiotic that a temperature, lung sounds and specific symptoms should have been documented daily. RN-A stated a change in condition should have been immediately documented.	F 309		

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F 309	Continued From page 9 Interview on 9/21/16, at 3:15 p.m. with director of nursing (DON), stated R72 was on Medicare charting and condition charting. R72 being on an antibiotic there should be specific information on a daily basis regarding tolerance of antibiotics, signs and symptoms of any adverse reactions, vital signs, nursing should have been checking temperature and anything else that would have indicated whether R72 was or wasn't responding to the antibiotic. DON stated a change in condition should have been immediately reported to the physician by either fax or telephone. DON stated if no response from medical provider another fax could be sent but nursing should have followed up with a phone call if they didn't receive a response. DON stated after an antibiotic is complete there should be at least three days of post completion antibiotic charting that is completed. DON verified there should have been at least 12 progress notes in the record identifying vital signs, lung sounds, response to antibiotics and any change in condition. Policy titled, Clinical Monitoring/Condition Charting Policy/Procedure, dated 7/1/16, identifies clinical monitoring/condition charting will be implemented on each resident who demonstrate change in conditions such as an infectious process to assure that necessary nursing services are being implemented, reviewed, and response to treatment monitored. Clinical monitoring/condition charting will be completed daily to determine resident response to interventions implemented and to assure that the resident's highest level of physical function is considered.	F 309		

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	245596	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/23/2016**

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

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

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

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on September 23, 2016. At the time of this survey, South Shore Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

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

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

By email to:

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/12/2016

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 50 beds and had a census of 43 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When	K 029		11/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/23/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 2 the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on a facility tour and staff interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1. This deficient practice could affect all residents within the smoke compartment. This deficient practice could affect 43 of 43 residents, visitors and staff. Findings include: During facility tour on September 23, 2016, between 10:00 AM and 1:00 PM, the following deficiency in a Hazardous Area was noted during the inspection: a.) Door on the Oxygen Storage Room in C-Wing does not latch into frame when closed. This deficient practice was observed by the Facility Maintenance Director.	K 029	1. Door on Oxygen Storage Room on C-Wing was repaired and closes appropriately. 2. 11/1/16 3. Mike McDaniels, Maintenance Director	
K 034 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Based on a facility tour and staff interview, the facility failed to provide stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4. This deficient practice could affect 15 of 43 residents,	K 034	1. All items under the exit stairwell from the maintenance shop were moved and area left open. 2. 11/1/16 3. Mike McDaniels, Maintenance Director	11/1/16

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K 034	Continued From page 3 visitors and staff. FINDINGS INCLUDE: During Facility tour on September 23, 2016, between 10:00 AM and 1:00 PM, observation during the inspection revealed the following discrepancy: Several items were observed stored within the exit stairwell from the Maintenance Shop. This deficient practice was observed by the Maintenance Director.	K 034		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on a facility tour and staff interview, the facility failed to provide exit access arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This deficient practice could affect 20 of the 43 residents, visitors and staff. FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 09/23/2016, observation revealed: 1.) D Wing Emergency exit was observed to have two locking/latches on the right exterior door. This deficient practice was confirmed with the Facility Maintenance Director.	K 038	1. Locks were removed from the D Wing Emergency Exit doors and panic bar installed. 2. 11/1/16 3. Mike McDaniels, Maintenance Director	11/1/16

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K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review and interview,fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2. This deficient practice could affect 43 of the 43 residents, visitors and staff. FINDINGS INCLUDE: During Facility Inspection and Documentation Review on September 23, 2016, between the hours of 10:00 AM and 1:00 PM, documentation review indicated that the fire drills conducted on the day shift were not done at varied times. Day shift drills were done at 8:51 a.m., 8:34 a.m. and 8:43 a.m. during the 1st, 2nd and 3rd quarters, 2016.	K 050	1. Education was provided to Maintenance Director by Administrator regarding frequency of fire drills and importance of staggering times of fire drills on each shift. 2. 11/1/16 3. Scott Buchanan, Administrator	11/1/16

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K 050	Continued From page 5 This was also observed by the Maintenance Director.	K 050		
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on a facility tour and staff interview, the facility failed to provide means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1.This deficient practice could affect 15 of the 43 residents, visitors and staff.	K 072	1. Obstructions to exits were moved and education provided to laundry staff regarding obstructions to emergency exits. 2. 11/1/16 3. Scott Buchanan, Administrator	11/1/16
	FINDINGS INCLUDE: During Facility Inspection on September 23, 2016, between 10:00 AM and 1:00 PM, the following deficiency was observed: Obstructions to the means of egress were observed at the external exit from the Laundry. The path to this exit was impeded by laundry carts and chairs.A chair was observed being stored within the southwest stairwell exit. This deficient practice was observed by the Maintenance Director.			

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K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5 This STANDARD is not met as evidenced by: Based on a facility tour and staff interview, penetrations of smoke barriers by ducts are not protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5. This deficient practice could affect 43 of the 43 residents, visitors and staff. FINDINGS INCLUDE: During Facility Inspection on September 23, 2016, between 10:00 AM and 1:00 PM, the following deficiency was observed: Documentation provided indicated that the last smoke damper inspection was conducted on 04/25/2011. Smoke dampers are required to be inspected every 4 years.	K 104	1. Documentation was found showing that Automatic Building Controls conducted a smoke damper inspection on 7/18/16. 2. 11/1/16 3. Mike McDaniels, Maintenance Director	11/1/16

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K 104	Continued From page 7 This deficient practice was observed by the Maintenance Director.	K 104		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on a facility tour and staff interview, the facility failed to provide Electrical wiring and equipment in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1. This deficient practice could affect 10 of the 43 residents, visitors and staff. FINDINGS INCLUDE: During Facility Inspection on September 23, 2016, between 10:00 AM and 1:00 PM, in Resident Room #302, a refrigerator was observed plugged into a power strip and in the Therapy Gym a microwave was observed plugged into a power strip. This deficient practice was observed by the Facility Maintenance Director.	K 147	1. Room 302 and therapy room were evaluated and power cords for refrigerators were moved from power strips and moved to be powered directly from outlet. 2. 11/1/16 3. Mike McDaniels, Maintenance Director	11/1/16

Electronically submitted
October 7, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5596026

Dear Mr. Buchanan:

The above facility was surveyed on September 19, 2016 through September 22, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00885	A. BUILDING: _____ B. WING _____	09/22/2016

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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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On September 19, 20, 21, & 22, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. " In addition, complaint investigation had been completed at the time of the licensing survey. " An investigation of complaint/s H5596019 was completed. The complaint was not substantiated.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form	2 265		11/1/16

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2 265	Continued From page 3 of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on record review and interview facility failed to ensure the medical provider was notified timely of a significant change in health status for 1 of 2 residents (R72) reviewed for a death record. Findings include: R72 was admitted to the facility on 5/6/16, following a hospital stay from 5/1/16 and with a diagnosis found on discharge summary of a stroke, sepsis and pneumonia. R72 had an indwelling bladder catheter placed at the hospital. Discharge summary dated 5/6/16 from the hospital identifies R72's urine was clear and yellow in color. R72 upon admission to the facility had an order for Amoxicillin-Clauvulanate Potassium 875-125 mg tablet by mouth two times daily for a total of nine tablets. R72 was receiving this for pneumonia. Medication administration record (MAR) indicates R72 received all nine tablets as ordered. Progress note dated 5/16/16, at 1:00 p.m. identifies R72 to have blood tinged urine present in the catheter. Progress note also identifies R72 to be refusing to eat more than bites at meals. Fax dated 5/16/16, from facility to the medical provider identifies,"today and over this past weekend resident has only ate bites of meals and drank sips of liquids. Have been offering liquids	2 265	Corrected	

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2 265	Continued From page 4 and supplements in between meals, but often resident refuses or only takes a sip." Fax did not address the presence of blood in the urine. Also there was no response from the medical provider regarding the fax that was sent. Facility unable to provide any further documentation of follow up with medical provider to determine if he received the fax and wanted to make changes to current orders. The doctor was faxed again on 5/17/16, regarding, "resident seized [sic] breathing and no vital signs present at 7:15am [a.m.]." Interview on 9/21/16, at 3:15 p.m. with the director of nursing (DON) stated the physician should have been notified immediately with the change in condition when it first began in regards to not eating/drinking well and blood in urine. DON stated a fax is sent first. If a response is not received another fax can be sent. DON stated the expectation is if staff do not get a response from the medical provider by fax a phone call should be placed. Policy titled Clinical Monitoring/Condition charting policy/procedure, dated 7/1/16, identifies residents who demonstrate failure to respond to treatment will require staff to promptly notify the primary physician of change in condition via fax to insure that each resident is receiving the necessary care and treatment to promote the highest practical level of well-being. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) could review and revise policies and procedures for notifying the physician of a change in condition. Nursing staff could be educated as necessary to the importance of prompt notification of a change in condition. The DON or designee, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 265		

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	00885	A. BUILDING: _____ B. WING _____	09/22/2016

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SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

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2 265	Continued From page 5 (21) days.	2 265		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals;	2 625		11/1/16

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2 625	Continued From page 6 M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This MN Requirement is not met as evidenced by: Based on record review and interview, the facility failed to ensure ongoing monitoring and adequate documentation of a decline in health status was completed for 1 of 2 residents (R72) reviewed for a death record. Findings include: R72 was admitted to the facility on 5/6/16, following a hospital stay from 5/1/16 to 5/6/16 with a diagnosis found on discharge summary of a stroke, sepsis and pneumonia. R72 had an indwelling bladder catheter placed at the hospital. History and Physical identifies R72's urine was clear and yellow in color during hospital stay. R72 admission to the facility had an order for Amoxicillin-Clauvulanate Potassium 875-125 milligrams (MG) tablet by mouth two times daily for a total of nine tablets. R72 was receiving this for pneumonia. Medication administration record (MAR) indicates R72 received all nine tablets as ordered. R72 received antibiotic from 5/7/16 to 5/11/16. Review of progress notes indicates a nurse to nurse report was completed on 5/6/16, at 5:49 p.m. Progress note identifies, Foley catheter was	2 625	Corrected	

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2 625	Continued From page 7 inserted on 5/6/16 related to high residual greater than 500 cubic centimeter and lungs are diminished in lower fields with crackles in the right lower lobe. Admission note dated 5/6/16, at 9:54 p.m. indicates blood tinged urine in catheter. Note indicates vitals were completed with temperature of 98.6, pulse of 88/minute, respirations of 22/minute and blood pressure of 130/74. Note does not indicate lung sounds were assessed on admission and does not identify the blood tinged urine which was seen earlier. Admission Evaluation and Interim Care Plan dated 5/6/16 indicates vital signs were assessed. Under section B of the evaluation for assessments of level of consciousness, cognitive/emotional factors, behavioral factors, sensory/communication, neurological, skin, Respiration (including lung sounds), Cardiovascular, and Pedal pulses were not completed and left blank. Progress note dated 5/7/16, at 3:15 a.m. identifies R72's vital signs were completed and R72 was "squirmy in bed." Progress note dated 5/7/16, at 2:57 p.m. indicates vitals were taken. Review of progress notes from 5/7/16 to 5/17/16 indicates only three nursing notes identifying vital signs or assessment of physical condition. The next nursing progress note was dated 5/16/16, at 1:00 p.m., indicating R72 had blood tinged urine in catheter and was refusing to eat more than bites at meals. Progress note dated 5/16/16, at 2:09 p.m. identifies R72 not eating well or drinking well today or over the weekend. Fax sent to the doctor to inform but no comment about blood tinged urine. Discharge summary dated 5/17/16, at 9:12 a.m. identifies R72 found at 7:15 a.m. with absence of vital signs. R72 was pronounced deceased. Interview on 9/21/16, at 12:50 p.m. with	2 625		

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2 625	Continued From page 8 registered nurse (RN)-B stated on admission vital signs are completed. RN-B stated the admission evaluation and interim care plan worksheet is to be filled out which would include lung sounds being assessed on admission. RN-B stated the night nurse completes a full head to toe assessment the evening of admission to include lung sounds and assessment of urine condition. Interview on 9/21/16, at 12:57 p.m. with licensed practical nurse (LPN)-B stated when a resident comes in on an antibiotic they are flagged for condition charting which should be completed on all three shifts. LPN-B stated the charting should include specific symptoms related to why the resident is on the antibiotic including vital signs. LPN-B stated a note should be added for any change in status as well as notifying the physician. Interview on 9/21/16, at 1:25 p.m. with RN-A stated R72 was on Medicare and condition charting. RN-A stated charting should have been completed at least daily to include how R72 was tolerating treatment, vital signs and lung sounds. RN-A stated her expectation would be while R72 was on an antibiotic that a temperature, lung sounds and specific symptoms should have been documented daily. RN-A stated a change in condition should have been immediately documented. Interview on 9/21/16, at 3:15 p.m. with director of nursing (DON), stated R72 was on Medicare charting and condition charting. R72 being on an antibiotic there should be specific information on a daily basis regarding tolerance of antibiotics, signs and symptoms of any adverse reactions, vital signs, nursing should have been checking temperature and anything else that would have indicated whether R72 was or wasn't responding to the antibiotic. DON stated a change in condition should have been immediately reported	2 625		

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2 625	Continued From page 9 to the physician by either fax or telephone. DON stated if no response from medical provider another fax could be sent but nursing should have followed up with a phone call if they didn't receive a response. DON stated after an antibiotic is complete there should be at least three days of post completion antibiotic charting that is completed. DON verified there should have been at least 12 progress notes in the record identifying vital signs, lung sounds, response to antibiotics and any change in condition. Policy titled, Clinical Monitoring/Condition Charting Policy/Procedure, dated 7/1/16, identifies clinical monitoring/condition charting will be implemented on each resident who demonstrate change in conditions such as an infectious process to assure that necessary nursing services are being implemented, reviewed, and response to treatment monitored. Clinical monitoring/condition charting will be completed daily to determine resident response to interventions implemented and to assure that the resident's highest level of physical function is considered. SUGGESTED METHOD OF CORRECTION: The DON and/or designee could monitor to assure the maintenance of accurate, complete, and organized clinical information about each resident. The DON or designee could also perform audits of resident records and report findings to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 625		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must	2 830		11/1/16

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2 830	Continued From page 10 receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on record review and interview, the facility failed to ensure the monitoring and documentation of a decline in condition was completed for 1 of 2 residents (R72) reviewed for a death record. Findings include: R72 was admitted to the facility on 5/6/16, following a hospital stay from 5/1/16 to 5/6/16 with a diagnosis found on discharge summary of a stroke, sepsis and pneumonia. R72 had an indwelling bladder catheter placed at the hospital. History and Physical identifies R72's urine was clear and yellow in color during hospital stay. R72 admission to the facility had an order for Amoxicillin-Clauvulanate Potassium 875-125 milligrams (MG) tablet by mouth two times daily for a total of nine tablets. R72 was receiving this for pneumonia. Medication administration record (MAR) indicates R72 received all nine tablets as ordered. R72 received antibiotic from 5/7/16 to 5/11/16. Review of progress notes indicates a nurse to nurse report was completed on 5/6/16, at 5:49	2 830	Corrected	

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2 830	Continued From page 11 p.m. Progress note identifies, Foley catheter was inserted on 5/6/16 related to high residual greater than 500 cubic centimeter and lungs are diminished in lower fields with crackles in the right lower lobe. Admission note dated 5/6/16, at 9:54 p.m. indicates blood tinged urine in catheter. Note indicates vitals were completed with temperature of 98.6, pulse of 88/minute, respirations of 22/minute and blood pressure of 130/74. Note does not indicate lung sounds were assessed on admission and does not identify the blood tinged urine which was seen earlier. Admission Evaluation and Interim Care Plan dated 5/6/16 indicates vital signs were assessed. Under section B of the evaluation for assessments of level of consciousness, cognitive/emotional factors, behavioral factors, sensory/communication, neurological, skin, Respiration (including lung sounds), Cardiovascular, and Pedal pulses were not completed and left blank. Progress note dated 5/7/16, at 3:15 a.m. identifies R72's vital signs were completed and R72 was "squirmy in bed." Progress note dated 5/7/16, at 2:57 p.m. indicates vitals were taken. Review of progress notes from 5/7/16 to 5/17/16 indicates only three nursing notes identifying vital signs or assessment of physical condition. The next nursing progress note was dated 5/16/16, at 1:00 p.m., indicating R72 had blood tinged urine in catheter and was refusing to eat more than bites at meals. Progress note dated 5/16/16, at 2:09 p.m. identifies R72 not eating well or drinking well today or over the weekend. Fax sent to the doctor to inform but no comment about blood tinged urine. Discharge summary dated 5/17/16, at 9:12 a.m. identifies R72 found at 7:15 a.m. with absence of vital signs. R72 was pronounced deceased.	2 830		

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2 830	Continued From page 12 Interview on 9/21/16, at 12:50 p.m. with registered nurse (RN)-B stated on admission vital signs are completed. RN-B stated the admission evaluation and interim care plan worksheet is to be filled out which would include lung sounds being assessed on admission. RN-B stated the night nurse completes a full head to toe assessment the evening of admission to include lung sounds and assessment of urine condition. Interview on 9/21/16, at 12:57 p.m. with licensed practical nurse (LPN)-B stated when a resident comes in on an antibiotic they are flagged for condition charting which should be completed on all three shifts. LPN-B stated the charting should include specific symptoms related to why the resident is on the antibiotic including vital signs. LPN-B stated a note should be added for any change in status as well as notifying the physician. Interview on 9/21/16, at 1:25 p.m. with RN-A stated R72 was on Medicare and condition charting. RN-A stated charting should have been completed at least daily to include how R72 was tolerating treatment, vital signs and lung sounds. RN-A stated her expectation would be while R72 was on an antibiotic that a temperature, lung sounds and specific symptoms should have been documented daily. RN-A stated a change in condition should have been immediately documented. Interview on 9/21/16, at 3:15 p.m. with director of nursing (DON), stated R72 was on Medicare charting and condition charting. R72 being on an antibiotic there should be specific information on a daily basis regarding tolerance of antibiotics, signs and symptoms of any adverse reactions, vital signs, nursing should have been checking temperature and anything else that would have indicated whether R72 was or wasn't responding to the antibiotic. DON stated a change in	2 830		

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2 830	Continued From page 13 condition should have been immediately reported to the physician by either fax or telephone. DON stated if no response from medical provider another fax could be sent but nursing should have followed up with a phone call if they didn't receive a response. DON stated after an antibiotic is complete there should be at least three days of post completion antibiotic charting that is completed. DON verified there should have been at least 12 progress notes in the record identifying vital signs, lung sounds, response to antibiotics and any change in condition. Policy titled, Clinical Monitoring/Condition Charting Policy/Procedure, dated 7/1/16, identifies clinical monitoring/condition charting will be implemented on each resident who demonstrate change in conditions such as an infectious process to assure that necessary nursing services are being implemented, reviewed, and response to treatment monitored. Clinical monitoring/condition charting will be completed daily to determine resident response to interventions implemented and to assure that the resident's highest level of physical function is considered. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to supervision and monitoring/documenting change in condition. The DON or designee, could provide training for all nursing staff related to change in condition monitoring/documenting. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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21426	Continued From page 14	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and record review facility failed to ensure tuberculosis screening was completed for 1 of 6 employees (E-1) and 1 of 6 residents (R40) as well as failed to ensure first-step Tuberculin skin test (TST), (skin test to determine the presence of tuberculosis) was assessed after completion for 1 of 6 residents (R78) and failed to complete second-step TST for 2 of 6 residents (R40 and R78). Findings include: E-1 received a chest x-ray on 5/24/16, and was found to be free from TB and communicable	21426	Corrected	11/1/16

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21426	Continued From page 15 diseases. Facility was unable to provide documentation that a tuberculosis baseline screening had been completed for this staff member. R40 had a first step TST on 6/15/16, which was read on 6/18/16. Facility was unable to provide documentation that a tuberculosis baseline screening had been completed or that R40 had received a second step TST. R78 had a baseline tuberculosis screening completed on 6/17/16 as well as the first step TST. Facility failed to assess the results of the first step TST and failed to administer a second step TST. Interview on 9/21/16, at 5:07 p.m. with licensed practical nurse (LPN)-A stated E-1 probably didn't receive the baseline TB screening because a chest x-ray had been completed. LPN-A stated upon new hire and upon new admission a baseline TB screening is supposed to be completed for each individual. The first step TST is supposed to be completed following the TB screening. This is then entered into the medication administration record (MAR) so nursing staff are aware of when they would need to assess the results of the test. LPN-A stated the individual is also entered onto a calendar to ensure they receive the second step TST two weeks following the results of the first step. LPN-A stated if she is unavailable to complete this it becomes the responsibility of the resident care coordinators. LPN-A stated she was out on medical leave around this time and is probably why the screenings and TST tests were missed. Facility policy titled, Tuberculosis Policy/Procedure, dated 7/1/16, identifies all new staff will meet with the infection control coordinator prior to direct contact with residents where a baseline TB screening will be conducted. Baseline TB screening will include assessment	21426		

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21426	Continued From page 16 for current symptoms of active TB disease. The facility will prescreen all admissions for possible TB. Baseline TB screening will include assessment for current symptoms of active TB and testing for the presence of infection by administering a two-step TST (Tuberculin skin test). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and the two step Mantoux process. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in	21800		11/1/16

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21800	Continued From page 17 residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident received the required liability notice (CMS 100123) two days before ending services and the appeals notice for 1 of 3 residents (R11) reviewed for liability and beneficiary rights. Findings include: R11's entry tracking record Minimum Data Set completed same day of admission which was 6/2/16. Progress Note dated 7/10/16 indicated R11 plateaued with physical therapy/occupational therapy, a Medicare denial was completed (CMS 100123), and R11's family (F)-A was informed via voicemail with instructions to come into the facility to sign the Medicare denial paperwork. On 9/20/16 at 2:28 p.m. when asked for R11's liability forms, the administrator reported R11's Medicare denial (CMS 100123) paperwork was unable to be located. Administrator said R11 had	21800	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00885	A. BUILDING: _____ B. WING _____	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21800	Continued From page 18 not met the 100 days maximum allowed by CMS. Facility policy, Medicare Policy dated 7/1/16, read; "4. The appropriate denial letter is also initiated on or before the last covered day when medicare skilled level of care is no longer needed and on or before the 100th day of coverage when benefits are exhausted. 5. The resident or the responsible party is notified of last covered day and the right to have bills submitted to Medicare and signs the response to verify notification. 6. If the responsible party is unavailable, attempt is made to notify by phone and documented on the denial letter that an attempt was made with the time attempt was made. 7. A completed denial letter is given to medical records and accounts receivable." SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the appropriate liability notices to provide residents at the end of Medicare services, and to ensure resident rights are communicated appropriately and acted upon. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21800		