Electronically delivered
December 2, 2020

Administrator
South Shore Care Center
1307 South Shore Drive PO Box 69
Worthington, MN 56187

RE: CCN: 245596
Cycle Start Date: November 6, 2020

Dear Administrator:

On November 6, 2020, a survey was completed at your facility by the Minnesota Department of Health 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 constituted immediate jeopardy (Level K), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On October 27, 2020, the situation of immediate jeopardy to potential health and safety cited at F880 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office forimposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered

professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

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

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver

along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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	245596	A. BUILDING _____ B. WING _____	11/06/2020

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

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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 11/4/20 through 11/6/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted on 11/4/20 through 11/6/10, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The COVID Focused Infection Control survey resulted in an Immediate Jeopardy (IJ) at F880 on 10/6/20, when it was identified the facility failed to immediately implement Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for isolation and use of transmission based precautions (TBP) when residents first exhibited symptoms of COVID-19. The IJ was removed on 10/27/20. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. Although NO plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 12/02/2020

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F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 2 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines to have ongoing surveillance and appropriate resident screening, monitoring, and quarantine or isolation for 6 of 30 residents (R2, R3, R4, R5, R6, and R7), who tested positive for COVID-19. The facility's failures resulted in an immediate jeopardy (IJ) situation for all 30 residents.	F 880	Past noncompliance: no plan of correction required.	

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F 880	Continued From page 3 The IJ began on 10/6/20, when it was identified the facility failed to immediately implement Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for quarantine or isolation and use of transmission based precautions when residents first exhibited symptoms of COVID-19. The facility had implemented measures to correct the deficient practice by 10/27/20, resulting in PAST NON-COMPLIANCE. Findings include: When interviewed on 11/4/20 at 11:49 a.m., the director of nursing (DON) stated she had been ill with COVID until 11/3/20. The DON stated, "the outbreak happened so fast, there was no time to update the surveillance documentation." The DON further stated, the infection preventionist (IP) in charge of the infection control program had resigned, with her last day of work being that day [11/4/20]. The DON verified infection surveillance consisted of reviewing resident infections and antibiotics every day and explained, the dashboard, last 24 hours of progress notes, and discussion of infections during stand-up meetings were to be completed daily to identify symptoms of infections and any changes in resident condition. Review of the facility's Infection Control Program documentation, identified processes located in a binder and an infection line list stored on an electronic spreadsheet. The infection control line list electronic document included: resident name, room number, infection type, body system for infection, and surveillance definitions met such as symptoms, onset date, infection risk factors, diagnostics performed, type of test, specimen	F 880		

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F 880	Continued From page 4 source, results, antibiotic name, type of precautions (such as whether transmission based precautions were in place), and date symptoms resolved. The facility's resident COVID-19 resident screening documentation tool identified staff were to notify the infection preventionist and implement transmission based precautions (TBP) when a resident had two or more symptoms present. Review of resident records and the infection control line listing identified the following: R2's nurses' notes identified between 10/6/20 and 10/15/20, R2 experienced frequent diarrhea. On 10/14/20, R2 tested positive for COVID and was moved to the COVID unit. The notes made no mention R2 was placed on TBP at the onset of diarrhea, a potential symptom of COVID-19. The October 2020, infection control line list did not include R2's symptoms of diarrhea. There was no indication R2's physician was notified when R2 developed the diarrhea. R3's nurses' notes identified between 10/7/20 through 10/14/20, R3 experienced frequent, intermittent diarrhea. On 10/14/20, R3 had nasal congestion, was tired, lethargic, hoarse and had crackles in her lungs. R3 was transferred and admitted to the hospital 10/14/20, and tested positive for COVID. R3 returned to the facility on 10/17/20, and was placed on TBP upon readmission. The October 2020, infection control line list did not include R3's symptoms of diarrhea. R3's progress notes did not indicate whether R3's physician was notified at the onset of diarrhea, and made no mention about whether R3 was placed on precautions at the onset of her	F 880		

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symptoms.

R4's nurses' notes identified on 10/11/20, R4 had diarrhea. On 10/14/20, R4 had a cough and tested positive for COVID. R4's notes made no mention R4 was placed on TBP at the onset of COVID symptoms. The October 2020, infection control line list did not include R4's symptoms of diarrhea.

R5's nurses' notes identified on 10/6/20, R5 was not eating because he felt it caused him to have diarrhea. On 10/7/20, R5 had shortness of breath and low oxygen saturation during physical therapy. On 10/12/20, the notes indicated R5 had low oxygen saturation and diminished lung sounds. R5's bowel records identified R5 had diarrhea on 10/13/20. On 10/14/20, staff explained to R5 he needed to remain in his room related to COVID. On 10/16/20, the nurses' notes indicated R5 had a new cough, fever, and low oxygen saturation at 77 percent. On 10/16 20, R5 was tested and found positive for COVID and was transferred to the facility's COVID unit. R5's progress notes did not indicate whether R5 was placed on TBP at the onset of COVID symptoms. The October 2020 infection control line list did not include R5's loose stools.

R6's nurses' notes identified R6 was hosptialized for a gastro-intestinal bleed on 9/27/20, returned to the facility on 9/30/20, and was on TBP and quarantine for 14 days. The nurses' notes indicated between 10/8/20 and 10/22/20, R6 experienced frequent diarrhea. R6 was tested for COVID and was positive on 10/22/20. R6's notes made no mention as to whether R6 remained on precautions after her 14-day isolation period ended 10/14/20, even when R6's diarrhea

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continued. No staff were able to verify the continued use of TBP or quarantine when symptomatic.

R7's nurses' notes identified on 10/1/20, R7 was seen by her medical provider and treated for nasal discharge. Additionally, the nurses' notes indicated R7 experienced diarrhea on 10/10/20, 10/11/20, 10/14/20, 10/15/20, 10/17/20, 10/27/20, and 10/29/20. R7's nurse notes from 10/21/20, indicated R7 "was placed on precautions during the past week", but did not specify the date. Review of the October 2020, infection control line list identified R7 was placed on TBP on 10/26/20 and was noted as having had no symptoms of COVID. The October 2020, line list made no mention R7 had nasal discharge on 10/1/20, or diarrhea between 10/10/20 and 10/29/20. There was no indication R7 was placed on TBP at the time of the initial onset of COVID symptoms.

During interview with registered nurse (RN)-A on 11/5/20 at 4:35 p.m., RN-A stated symptoms of infection were reviewed during daily stand-up meetings, and the DON and the infection preventionist were responsible for the infection control program. RN-A stated symptoms of infection are documented in each resident's electronic medical record (EMR) in the progress notes, or included in the resident User Data Assessment (UDA) record. RN-A stated there was a UDA for COVID symptom documentation to be utilized in the EMR so if a resident had symptoms of COVID, staff were to document those symptoms on the UDA. Further, RN-A stated PPE was implemented only by the DON or the infection preventionist when symptoms of COVID were identified as present.

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F 880	Continued From page 7 When interviewed on 11/6/20 at 11:00 a.m., the DON identified the facility had experienced two COVID outbreaks, a small one in September 2020, and a larger one in October 2020. The DON verified following the September 2020 outbreak, the facility had not reviewed the data from the outbreak to identify any potential breaks in their infection control practices. During the second outbreak, most staff were unable to work due to COVID symptoms or had COVID positive test results. The DON stated she was unable to maintain an ongoing infection surveillance process due to the sudden outbreak. She agreed infection surveillance was supposed to be ongoing and continuous, and verified that had not occurred. The review of residents with COVID symptoms between the outbreaks identified residents with diarrhea, and respiratory symptoms without initiation of transmission based precautions. The DON verified residents with diarrhea were not necessarily included in their facility infection surveillance and stated she felt some of the residents had long-standing diarrhea. However, the DON agreed diarrhea was a symptom of COVID and was included in the resident COVID screening tool. She confirmed residents with long term diarrhea symptoms were not reviewed to identify any changes in bowel patterns, and the symptoms were not addressed with the resident's physicians to determine need for TBP. The DON further stated they would only initiate TBP when residents had two or more symptoms of COVID according to facility policy. The DON was unsure how the decision to implement TBP when two or more symptoms were present was identified. The DON said she expected staff to follow recommendations outlined by the CDC and CMS. The DON also stated she and the facility's infection preventionist	F 880		

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were solely responsible for identifying and initiating TBP when COVID symptoms were identified. The DON stated nurses were to call her and the infection preventionist immediately to review symptoms and implement precautions. She agreed, there be would no way to monitor symptoms if they were not documented in the COVID Screening tool, or on a line list to determine potential outbreaks present in the facility. The DON stated she had felt the facility had implemented TBP appropriately and monitored appropriately for symptoms of COVID, and felt there was nothing further the facility could have done to prevent transmission of COVID after it was present in the facility. However, stated when she returned to work on 11/4/20, the facility had already initiated a new infection monitoring system.

Nursing assistant (NA)-A was interviewed on 11/6/20 at 10:04 a.m. NA-A stated staff notify the charge nurse when residents have COVID symptoms, and the DON and infection preventionist tell staff when to implement PPE.

During interview on 11/6/20 at 9:09 a.m., the administrator stated the facility had a COVID outbreak in September 2020, and again in October 2020. The administrator stated in October, almost all staff had became ill and they'd had to seek staffing supports from the State Emergency Operation Center to assist in providing resident care. The administrator also stated he'd been out with COVID and returned yesterday. The administrator verified they had not reviewed the September 2020 outbreak to identify any breeches in infection control practices to determine whether the facility could have done anything differently to prevent/minimize the

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COVID outbreaks. He agreed infection prevention should be ongoing and continuous, but stated the outbreak in October "happened so fast", they were unable to keep up.

On 11/6/20 at 10:52 a.m., an attempt was made to contact the facility's medical director. A message was left, but no call was returned at the time of the survey exit.

The facility's undated, Pandemic COVID-19 Plan, identified the infection preventionist was to create a system to monitor and internally review transmission of COVID-19 among residents and staff in the facility. Information from monitoring was to be used to implement infection prevention interventions.

The facility's 12/29/19, Infection Prevention and Control Program, identified the program was developed to address facility-specific infection control needs and requirements identified by the facility assessment and the infection control risk assessment. The policy indicated the program was reviewed annually and updated as necessary. The infection preventionist was responsible for coordination and oversight of the infection control program. The infection control committee was responsible for reviewing and providing feedback on the overall program. Surveillance data and reporting information was used to inform the committee of potential issues and trends. The reviews were to include documented infection incidents and corrective actions taken. Surveillance tools were used to recognize occurrences of infections, recording their number and frequency, detecting outbreaks and monitoring employee infections, adherence to infection prevention and control practices and

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detecting unusual pathogens with infection control implications. Outbreak management was a process to determine presence of an outbreak, manage affected residents, prevent the spread to other residents, documentation of information about the outbreak, reporting information to the appropriate public health officials, education of staff and the public, monitoring for recurrences, reviewing the care after the outbreak and recommending new or revised policies to handle similar future events.

The facility's 8/13/20, COVID-19 Guidelines and Procedures for All Facilities, identified the facility was to continue surveillance of all residents using the UDA titled Existing Resident COVID-19 Screening Tool. Staff were to immediately place residents with suspected COVID into isolation, place a mask on the resident and close their door, contact the designated State Agencies, regional clinician and local hospital, resident's guardians, physicians, and any other providers of the resident's status. Staff were to also remember to update the infection control line list and resident care plan.

The facility's undated, COVID-19 Recommendations for Long Term Care Facilities, identified all residents and staff were to be tested if symptomatic. Symptoms included fever greater than 100.0 degrees, or two or more temperatures greater than 99.0 degrees Fahrenheit (F), shortness of breath new or change in cough, chills, sore throat, muscle aches, new or worsening malaise, headache, new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, new confusion/altered mental status, and new or worsening hypoxia. A negative test only indicates an individual did not have detectable virus

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 _____	11/06/2020

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 880	Continued From page 11 material at the time of testing, and repeat testing may be needed, testing compliments existing infection prevention practices and was not a replacement of good infection prevention control practices. The past non-compliance that began on 10/6/20, was verified to have been corrected by 10/27/20 when the facility had appropriately identified and initiated transmission based precautions for residents who were symptomatic for COVID-19. In addition, surveillance was updated. Verification of corrective action was confirmed through interview with facility staff, observation of care, and review of residents' medical records, infection control surveillance, policies and procedures, and staff training.	F 880		