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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: R9Y3

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/12/2015** (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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 10/15/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/15/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/09/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245596

October 15, 2015

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

Dear Ms. Atchison:

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

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

Effective October 6, 2015 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, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 13, 2015

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

RE: Project Number S5596025

Dear Ms. Atchison:

On September 9, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 27, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On October 12, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 7, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 27, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 6, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 27, 2015, effective October 6, 2015 and therefore remedies outlined in our letter to you dated September 9, 2015, 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, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245596	A. Building B. Wing	10/12/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**09/30/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	**09/30/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**09/30/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	10/13/2015	10160	10/12/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/27/2015				

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245596	A. Building / B. Wing: 01 - MAIN BUILDING 01	10/7/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0025	10/06/2015	ID Prefix Reg. # NFPA 101 LSC K0072	10/06/2015	ID Prefix Reg. # NFPA 101 LSC K0144	09/02/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/kfd	10/13/2015	35482	10/07/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/25/2015

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: R9Y3

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/27/2015** (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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Kyla Einertson, HFE NE II 09/18/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/09/2015 (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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 9, 2015

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

RE: Project Number S5596025

Dear Ms. Atchison:

On August 27, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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
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 October 6, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 27, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 27, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for 1 of 1 resident (R32) who was reviewed for urinary incontinence and repositioning. In addition, the facility failed to follow the plan of care for fall interventions for 1 of 2 residents (R21) who had a history of falls. Findings include: R32's quarterly Minimum Data Set (MDS) dated 8/11/15, identified R32 required extensive assistance with toilet use, bed mobility, transfer,	F 282	It is the facility policy that care is provided by qualified persons in accordance with the resident's written plan of care. R-32's bladder evaluation was reviewed and updated on 9/8/15. R-32 refused all attempts of toileting program and was determined unable to participate in bladder program. R-32's pressure risk evaluation was updated on 9/8/15 with a score of 10 indicating that resident remains at high risk of pressure development. Resident will continue to	9/30/15

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

Electronically Signed | 09/18/2015

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	245596	A. BUILDING _____ B. WING _____	08/27/2015

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

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F 282	Continued From page 1 locomotion on/off the unit and personal hygiene. The brief interview for mental status (BIMS) score was 4 indicating severe cognitive impairment. R32's comprehensive care plan last revised on 8/25/15, identified R32 as having a self-care deficit of toileting due to being incontinent of bowel and bladder. Interventions included: (1) staff provides all incontinent care, incontinent pads and pants during the day; (2) check pads every 2 hours and change as needed; (3) toilet resident every 2 hours and as needed; (4) resident needs assistance with transferring to commode or toilet. The care plan also identified R32 as having a potential for skin breakdown related to mobility deficit, skin desensitization and has moisture associated areas to folds. Interventions included: (1) turn resident or encourage resident to turn every 2 hours and as needed; (2) toilet resident at appropriate times and/or as requested by resident; (3) check incontinent pads every 2 hours and change as needed; (4) monitor skin with cares and report any redness, rash or open areas if noted. During continuous observations of R32 on 8/26/15, from 8:44 a.m. to 11:20 a.m. a 2 hour and 36 minutes of continuous observation R32 had been lying in her bed on her back. R32 remained in this position throughout the observation period and no repositioning or incontinence checks were completed. . At 11:20 a.m. observed NA-A and NA-B enter R32's room to get her up for dinner and they found R32 to be incontinent of urine which had soaked through her clothing and into the bedding. NA-A stated sometimes R32 tells them she has to go to the bathroom, however if she is tired she sleeps right through it. NA-A stated they lie R32 down after	F 282	require every two hour reposition for pressure prevention. Secondary to decline in condition, R-32 was admitted to Hospice Services on 9/3/15 following Hospice Referral and meeting criteria for Hospice admit. R-32's individualized plan of care was updated following decline in condition. R-21's falls risk evaluation was reviewed and updated on 9/14/15 with a score of 12 which continues to indicate need for interventions to minimize risk of personal injury associated with fall risk. The nursing assistant assignment sheet was updated with the Safety First symbol and with need for floor mat when in bed on 9/14/15. The Safety First symbol was placed outside R-21's door to alert the IDT of safety interventions in place on 9/14/15. The facility has reviewed and updated its policy on following the care plan/ nursing assistant assignment sheets on 9/11/15. The facility developed a policy "Safety And Supervision Of Resident-Safety Locator." on 9/11/15. The SAFETY ALERT symbol was placed on the nursing assistant assignment sheets and outside the resident doors on all residents identified at risk for injury and whose care plan indicated that specific interventions were in place to minimize risk for personal injury on 9/15/15. An in-service will be held on 9-30-15 to review policy development and staff roles/responsibility with regards to following the plan of care as well as	

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F 282	Continued From page 2 breakfast and when they get her up at noon for dinner she is always incontinent of urine. NA-A admitted they don't regularly check on her in between that time. Review of the quarterly bladder evaluation dated 8/10/15, indicated R32 has frequency as the only sign and symptom of infection. R32 is toileted on a program with some success and to keep resident as dry as possible without redness or irritation noted. Review of pressure ulcer risk evaluation dated 8/11/15, indicated R32 scored an 8 which indicated she was at high risk for developing a pressure ulcer. Review of the individualized turn and reposition log in the high risk skin turn and reposition charting clip board dated 8/26/15, lack documentation that any turning and repositioning had been done since 4:00 a.m. Review of the CORP-Turn and Reposition Detail Report dated 8/26/15, lacked documentation R32 had been turned and repositioned between the hours of 7:03 a.m. to 5:38 p.m. Review of the CORP-Bowel and Bladder Chart Detail Report dated 8/26/15, lacked documentation R32 had been toileted or the incontinent product checked between 7:04 a.m. to 11:53 a.m. During an interview on 08/26/15, at 3:42 p.m. registered nurse (RN)-A stated about R32, "Can be incontinent and changed and you can go right back and check on her and she will have been incontinent again." Also during the interview,	F 282	resident safety and supervision. The Director of Nursing will audit the individualized turn and reposition logs and bowel and bladder logs on random residents on a daily basis for a period of four weeks and weekly thereafter and make rounds of residents' rooms randomly on an ongoing basis to ensure compliance with individualized toileting, repositioning and safety measures per care plans. Results of audits will be reviewed with the Quality Assurance Committee to assess the effectiveness of the plan and determine whether further systemic changes are necessary.	

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F 282	Continued From page 3	F 282		

RN-A stated staff should check on residents if they have odor of urine, and/or to wait longer than 2 hours to check on a resident. RN-A confirmed the lack of documentation for R32 in the individualized turn and reposition log and in the CORP-turn and reposition detail report for 8/26/15. RN-A stated if the NA's were finding R32 incontinent every time they got her up for dinner, they should be doing more checks on her. RN-A also confirmed the staff weren't following the care plan for R32.

During an interview on 8/26/15, at 4:13 p.m. director of nursing (DON) stated she would absolutely expect staff to check on a resident if a strong urine odor was coming from the room. DON also stated she expected staff to not leave residents more than 2 hours before checking on them.
R21's comprehensive care plan dated 5/25/15, revealed the resident at risk for falls. The goal for R21 was to have fewer falls through the review date. Approaches that were initiated included a floor mat to be in place.

During an observation on 8/26/15, at 8:41 a.m., R21 was observed to be in her room lying on her bed with no floor mat on the floor.

During an observation on 8/26/15, at 9:27 a.m. R21 was observed to lying in her bed on her back with no floor mat near her bed.

During an observation on 8/26/15, at 10:25 a.m., R21 was observed to be in her room, lying on her bed with no floor mat beside her bed.

During an observation on 8/26/15, at 11:07 a.m., R21 was observed to be lying in bed with no floor

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F 282	Continued From page 4	F 282		

mat beside her bed. The floor mat was observed to be propped up between her recliner and her lamp. It was observed to be folded up in an upright position nowhere near the bed.

During an observation on 8/26/15, at 11:17 a.m., R21 was observed to be lying in bed with no floor mat in place next to her bed. The floor mat was propped up away from her bed.

A document titled Fall Risk indicated that the resident had last been assessed on 8/10/15 for a potential fall risk. R21's score was 12. A note underneath stated that any resident with a total score greater than 10 was at a high risk for falls.

A review of R21's most recent care conference dated 8/25/15 stated that R21 needed to have a floor mat in place when the resident is lying in bed.

A review of R21's incident reports indicated that R21 was found on the floor in her room and had fallen from her bed on these three dates 8/2/15, 8/5/15 and 8/9/15. In each case, R21 did not have a fall mat in place even though the comprehensive care plan included the mat as an intervention to reduce injuries in case of falls.

When interviewed on 8/26/15, at 11:41 a.m., Nursing Assistant (NA)-C stated that R21 has had a floor mat beside her bed whenever she is resting in bed for at least the past month. NA-C noted that R21 has been falling a lot. NA-C did verify that the floor mat was not in place when R21 was in bed today. NA-C stated that the floor mat should have been in place.

When interviewed on 8/26/15, at 12:48 p.m.,

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F 282	Continued From page 5 licensed practical nurse (LPN)-A stated that R21 should have a floor mat in place whenever the resident is lying in bed. When interviewed on 8/27/15, at 11:10 a.m., the Director of Nursing (DON) stated that the floor mat was determined to be safe for R21. She expected staff to know to use it when it is care planned and that it should have been in place. A review of the policy titled, Comprehensive Care Plan Development and Revision, last reviewed on 7/9/14, indicated that each resident's comprehensive care plan has been designed to incorporate identified problem areas, incorporate risk factors associated with identified problems, reflect treatment goals and objectives in measurable outcomes, enhance the optimal functioning of the resident by focusing on a rehabilitative program, aid in preventing or reducing declines in the resident's functional status and/or functional levels.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced	F 315		9/30/15

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F 315	Continued From page 6 by: Based on observation, interview and document review, the facility failed to provide toileting needs for 1 of 1 resident (R32) reviewed who was incontinent of urine and had developed a urinary tract infection. Findings include: R32 had been observed on 8/26/15, continuous observation from 8:44 a.m. to 11:20 a.m. (2 hours and 36 minutes) with R32 lying in her bed on her back the entire time and no staff assisted her to reposition or check for incontinence. At 9:39 a.m. observed urine odor in the room and at 1:03 a.m. the urine odor could be smelled in the hallway by room 313, which is the room next to R32's. At 11:20 a.m. observed NA-A and NA-B enter R32's room to get her up for dinner and they found R32 to be incontinent of urine which had soaked through her clothing and into the bedding. NA-A acknowledged there was a very strong urine smell in the room and stated, R32 hasn't been drinking much today so she thought that was why the smell was so strong. NA-A stated sometimes R32 tells them she has to go to the bathroom, however if she is tired she sleeps right through it. NA-A stated they lay R32 down after breakfast and when they get her up at noon for dinner she is always incontinent of urine. NA-A said they don't regularly check on her after helping to bed after breakfast until time to get up for dinner. On 8/26/15, at 12:24 p.m. observed housekeeping cleaning the mattress on R32's bed due to urine soaking through the bedding onto the mattress. R32's quarterly Minimum Data Set (MDS) dated	F 315	It is the facility policy that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. R-32's bladder evaluation was reviewed and updated on 9/8/15. R-32 refused all attempts of toileting program and was determined unable to participate in bladder program. Secondary to decline in condition R-32 was admitted to Hospice Services on 9/3/15 following Hospice Referral and meeting criteria for Hospice admit. R-32's individualized plan of care was updated following decline in condition. The facility reviewed and updated its policy on perineal/incontinent care on 9/14/15. An in-service will be held on 9-30-15 to review policy development for perineal/incontinent care. Review and direction on incontinent care will be presented to the nursing staff. Unit charge nurses will be responsible to monitor the individualized turn and reposition logs and bowel and bladder logs each shift and supervise direct care staff so that residents' who are incontinent receive appropriate care. The Director of Nursing will audit the individualized turn and reposition logs and	

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F 315	Continued From page 7 8/11/15, identified R32 required extensive assistance with toilet use, bed mobility, transfer, locomotion on/off the unit and personal hygiene. The brief interview for mental status (BIMS) score was 4 indicating severe cognitive impairment. Review of the quarterly bladder evaluation dated 8/10/15, indicated R32 has frequency as the only sign and symptom of infection. R32 was catheterized for residual urine's on 7/28/15, 7/29/15, and 7/30/15, with residuals of 150 or less. R32 is toileted on a program with some success and to keep resident as dry as possible without redness or irritation noted. Review of the care plan last revised on 8/25/15, identified R32 as having a self-care deficit of toileting due to being incontinent of bowel and bladder. Interventions included: (1) staff provides all incontinent care, incontinent pads and pants during the day; (2) check pads every 2 hours and change as needed; (3) toilet resident every 2 hours and as needed; (4) resident needs assistance with transferring to commode or toilet. Review of the individualized turn and reposition log in the high risk skin turn and reposition charting clip board dated 8/26/15, lack documentation that any turning and repositioning had been done since 4:00 a.m. Review of the CORP-Turn and Reposition Detail Report dated 8/26/15, lacked documentation R32 had been turned and repositioned between the hours of 7:03 a.m. to 5:38 p.m. Review of the CORP-Bowel and Bladder Chart Detail Report dated 8/26/15, lacked	F 315	bowel and bladder dlogs on random residents on a daily basis for a period of four weeks and weekly thereafter and make rounds of residents' rooms randomly on an ongoing basis to ensure compliance with individualized toileting, repositioning and safety measures per care plans. Results of audits will be reviewed with the Quality Assurance Committee to assess the effectiveness of the plan and determine whether further systemic changes are necessary.	

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F 315	Continued From page 8	F 315		

documentation R32 had been toileted or the incontinent product checked between 7:04 a.m. to 11:53 a.m.

During an interview on 08/26/15, at 3:42 p.m. registered nurse (RN)-A stated she had just received a call from the emergency room and R32 had a urinary tract infection (UTI) and was placed on an antibiotic. RN-A stated since July 2015 the staff were noticing a strong smelling urine and they received an order for intermittent catheterization on 7/27/15, for complaints of frequency and possible urinary retention. RN-A stated R32 was catheterized for residuals but only had 50-150 remaining so that wasn't the problem. RN-A stated R32 can be incontinent and changed and you can go right back and check on her and she will have been incontinent again. Also during the interview, RN-A stated staff should check a resident when they have a strong urine odor coming from their room and not to wait longer than 2 hours to check on a resident. RN-A confirmed the lack of documentation for R32 in the individualized turn and reposition log and in the CORP-turn and reposition detail report for 8/26/15. RN-A stated if the NA's were finding R32 incontinent every time they got her up for dinner, they should be doing more checks on her. RN-A also confirmed the staff weren't following the care plan for R32.

During an interview on 8/26/15, at 4:13 p.m. director of nursing (DON) stated she would absolutely expect staff to check on a resident if a strong urine odor was coming from the room. DON also stated she expected staff to not leave residents more than 2 hours before checking on them.

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F 315	Continued From page 9 A policy was requested for incontinent cares and services however, none had been provided.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assess effectiveness of as needed (PRN) medications or attempt non-pharmacological interventions before use of medications for 2 of 5 residents (R21, R33)	F 329	It is the facility's policy that each resident remain free from unnecessary drugs and that PRN (as needed) medications are assessed for effectiveness.	9/30/15

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F 329	Continued From page 10 reviewed for unnecessary medications. Findings include: R21 diagnoses included osteoarthrosis according to the admission form. Review of the physician orders for R21 indicated the resident had an order for Tramadol [pain medication] 50 mg tablet orally every 4 to 6 hours as needed (PRN) for breakthrough pain with start date of 7/29/15. R21's Medication Administration Record (MAR) indicated that R21 was given a PRN dose of Tramadol on 7/30/15 but was not reassessed for its effectiveness. On 8/1/15 R21 received a PRN dose of Tramadol but was not reassessed for its effectiveness. On 8/5/15, R21 received a PRN dose of Tramadol but was not reassessed for its effectiveness. On 8/9/15, R21 received a PRN dose of Tramadol, however, was not reassessed for its effectiveness. From 7/29/15 through 8/1/15 R21 received Tramadol 1 our of 5 times there was no reassessment of pain control. A review of the interdisciplinary notes dated 8/3/15 indicated that charge personnel are to administer Tramadol as ordered and record the response to pain. A review of R21's plan of care (POC) effective date 5/25/15, identified the problem of pain. The goal for pain relief indicated that the resident would verbalize relief of pain within thirty minutes of receiving medication or comfort measures. One approach to meet this goal was to assess episodes of pain and evaluate effectiveness of interventions used. This effectiveness was to be	F 329	R-21's pain assessment was reviewed and updated on 9/15/15 as resident pain management was revised on 8/11/15. Since revision of pain management resident indicates "My pain is almost gone." R-21 requests cold pack to base of neck for breakthrough pain as this worked at home, will use PRN Tramadol only if non-pharmacological intervention ineffective. The MAR has been updated to alert Charge Nurses to use non-pharmacological intervention prior to medication. The care plan has been updated to reflect resident's current pain and intervention updates. R-33's pain assessment was reviewed and updated on 9/15/15. Resident currently denies pain or discomfort and has not used PRN medication since 8/30/15. Resident verbalizes "I don't have any pain." The care plan has updated to reflect residents current pain level and interventions for pain management. Resident is scheduled for discharge to home on 9/22/15. The facility's policy for medication administration was reviewed and updated on 9/14/15. Non-pharmacological intervention alert/effectiveness of PRN analgesic usage was placed on each MAR kardex on 9/15/15. An in-service will be held 9/30/15 to review policy development for medication administration. Education will also be provided on use of non-pharmacological interventions prior to analgesic use and	

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F 329	Continued From page 11 documented on the PRN MAR and/or in interdisciplinary notes. A review of R21's POC did not indicate anywhere that non-pharmacological measures were to be used prior to prn pain medication administration. R33 included diagnoses of migraine found on the admission form. Review of the physician orders indicated that R33 received Tylenol 650 milligrams (mg) every four hours as needed. A review of R33's MAR and interdisciplinary notes from 6/1/15 through 8/31/15 indicated the resident received PRN Tylenol a total of four times. Of these four times the resident was not reassessed for its effectiveness a total of two times. A review of R33's plan of care (POC) effective date 6/25/15, identified the problem of pain. The goal for pain relief indicated that the resident would verbalize relief of pain within thirty minutes of receiving medication or comfort measures. One approach to meet this goal was to assess episodes of pain and evaluate effectiveness of interventions used. This effectiveness was to be documented on the PRN MAR and/or in interdisciplinary notes. A review of R33's POC did not indicate anywhere that non-pharmacological measures were to be used prior to prn pain medication administration. During an interview on 8/27/15, at 9:33 a.m. Registered Nurse (RN)-A stated that she would expect the nursing staff would chart the	F 329	charting effectiveness of PRN analgesics will be reviewed with all licensed staff. The Director of Nursing will audit MARs on a random daily basis for a period of four weeks and weekly thereafter. Results of audits will be reviewed with the Quality Assurance Committee to assess the effectiveness of the plan and determine whether further systemic changes are necessary.	

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	245596	A. BUILDING _____ B. WING _____	08/27/2015

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F 329	Continued From page 12 effectiveness of the PRN medication. She stated that if a PRN medication was given prior to shift change, then they should alert the next staff to assess for effectiveness. The nursing staff should be charting the effectiveness of prn medication. When the MAR was reviewed to identify the lack of documentation, RN-A stated that it looked like a lot of the missing documentation was done by pool staff. In regards to administration of non-pharmacological measures that should be attempted prior to PRN pain medication, RN-A, stated that she would have expected staff to be changing the resident's position, offering warm packs, etc. She noted that the documentation on the care plan only states to provide these as requested by the resident. RN-A verified that there is no such documentation for non-pharmacological measures prior to PRN administration on the MAR. During an interview on 8/27/15, at 10:29 a.m., the Director of Nursing (DON) stated that it is the facility's policy to monitor for the effectiveness of a prn medication within an hour of administration. She reiterated that the nursing staff should have followed up with the resident to check and see if the medication had been effective. The DON stated that it is the facility's practice to always try non-pharmacological measures prior to prn pain medications. She stated that the non-pharmacological measures should have been tried prior to administration of PRN pain medications. A policy was requested for prn medication use but not provided.	F 329		

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	245596	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/25/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on August 25, 2015. 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	K 000	EPOC	

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

Electronically Signed | 09/18/2015

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 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. South Shore Care Center is a two-story building with partial basement. The original building was constructed in 1962, with building additions constructed in 1964 and 1968. All are fully sprinklered, and were determined to be of Type I (332) construction. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 39 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may	K 025		10/6/15

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K 025	Continued From page 2 terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier wall in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, 8.3.2 and 8.3.6. The deficient practice could affect 12 out of 39 residents. Findings include: On facility tour between 9:00 AM and 11:00 AM on 08/25/2015, observation revealed that the smoke barrier in the B Wing has an open penetration around cables above smoke barrier doors above the lay in ceiling. NOTE: All smoke barriers need to be checked from exterior wall to exterior wall. This deficient practice was confirmed by the Facility Maintenance Director (DV) at the time of discovery.	K 025	The Maintenance Supervisor (MM)repaired the smoke barrier with approved sealant on 8/29/15. He will check all smoke barriers and close with approved sealant if necessary by 10/6/15. In the future, the Maintenance Supervisor will be responsible for ensuring that either he or any paid contractors who do work at the facility seal any new openings to smoke barriers immediately after work is completed.	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free	K 072		10/6/15

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K 072	Continued From page 3 of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain an egress corridor free from impediments to full instant use in the case of fire or other emergency, in accordance with NFPA 101 (2000), Chapter 7, Sections 7.1.10.1 and 7.1.10.2.1, and, the 2007 edition of Minnesota State Fire Code (MSFC) Chapter 10, Section 1028. In an emergency evacuation situation, these impediments could interfere with the prompt and orderly evacuation of all 39 residents, staff and visitors. Findings include: On facility tour between 9:00 AM and 11:00 AM on 08/25/2015, observation revealed : 1.) External exit from the Laundry blocked by several laundry carts. 2.) The external exit path on the outside of the Physical Therapy Room had numerous rocks, landscape debris and extension cords causing trip hazards. 3.) D-Wing South Exit had a hand truck stored within the exit path. This deficient practice was confirmed by the Director of Maintenance (DV) at the time of discovery.	K 072	The laundry carts and hand truck were removed from the areas cited on 9/1/15 and stored elsewhere. The external path outside the Physical Therapy room was cleared of debris and extension cord removed on 8/26/15. Laundry staff have been reminded that nothing can be stored in front of an emergency exit. The Maintenance Supervisor will audit the laundry room and emergency exits to assure that they are free of impediments weekly. Results of these audits will be provided to the QA Committee at its next meeting to review/determine if plan is effective	

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K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on inspection and interview, the facility has failed to properly test all components of the emergency generator in accordance with NFPA 99 and NFPA 110. This deficient practice could affect all 39 residents, staff and visitors in the event of a loss of power and generator failure. Findings include: On facility tour between 9:00 AM and 11:00 AM on 08/25/2015, observation and an interview with Maintenance Director, it was revealed that the audible alarm at the generator annunciator panel at the D-Wing Nurses Station did not function when tested. This deficient practice was confirmed by the Facility Maintenance Director (DV) at the time of discovery.	K 144	The audible alarm to the generator annunciator panel was repaired by a licensed electrician on 9/2/15. The Maintenance Supervisor will test the alarm monthly to assure continued compliance.	9/2/15