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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: VZX7
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 **09/06/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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 — Angela Hatch, HFE NE II — Date: 09/21/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Kamala Fiske-Downing, Sr. Health Program Rep — Date: 09/21/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
CMS Certification Number (CCN): 245596

September 21, 2018

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

Dear Administrator:

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 September 12, 2018 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
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered

September 21, 2018

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

RE: Project Number S5596028

Dear Administrator:

On July 31, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective August 5, 2018. (42 CFR 488.422)

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective October 1, 2018.

This was based on the deficiencies cited by this department for a standard survey completed on July 12, 2018. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On September 6, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 20, 2018 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 July 12, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 12, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 12, 2018, as of September 12, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 12, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 1, 2018 be rescinded as of September 12, 2018. (42 CFR 488.417 (b))

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
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered

September 21, 2018

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

Re: Reinspection Results - Project Number S5596028

Dear Mr. Molgard:

On September 6, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 6, 2018. At this time these correction orders were found corrected.

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
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: VZX7
Facility ID: 00885

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

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(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

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6. DATE OF SURVEY **07/13/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
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01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
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04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

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And/Or Approved Waivers Of The Following Requirements:
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__ 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)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 08/24/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 09/08/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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04-Other Reason for Withdrawal

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OTHER
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30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

REVISED LETTER

September 11, 2018

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

RE: Project Number S5596028

Dear Mr. Molgard:

This letter will replace the letter dated July 31, 2018. We have corrected the survey exit date. All remedies dates will be based of the letter from July 31, 2018.

On July 12, 2018, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

Appeal Rights - the facility rights to appeal imposed remedies;

Potential Consequences - the consequences of not attaining substantial compliance 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), and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective August 5, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition. CMS Region V Office concurs, is imposing the following remedy, and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective October 1, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective October 1, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 1, 2018.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, South Shore Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 1, 2018. This prohibition is not subject to appeal.
Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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 remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be

discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 1, 2018 (80 days 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 discretionary 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 discretionary 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 January 13, 2019 (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.

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

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
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING ______ B. WING ______	07/12/2018

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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on July 9, 2018 through July 12th, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On July 9, 2018 through July 12th, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		8/10/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 08/10/2018

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 ______	07/12/2018

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 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 2 residents (R23& R287) reviewed for dignity received assistance to the bathroom in a timely manner.	F 550	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. however, submission of the Plan of Correction is not an	

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F 550	Continued From page 2 Findings include: R23's electronic medical record (EMR) dated 7/12/18, included diagnoses of: hypertension, hypothyroidism, chronic atrial fibrillation, psychotic disorder with delusions, heart failure, chronic kidney disease, major depressive disorder, obesity, restlessness and agitation, macular degeneration, and obstructive sleep apnea. R23's 5 day Minimum Data Set (MDS) assessment, dated 6/28/18, indicated R23's Brief Interview for Mental Status (BIMS) score was 13, indicating cognition was intact. The MDS activities of daily living (ADL) assessment further indicated R23 required extensive assistance of two for toileting and transfers and was incontinent of bladder and occasionally incontinent of bowel. R23's care plan, dated 5/25/18, indicated bladder incontinence and some bowel incontinence. Interventions included staff were to check R23 every two hours and assist with toileting as needed. Staff were also to provide toileting at same time each day. R23's bowel habits included toileting at the same time each day in the afternoon. During interview on 7/10/18, at 3:34 p.m., R23 indicated she was incontinent of her bowels from waiting 45 minutes to get help after placing her call light on while her brother was here visiting. R23 further indicated this took time away from visiting with her brother and his wife while staff assisted her to get cleaned up. During interview with nursing assistant (NA)-B on	F 550	admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the policy of this facility to ensure each resident is treated with respect and dignity and care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. Some of the many ways that this has been achieved for residents #23 and #287 is by ensuring resident call light are responded to timely and efficiently. Immediately all call lights were checked to ensure that they were working on 7/9/18. Following identification of this issue all staff were immediately notified of the importance of timely call light response. Per interview with R-23 on 8/1/18 she did indicate that response times are improving. R-287 was discharged to home on 7/20/18. The facility implemented random call light audits beginning 7/19/18. These audits will facilitate identification of all residents and the timeliness of staff response to personal care needs. On 8/1/18 an audit of each resident room was completed to ensure that each unit had the necessary call light equipment for all licensed beds and each device was in working order, any identified concerns were forwarded to maintenance for correction. An in-service will be conducted on 8/14/18 and 8/15/18 to provide staff with review of facility call light policy with emphasis that call light response times are all staffs responsibility. Emphasis was placed on	

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F 550	Continued From page 3 7/12/18, at 9:17 a.m., NA-B described the function of the call light system. The NA's would look at the screen at the end of the hall or on the computer at the nurses station to see whose call light was on. The computer at the desk would indicate how long the call light had been on. Staff used to have beepers, however, they were no longer using them. NA-B stated, "It is hard to answer lights in the morning." NA-B stated they felt it would be helpful to have more staff available to toilet and bathe residents. During interview on 7/12/18, at 9:27 a.m. licensed practical nurse (LPN)-A indicated everyone in the building was responsible for answering call lights in a timely manner. Any staff could page for assistance for a resident if they were not able to assist. During interview on 7/12/18, at 1:49 p.m. regional director of clinical services (RDCS)-A indicated in 2015, call light pagers staff carried were bothersome and they "disappeared". It was every employee's job to answer call lights. A resident council meeting held at that time indicated a fifteen minute call-light response time was acceptable to memebers of the coun cil and she would expect that as timely. Facility staff had not performed any call-light audits to ensure timliness of answer, and RDCS-A acknowledged there was a problem. During interview on 7/12/18, at 2:35 p.m., NA-A indicated it was hard to answer call lights timely after the supper meal. She felt more staff was needed to answer call lights, especially on the D wing, as those residents had experienced incontinent accidents from waiting too long for their call light to be answered.	F 550	the need for timely response times for resident call lights to promote maintenance or enhance each residents quality of life. Effective 8/6/18, the Director of Nursing or designee will complete audits on resident call lights by pulling response times 3x/week times three weeks, then 1x/week times two months. Audits will be reviewed at the QAPI quarterly meeting. The QAPI Committee will review concerns and determine the need for further interventions or monitoring. The Director of Nursing will be responsible to ensure facility compliance with this plan of correction.	

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F 550	Continued From page 4	F 550		

During further interview with R23 on 7/12/18, at 3:52 p.m., R23 stated it made her feel sad as she does not want to have accident. Staff always say "Just a minute... I will be there in just a minute," however, it would be 30 minutes before they came back. At times, she could hear staff down the hall laughing and giggling, while R23 continued to wait for assistance. R23 stated it made her "very angry".

Review of the facility call light documentation for the dates of 7/03/18 - 7/10/18, documented R23's call light as on for 30 minutes or longer seven times during this time frame. On 7/5/18, the call light was activated at 6:30 a.m. and cleared at 7:32 a.m. (61 minutes later).

R287's Admission record dated 6/29/18, included diagnoses of wedge compression fracture of T11-T12 vertebra, pemphigus (a disorder of the skin), congestive heart failure, anemia, chronic pain, and atherosclerotic heart disease of coronary artery, constipation and chronic kidney disease. R287 resides on the 400 wing which is labeled as a transitional care unit (short term stay rehabilitation unit).

R287's Minimum Data Set (MDS) assessment, dated 7/6/18, reflected a BIMS score of 13 indicative of intact cognition, requires assist of one staff with transfers, bed mobility, walking in and out of room, dressing, toileting, and personal hygiene.

R287's temporary care plan dated 6/29/18, indicates R287's goal was to go home after rehabilitation, toilet upon rising, before and after meals, before bed, and as needed. R287

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F 550	Continued From page 5 identified as a fall risk. R287's electronic medical record (EMR), printed on 7/12/18, included a physician order for furosemide (a pill to take excess fluid away from the heart) daily at 9 a.m. During interview with R287 on 7/10/18, at 9:50 a.m. R287 stated, "I am only incontinent of water (urine) when it takes them too long to get here". A subsequent interview with a family member (unidentified) confirmed this. R287's call light response times were reviewed for 7/4/18 to 7/10/18, response times were more than 17 minutes thirteen times, and over 30 minutes seven times with the longest wait time 59 minutes and 38 seconds. The facility call light policy/procedure last reviewed 4/2/2018, indicated staff were to respond promptly to residents' calls for assistance. Ensure call system is in proper working order. Ensure residents can call for help when needed. The policy also indicated that a15 minute response time was approved by the resident council and was reviewed yearly to determine appropriate call light response times per resident requests.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.	F 558		8/10/18

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F 558	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop interventions to accommodate needs and promote independence with eating for 1 of 1 resident (R10) who had difficulty reaching the table for meals in the dining room. Findings include: R10's diagnosis report, dated July 12, 2018, indicated R10's active diagnoses of major depressive disorder, Vitamin D deficiency, hypomagnesemia, hypertension, heart failure, gastro-esophageal reflux disease, rheumatoid arthritis, arthropathy, pain, anxiety disorder, and age-related osteoporosis. R10's Minimum Data Set (MDS), dated 4/18/18, indicated a Brief Interveiw for Mental Status (BIMS) of 13, and indicated R10 was independent with eating after staff assistance with set up. R10's care plan, revised on 6/14/18, indicated R10 came to the dining room for meals and was able to feed herself after her tray was set up, with encouragement to finish her food. Occupational Therapy progress notes, dated 6/19/18, indicated R10 was fitted for a wheelchair of an 18 inch height versus 20 inches after a fall out of the wheelchair. The OT notes indicated R10's arm rests were too high, but were unable to be adjusted. The notes also indicated nursing was educated on the chair change and the location of the previous chair if R10 had complaints about the new one.	F 558	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. It is the facility standard of practice to provide each resident with reasonable accommodations for their individualized needs. R-10 was provided a smaller T.V tray table in the dining room to promote independence with eating on 7/13/18. Per interview and observation of R-10 on 8/1/18 she indicated that the tray table has made eating easier. "Isn't this wonderful." Per observation on 8/1/18 and 8/6/18 R-10 was consuming her breakfast meal and appeared to be having no difficulty with reaching her food, beverage or utensils. The Director of Nursing and Occupational Therapist will work together completing assessment of the dining room to ensure that all residents are provided reasonable accommodations to promote independence with meal consumption. Effective 8/6/18 audits will be conducted 3x/week times three weeks, then 1x/week weekly times two months. An in-service will be conducted on 8/14/18 and 8/15/18 for all staff to review the facility expectation of providing reasonable accommodations to promote resident independence with respect to meal consumption. Audits will be reviewed with the QAPI	

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F 558	Continued From page 7 During observation on 7/10/18, at 5:23 p.m., R10 was observed sitting at the dining room table with chin below the table top reaching up to the plate, complaining to her tablemates about sitting too low in the wheelchair. R10 held soup in the left hand, had a dessert bowl on her lap, and used a spoon with the right hand to eat. R10 was observed on 7/11/18, at 8:08 a.m., in the dining room with her chin just above the table. R10 was not able to see over the bowl she was eating out of to visualize its contents. R10 was also noted to be pulling her head up and squinting her eyes to fill out a menu. No staff came to assist R10. During observation on 7/11/18, at 11:48 a.m., R10 was seated at the dining room table, with her chin level with table surface, bringing a fork up to her plate and down to her mouth, and had pulled a bowl off of the table and was holding the bowl with her left hand and eating with right fingers. During interview on 7/10/18, at 8:48 a.m., R10 stated, "My wheelchair is too low, I told them I wanted a shorter table. I complain about it to everybody and nobody ever says anything and nothing changes. It is hard for me to eat because I have to get everything up to my mouth just right." During interview on 7/11/18, at 7:11 a.m., R10 stated, "I hate this chair, I don't like to eat in the dining room because my chair is too low". R10 further stated, "It is hard to reach my food with my chin on the table". During interview with licensed social worker (LSW) on 7/11/18, at 1:05 p.m., the LSW stated	F 558	quarterly meeting. The QAPI Committee will review concerns and determine the need for further interventions or monitoring. The Director of Nursing and Occupational Therapy will be responsible to ensure facility compliance.	

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F 558	Continued From page 8 she was aware that R10 was complaining the wheelchair was too small but was not aware of the difficulties R10 was having reaching food at the dining room table. The LSW further stated that she would make a referral to therapies. During interview with nursing assistant (NA)-C on 7/11/18, at 12:38 p.m., NA-C stated R10 had complained about not liking the wheelchair because it was too low and would let the nurse and therapy know. During interview with certified occupational therapy assistant (COTA) on 7/12/18 at 1:29 p.m., COTA-B confirmed that it was very difficult for R10 to eat meals and reach eating utensils because the table was too high for her chair and even her bedside table was too tall for R10 in the existing wheelchair. COTA-B further stated that R10 had kyphosis and the new wheelchair was the correct fit for her, however, needed a table of the appropriate height. During interview on 7/12/18, at 2:09 p.m., licensed practical nurse (LPN)-B, stated R10 was offered to move to another table but didn't want to at that time. R10 had a family member that sat at the same table. LPN-B further stated, the height of the tables could be lowered.	F 558		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655		8/10/18

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F 655	Continued From page 9 effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 655	This Plan of Correction constitutes my	

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F 655	Continued From page 10 facility failed to ensure a baseline care plan (detailing the cares/services needed for each individual resident) was developed and implemented within 48 hours of admission. This resulted in no initial documented plan of care following admission for 2 of 2 residents reviewed for recent admission/readmission to the facility (R38 & R86). Findings include: R38 was originally admitted on 10/23/17, and hospitalized on 4/14/18 - 5/1/18, with diagnoses obtained from the electronic medical record (EMR) which included: Acute respiratory failure, osteoarthritis, diastolic congestive heart failure (CHF), Anxiety disorder, Tachycardia, Sepsis, acute respiratory distress syndrome, Encephalopathy, and obesity. R38's most recent Minimum Data Set (MDS) assessment dated 5/2/18 was the five (5) day assessment and indicated a Brief Interview of Mental Status (BIMS) was not able to be completed due to severe cognitive impairment. R38 had a feeding tube in place and required total assistance of staff for all personal cares. Prior to this hospital admission the quarterly MDS indicated a BIMS score of 15/15 which indicated cognition was intact. R38 required extensive assistance with bed mobility and personal cares, but was independent with eating and was able to direct her own cares. R38 experienced a significant decline in status while hospitalized and was no longer able to direct her own plan of care, but was dependent on family members to do this for her. Demise was not considered impending so decision was made to transfer R38 back to the facility on	F 655	written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the facility policy that a baseline care plan be developed immediately upon admit and completed in 48 hours. R-38 and R-86, did not have baseline care plans completed as required within 48 hours of admission. The baseline care plan has been revised and now in the resident admission packet. Licensed staff have been instructed on the importance of the completion of the baseline care plan within the first 48 hours of admit. Beginning 8/6/18 the Clinical Nurse Lead will monitor and ensure that baseline care plans are completed within 48 hour of admit and a copy provided to the resident or their POA and a copy placed in the medical record. An in-service will be conducted on 8/14/18 and 8/15/18 for all staff to review the facility expectation/policy on completion of the baseline care plan. Effective 8/6/18 the Clinical Nurse Lead will audit for facility compliance regarding completion of the baseline care plan within 48 hours of admission. The Clinical Nurse Lead will complete three audits per week times three weeks, then one audit weekly time two months. Audits will be shared with the QAPI quarterly meeting. The QAPI Committee	

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F 655	Continued From page 11	F 655		

palliative care. The care plan in place in the medical record was from prior to hospitalization and indicated R38 was alert and oriented, and required assistance with activities of daily living (ADLs), but was able to direct her plan of care. Review of R38's electronic and hard copy medical record did not include a baseline care plan with R38's multiple changes in care needs and/or restrictions following her hospitalization and decline.

Review of the documentation indicated R38 had extensive changes in physical and mental status which included:

1.) Progress note dated 5/1/18, at 9:12 p.m. Primary diagnosis (Dx): Septicemia r/t E.coli(bacteria normally found in the intestinal tract); Acute respiratory failure, assistance of 2 persons with a sling lift (Hoyer) for all transfers. Non-ambulatory due to (d/t) decline with weakness. R38 has had an overall decline demonstrated by lack of understanding, confusion, (Just stares into air when staff speaking to her), and unable to eat well: Nasogastric (NG) tube is placed and receives continuous feedings at night 8:00 p.m. -8:00 a.m. The documentation further indicated in the instance the NG tube became clogged the family did not want it replaced. The documentation following R38's hospital return further indicated a problem with dysphagia (difficulty swallowing) and was to be offered a mechanically altered diet with nectar thickened liquids during the day hours. The initial documentation with relation to skin care identified bruising to bilateral arms, a reddened groin area and orders for Nystatin cream to be applied to reddened areas. R38's legs had areas of poor circulation indicated by

Plan of correction (F 655):

will review concerns and determine the need for further interventions or monitoring.
The Clinical Nurse Lead will be responsible to ensure facility compliance.

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F 655	Continued From page 12	F 655		

spots, but the skin was intact. R38's bilateral heels were mushy and "Blue Boots" were to be utilized in bed to protect her heels. In addition R38 had a dressing on the sacral area that was to be changed every 3 days or as needed. When in bed with feeding running the head of the bed was to be elevated 45 degrees. R38 was also receiving Oxygen (O2) per nasal cannula at 1 liter (L)/minute to maintain oxygen saturation in the 90's.

The social service progress note dated 4/3/18, for the assessment period prior to hospitalization on 4/14/18, detailed R38's status as: "Resident had no changes noted in this assessment period. She remains alert x 3. Able to express self and understand. Vision and hearing good, speech clear. Resident has no mood or behavioral issues. No room concerns. No personal items needed. She has the support of her sister who calls daily.

On 7/12/18, at 5:02 p.m. The Regional Director of Clinical Services (RDCS) indicated her expectation would have been for a base line care plan to be developed upon R38's readmission to the LTC facility on 5/1/18, due to the major change in both physical and mental status, in addition to the changes in care needs. Upon review of both the electronic paper record it was verified that no plan of care had been developed for R38.

R86's date of admission was 76/18, with diagnoses obtained from the electronic medical record (EMR)-Med Diagnoses. which included: Fracture (Fx) of the left femur; long term use of anticoagulants, Atrial Fibrillation (an irregular heart rhythm), Asthma, hypertension, and

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emphysema.

During observation on 7/9/18, at 3:11 p.m. R86 was seated in a recliner in room 108 with no lights on, a TV in front of her that was not on and bare walls which had no clock or items of interest. R38 was alert and oriented to her surroundings and during interview expressed her displeasure regarding admission on Friday 7/6/18, and failure of staff to make any attempt to provide for her care needs. R38 indicated she had been admitted for therapy following a fall with a fracture, but due to the lack of the facility providing for her care needs she was going to transfer to another facility as soon as it was able to be arranged. A call light with both the cord and attached box were lying on the bedside table beside the recliner and R 38 indicated she had nothing to do other than sleep. When asked about her admission and development and review of a plan of care, R38 indicated that she had not been included in or received any form of a plan of care either verbally or in writing. R38 indicated she had received a packet of papers, but nothing had been discussed with her and upon review of documents contained in the admission folder there was not a baseline care plan included.

The Hospital Discharge Summary dated 7/6/18, indicated R86 had been admitted 7/4/18 with a diagnosis of periprosthetic fracture around internal prosthetic left hip joint. The plan of care was for discharged to an acute rehabilitation facility for further recuperation.

During interview on 7/12/18, at 9:48 a.m. with the RDCS (standing in for DON who is out of building)-indicated the expectation is for the 48 hr Baseline Care Plan to be included/completed with

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F 655	Continued From page 14 the admission packet. The process is supposed to begin as soon as possible with the admission assessment and within the 48 hour time period nursing staff would send the document to be reviewed and update with information from the MDS nurse, activities and the licensed social worker. In addition the care plan is then reviewed at the Interdisciplinary meeting nsg for any input from therapies with the base line care plan placed into the chart until the permanent care plan is developed within 21 days. The RDCS confirmed that the development and initiation of the baseline care plan did not take place according to facility policy. The facility policy titled: Care Plans - Comprehensive created 12/23/17 and reviewed 4/28/18: All new admits will have base line care plan in admission packet and started by staff nurse upon admit. Once completed and reviewed within 48 hours. Then will be copied and given to resident for review or power of attorney (POA) and original in chart.	F 655		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 684	This Plan of Correction constitutes my	8/10/18

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F 684	Continued From page 15 review the facility failed to monitor 1 of 1 resident (R2) who was reviewed for dialysis services. Additionally, the facility failed to monitor and complete physician ordered treatments to skin wound for 1 of 1 resident (R288) reviewed for non-pressure related skin conditions. Findings include: R2 was admitted to the facility on 2/21/15, with diagnoses obtained from the electronic medical record (EMR)- Med Diag which included: Atherosclerotic heart disease, schizophrenia, unspecified psychosis, edema, anemia in chronic kidney disease, angina, anxiety disorder, dialysis, end stage renal disease, hypertension, major depressive disorder, pain, and type 2 diabetes. According to the EMR R2 received dialysis services three days per week at the local hospital dialysis center. On 7/9/18, at 3:00 p.m. R2 was observed walking in the hall with a padded, white gauze dressing on his left forearm. R2 was not able to respond to questions as to what was the reason for the dressing, but staff nurses indicated R2 had returned from his dialysis session a short time earlier. R2 ambulated into the day room and other areas of the facility at will, but no one was observed checking R2's shunt site, dressing or vital signs. Arrangements were made to obtain a Spanish speaking interpreter to allow for R2's interview. R2 was interviewed with the assist of a Spanish speaking interpreter on 7/9/18, at 5:30 p.m. and via the interpreter indicated he went to dialysis three times a week, and felt the dialysis center and the facilty communicated regarding his care	F 684	written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the policy of this facility to assist with monitoring residents with chronic diseases for appropriate treatment and care in accordance with professional standards. R-2's medication and treatment record has been updated to reflect monitoring of the fistula site for bleeding and completion of vitals post dialysis by licensed staff. All other residents receiving dialysis medical record has been updated in a similar fashion on 8/1/18. R-288 had orders for wound care verified, skin assessment completed, and weekly monitoring in place. R-288 was discharged to home on 7/31/18. An in-service will be conducted on 8/14/18 and 8/15/18 to review and educate staff on the importance of resident monitoring, reporting data to the physician and follow with dialysis documentation as well as wound documentation. All new admissions will be assessed if they have any special need for monitoring and it will be on the baseline care plan and on treatment sheets. Effective 8/6/18 the Director of Nursing will perform systematic audits on all dialysis residents weekly times three weeks, then one dialysis resident weekly times two months. Also audit three	

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needs. R2 indicated he bled easily and if he scratches himself he would bleed for a long time. R2 indicated he let staff know when he returned from dialysis on Monday, Wednesday, and Saturday, but no one checked the dressing on his arm on a routine basis and in addition the staff at dialysis checked his vital signs frequently, but when he returned to the facility they were not usually checked. . When asked about weights R2 indicated he was not weighted before he went to dialysis and was not certain how often he was weighed, but thought it was probably with his weekly bath.

On 7/11/18, at 1:30 p.m. R2 was observed entering the building with family members in attendance after receiving dialysis in the morning. R2 went up to the nursing station and waved at staff, and verbalized he was back. Staff greeted resident, but made no attempt to check the dressing located on his left forearm shunt site, nor did they attempt to obtain a set of vital signs. R2 proceeded to walk to room and back and then went into the lounge area where he watched an activity taking place. During the time period of 1:30 p.m. - 2:15 p.m. R2 walked about in the facility and sat in the day room, but no staff person was observed to check the dressing covering the shunt site or take vital signs.

Review of the medical record did not include documentation of shunt assessment/monitoring or checking of vital signs following R2's return from dialysis.

During an interview with licensed practical nurse (LPN)-A on 7/12/18, at 1:39 p.m. it was indicated fluid restriction distributions were listed on the medication administration record (MAR) and fluid

residents with wounds for treatment changes/orders for three weeks, then two residents weekly for two months.
Audits will be shared with the QAPI quarterly meeting. The QAPI Committee will review concerns and determine the need for further interventions or monitoring.
The Director of Nursing will be responsible for facility compliance.

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intake was adjusted according to this record. LPN-A indicated the routine for dialysis days was for R2 to be up early, the shunt site was prepared according to orders with Lidocaine and then a saran wrap covering. R2 left for dialysis at 6:00 a.m. and usually returned around 10:00 a.m. unless he was with family members then it could be later. LPN-A confirmed there were no routine checks of shunt, dressing, and vital signs following dialysis, but that staff looked at the area when R2 came to the desk, but there was no documentation and if R2 had a complaint then vital signs would be checked.

On 7/12/18, at 1:39 p.m. the regional director of clinical services (RDCS) (covering for director of nursing who was out of building), confirmed there was not monitoring being provided of R2's shunt or vital signs following return from dialysis and her expectation was that monitoring should be documented and care planed.

Review of the facility Dialysis Policy with the most recent review date of 4/28/18 included: The facility must develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet a resident's medical, nursing and psychosocial needs. 1.) the care plan should address: Monitor for complications, Frequency of monitoring vital signs, respiratory distress, chest pain, headache, seizure, etc.; Monitoring of shunt or access site for signs of infection, Potential for bleeding, care of the access site.

R288 was admitted to the facility on 7/2/18. BIMS (brief interview for mental status)

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moderately impaired cognition. Diagnoses listed on the diagnosis sheet included: venous insufficiency, arthropathy, non-pressure chronic ulcer of lower leg, diplopia, nutritional anemia, major depressive disorder, restless legs syndrome, migraine, macular degeneration, history of falling, and nondisplaced fracture of seventh cervical vertebra.

On 7/10/18, at 10:21 a. m. R288 was observed to have an open sore on her lower left leg which was open to air, a large bandage over her left elbow, along with suture area to her head. R288 stated that the sores on the leg were not healing and they (nursing staff) weren't doing much with them; further stating nurse's had not changed the dressings since arrival at the facility.

During observations on 7/10/18, at 11:48 a.m., R288 was sitting in the dining room wearing shorts. The open sore was visible with bloody drainage dripping down her lower leg to her ankle. Original bandage intact on left elbow.

On 7/11/18, at 8:03 a.m., resident was sitting in her recliner with the open sore visible with dried blood on her lower leg. No dressing or tubigrip on leg. Original bandage intact on left elbow.

7/12/18, at 10:19 a.m. R288 was observed in recliner with no tubigrip stockings on as ordered. R288 stated, "they couldn't find them or they were wet or something". Bandage taped to her lower leg wound with paper tape.

7/12/18, at 1:34 p.m. R288 observed sitting in recliner with no tubigrip stockings on, lower leg wound open to air.

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F 684	Continued From page 19 Skin assessment done upon admission signed by LPN-B on 7/2/18, notes two areas of concern; top of scalp wound measuring 1.0 cm x 0.1 cm and left lower leg (front) bruising 10 cm x 10 cm. Details included "has healed vascular ulcers to bilateral LE (lower extremity), skin discolored to LE". The assessment did not indicate that R288 had any open areas on leg or wound on the left elbow. Individual Resident Baseline Care Plan dated 7/2/18 and reviewed on 7/5/18, lacks any information or direction on skin or wounds. Sanford Health Interagency Transfer Orders dated 7/2/18, direct wound care as: apply wound wash saline topically one time a day for multiple open wounds of lower leg and apply 4 x 4 gauze pad dressing one time day to ulcer of left lower extremity with fat layer exposed. Per progress note dated 7/5/18 at 6 p.m. by LPN-A stated normal saline and 4 x 4 pads were not in supply. Weekly skin assessment dated 7/7/18 by LPN-E indicates overall skin is dry, warm, and pink. Left side of head has a laceration. Lower extremities bilateral have vascular insufficiency. Coccyx area has a heart shaped dressing. Assessment lacked documentation of left elbow wound and lower left leg extremity wounds. Wound Clinic Note dated 7/9/2018, indicates the left lateral wound is 3 cm(centimeters) x 2 cm x 0.3 cm. Further indicates that the area has a moderate amount of old bloody drainage noted. Superficial debridement done and the hematoma appears fairly deep. Mepelix foam dressing	F 684		

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F 684	Continued From page 20 applied to absorb drainage and tubigrip applied for compression. Ultrasound of the wound was ordered to assess depth of hematoma. Orders were to keep the area covered with Mepelix and tubigrip stockings to provide light compression. Signed Doctor's Orders and Progress Notes dated 7/9/18, at 11 a.m. ordered wound care to be completed by applying Mepelix foam to open areas of left leg, change Monday, Wednesday, and Friday. Apply tubigrip from toes to knee on left leg during the day and take off at bedtime. Interview on 7/12/18, at 9:53 a.m. revealed that RN-A had not done R288's dressing change yet that day but was not notified in report of any new orders. At 1:47 p.m. on 7/12/18, RN-A entered R288's room to do wound care. When questioned about the wound under the bandage on R288's left elbow, RN-A stated wasn't sure what was underneath the dressing and not sure if there were any orders for the care of it. Interview on 7/12/18, at 1:52 p.m. with LPN-B confirmed information on the initial skin assessment on 7/2/18, but stated that DON (director of nursing) did the assessment and LPN-B only documented the data in the record. Stated had not seen the wounds and did not know of any orders except the orders received from the wound nurse orders on 7/9/18. Further stated that the skin assessment should have been done the day of admission, any skin issues faxed to the doctor but that was not done. Wound Care policy last reviewed 4/20/18, indicates the following information should be	F 684		

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F 684	Continued From page 21 recorded in the resident medical record; type of wound care provided, the date and time the wound care was given, the position in which the resident was placed, the location of the wound, any change in the resident's condition, all assessment date (for example, wound bed color, size, drainage, etc.) obtained when inspecting the wound, how the resident tolerated the procedure, any problems or complaints made by the resident, if the resident refused the treatment and the reason why, and the signature and title of the person recording the data. There was no documentation on wound in the initial and subsequent assessments, no documentation in the Non-Pressure Skin Record in the weekly wound documentation binder which was to be done every Tuesday.	F 684		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 1 resident (R287) reviewed for pain, received pain medications in a timely manner. This resulted in actual harm for R287 who experienced severe pain when the facility ran out of her supply of narcotic pain medication. The findings include:	F 697	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the policy of the facility to provide	8/10/18

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F 697	Continued From page 22 R287 was admitted to the facility on 6/29/18 with diagnoses including: Wedge compression Fracture of T11, T12 Vertebra initial encounter for closed fracture, and other chronic pain. During interview with R287 on 7/9/18 at 6:58 p.m., she reported she'd been out of pain pills for an entire day and was in pain. R287 was crying and her posture/movements indicated she was in pain. She stated she was supposed to take a pain pill every four hours for pain control but added, "they don't always last that long." R287's family member also present during the interview, verified R287's report, "She was out of pain pills all night, the doctor had ordered 20 tablets but when they are taken every four hours they don't last that long, she went a whole day without her pills, she was very uncomfortable and crying." During interview with licensed practical nurse (LPN)-C on 7/11/18 at 7:44 a.m., LPN-C stated, "Most of the medications come from the machine upstairs, and if it is an Oxycodone or something, the pharmacy will let us know we need a script and we will fax the doctor for a script. It usually is taken care of by the next shift." Registered nurse (RN)-A stated during interview on 7/12/18 at 9:49 a.m., "Nursing calls the pharmacy and they will send it out on the delivery for the same night. If it is needed now, the nurses call the pharmacy from town." Although RN-A stated that the doctor had given R287 20 tablets of the pain medication and they ran out. RN-A stated they had faxed the doctor for a script but the regular doctor was on vacation, so they had to call the clinic on call. RN-A said once the pharmacy received a prescription, they would authorize it so it could be sent out. During interview on 7/12/18, at 2:04 p.m., LPN-B stated, "[R287] has chronic and acute pain.	F 697	adequate supervision and assistance with pain management. R-287 had been in facility with a diagnosis of pain related to a compression fracture and chronic pain. Resident stated had told nurse was in pain and the nurse explained the medication was not available. Staff were not consistent on ordering within 5 day window and pharmacy had difficult time managing refills or assisting facility to get medication efficiently and effectively due to needing script. R-287 script was renewed immediately and pain management was resumed following script renewal. Effective 8/6/18 the Clinical Nurse Lead or their designee will be responsible to complete the pain evaluation on all residents during the ARD assessment period. Information gathered from these assessments will be reviewed weekly at the facility Patient at Risk Meeting. In-service will be conducted on 8/14/18 and 8/15/18 with regards to pain management and the facility responsibility to ensure that those residents experiencing pain are provided necessary care and treatment to promote quality of life. Pain management will be shared at the QAPI quarterly meeting. The QAPI Committee will review concerns and determine the need for further interventions or monitoring. The Director of Nursing and pharmacy will be responsible for facility compliance.	

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F 697	Continued From page 23 There was some lag time between the getting the script from the clinic to the pharmacy. Usually the pharmacy contacts the clinic but not always, and they don't communicate it with us. We may not know until it doesn't come out of the medication administration machine. We tried Tylenol and ice for pain control [for R287] which may have given her some relief but not 100%. I don't think her quality of life was affected, she [R287] wasn't stuck in bed or anything. Review of the electronic medical record (EMAR) indicated R287 had not received the scheduled doses of Oxycodone-Acetaminophen 5-325 mg (milligrams) on 7/3/18 at 12 a.m., 4 a.m., 8 a.m., or 12 p.m. According to the documentation, R287's pain rating was documented at a "9" on a 0-10 pain scale (0=no pain to 10=the worst pain ever) during this time frame. A facsimile (fax) request to R287's physician dated 7/3/18, indicated: "Resident came to facility with Oxycodone-Acetaminophen tablet 5-325 mg give one tablet by mouth every 4 hours for pain control r/t (related to) wedge compression fracture of T11-T12 Vertebra. Initial encounter for closed fracture order was only for 20 doses and is completed. Gave Tylenol and ice throughout the night with little to no relief. Resident is still in constant pain and rates pain 8-10 [10 being the most severe pain] all day. Can you send a new script to pharmacy so resident can resume pain regimen." The physician's response included: "RX (prescription) sent to [Dr's name] to sign electronically." The facility's policy Medication Orders 12/28/17, indicated staff were to reorder medications when the resident has not less than 5-7 days worth. In addition the policy indicated hard scripts must be current if not on file can in order to refill a narcotic. "Pharmacy can try to reach physician,	F 697		

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

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F 697	Continued From page 24 but facility staff are responsible for getting new order." The facility's Medication Administration policy last reviewed 5/10/18, indicated medications were to be administered within one (1) hour of their prescribed time, unless otherwise specified. The contracted pharmacy policy Unavailable Medications last revised 6/15, indicated if facility nursing staff were unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the facility medical director for orders and/or direction. The contracted pharmacy onsite formulary printed on 7/12/18, indicated Oxycodone/APAP tablet 5-325 mg were available in the automated dispensing unit (ADU) emergency supply kit.	F 697		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 725		8/10/18

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(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on interview, and document review, the facility failed to provide sufficient nursing staff to meet the toileting and safety needs of residents located on the transitional care unit (TCU). This had the potential to affect 13 of 43 residents who resided in the TCU.

Findings include:

During an interview on 7/9/18, at 7:01 p.m. certified nursing assistant (NA)-D indicated NA-D felt more help was needed in the TCU. NA-D stated "I'm not going to lie, staffing is horrible." During a typical shift, one NA and one nurse were regularly assigned to residents in the TCU. There were twelve residents in the TCU. Additionally, the residents needs in the TCU were higher, and more complex than the rest of the facility. The nurse was regularly assigned to both the TCU and C-Wing, which was located on the upper level of the facility. At times, the NA was the only staff covering residents in the TCU. Residents in the TCU frequently require assistance of two, and presently, three residents required the use of a full body lift to toilet and transfer. NA-D indicated residents waited up to an hour to get help to toilet and transfer, almost on a daily basis and they also complained of waiting for help on a daily

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This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.
It is the policy of the facility to ensure sufficient nursing staff are scheduled daily to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and individual plan of care and considering the census, acuity and diagnoses of the facility population in accordance with facility assessment. Timeliness of staff call light response times directly impacts resident question of adequate staffing. The facility implemented random call light audits beginning 7/19/18. These audits will facilitate identification of all residents and the timeliness of staff response to personal care needs. On 8/1/18 an audit

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basis.

During an interview on 7/10/18, at 11:30 a.m. registered nurse (RN)-A, indicated the TCU had staffing issues. Residents cares were more difficult, because they require a higher level of care than residents in the other wings. "The TCU is "almost like a med-surg unit." One nurse and one NA were assigned to 12 residents. The nurse frequently worked both C-wing and TCU. The wings were on separate floors which left the NA alone in the TCU when the nurse needed to be in C-Wing. RN-A stated an assignment to both C-wing and TCU made it difficult to provide needed cares. Documentation frequently was not done, and residents missed appointments. The NAs had difficulty completing cares in a timely manner, including toileting. Residents have longer wait times with only one NA, and they complain about having to wait "all the time." Residents continent prior to admission, were incontinent in the TCU.

During an interview on 7/10/18, 12:11 p.m. NA-C indicated residents complain frequently about waiting for help. Complaints were highest in the morning when residents wanted to get up, and in the evenings when they wanted to go to bed. NA-C has observed residents in distress and tearful because they were incontinent from having to wait for help. NA-C stated sometimes "all I can do is apologize."

A voicemail from the ombudsman on 7/10/18, at 12:20 p.m. identified staffing was a concern for the facility. Ombudsman recommended interviewing residents and staff for information.

During the resident council meeting on 7/10/18, at

F 725

of each resident room was completed to ensure that each unit had the necessary call light equipment for all licensed beds and that each device was in working order, any identified concerns were forwarded to maintenance for correction. Effective 8/6/18 the Director of Nursing will complete call light audits by pulling response times three times a week times three weeks, then one time a week times two months. Call light response times and concerns will be placed on the Resident Council Agenda and followed up by the Director of Nursing if concerns are presented by the residents.
The facility will review current job roles and responsibilities and identify further opportunities to re-define staff responsibilities during shifts to assist the facility to reach its highest level of quality of care. Current staffing patterns based on unit acuity will be reviewed and adjustments made as needed to promote optimum quality of care as identified by the individualized resident plan of care.
On 8/14/18 and 8/15/18 an in-service will be held where staffing needs will be discussed. Emphasis on the importance of all staff addressing resident needs, including the importance of response to call lights, assistance with ADL's and expectations of licensed staff and non-licensed staff to aid residents with their identified personal care needs.
The ED, DON, and scheduler have reviewed staffing pattern to ensure sufficient staffing based on facility census, and acuity is maintained. The ED, DON, and scheduler will continue to monitor

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F 725	Continued From page 27 1:20 p.m. council members identified wait times for call lights that were greater than thirty minutes, especially after lunch, and longer wait times during the night when less staff were on shift. Resident (R)20 felt there were not enough staff to help meet needs, because more staff are needed when using a lift, and it takes a longer time to help them. R20 reported having to wait many times for longer than thirty minutes, and recalled being incontinent about a month ago, as a result of having to wait. R20 indicated the nurse came into the room, shut the call light off, left, and never returned. R20 indicated that the call light was put back on, but when help finally came, it was too late, "I was incontinent." During an interview on 7/11/18, at 11:49 a.m. licensed practical nurse (LPN)-C stated the TCU was understaffed. Two NAs are working today because, "State is here." Normally, TCU had one nurse and one aid assigned to the unit. When the nurse was assigned both the TCU and the C-wing, the NA was left alone in TCU. Cares were more difficult in the TCU because residents' conditions were more acute, required more accurate documentation, and more monitoring. LPN-C felt even though resident cares were getting done, they "were not getting done well." LPN-C identified negative resident outcomes related to insufficient staffing. Recently, a newly admitted resident (R)289 fell a few times. One fall occurred on LPN-C's shift. Both staff were assisting residents and did not hear the resident call for help. R293 had cognitive deficits, was unable to use the call light, and would self transfer to try to get to the bathroom. LPN-C was aware of residents who were upset and tearful when incontinent, and that upset residents occurred on a regular basis related to wait times.	F 725	staffing pattern and provide support to current staff and ensure that adequate staffing is maintained to promote quality of care to all of our residents. Sufficient staffing will be shared at the QAPI quarterly meeting. The QAPI Committee will review concerns and determine the need for further interventions or monitoring. The ED and Director of Nursing along with corporate recruitment and retention team will be responsible for ensuring sufficient staffing.	

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LPN-C stated wait times were up to forty minutes for assistance to the bathroom at times. LPN-C indicated that incontinence occurred at least three to four times per week, and stated "I am sure it is happening daily on all shifts, every shift."

During an interview on 7/12/18, at 9:54 a.m. TCU resident R293 stated was admitted to the facility in June 2018, with a broken leg and was unable bear weight on the right leg, and was unable to walk. Two staff were required to help R293 with transfers, toileting and some repositioning. R293 confirmed that wait times for assistance were regularly up to 30 minutes. R293 confirmed they were incontinent to the extent of needing a clothing change at leas three or four times since admission two weeks ago. "It's embarrassing, you know, I'm such an independent person usually, I have multiple sclerosis, but I am usually continent. I think they need more help on the floor all the time." R293 indicated before state came this week, it was really tough to get help. Getting help depended upon how many staff were working. When only one NA was working, it took twenty to thirty minutes for help after putting on the call light. R293 felt having only one NA on the floor was not fair to the patient or to the worker because everyone had to wait longer for help. R293 indicated the staff were really good, but "they just need more of them."

During a resident council follow-up interview on 7/12/18, at 10:17 a.m. R20 described the incontinent episode a month ago was "humiliating." R20 stated "staff make you wait because they don't want to come around because it is a lot of work." R20 indicated when staff answer call lights, they say they have to find some one else to help, then they leave. It may

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take up to an hour for them to return. R20 talked to the social worker last month when the call light was shut off and discussed the issue in resident council. R20 observed another resident's call light on for over an hour during the day shift. R20 routinely sat at the end of the hallway during the day and observed call lights on that "don't get answered." R20 observed staff sitting around on their cell phones, but other times observed there just was not enough help.

Review of the Facility Device Activity Report dated from 7/3/18, to 7/10/18, indicated R293 had the following call light wait times greater than fifteen minutes: 7/7/18, the call light was on for 53 minutes; 7/7/18, 28 minutes; 7/8/18, 38 minutes; 7/4/18, 36 minutes; 7/4/18, 34 minutes; 7/4/18, 32 minutes; 7/9/18, 35 minutes; 7/3/18, 32 minutes; 7/5/18, 26 minutes; 7/5/18, 24 minutes; 7/5/18, 19 minutes; 7/9/18, 18 minutes; 7/10/18, 17 minutes; and 7/6/18, 17 minutes.

Review of the Facility Device Activity Report dated 7/3/18, to 7/10/18, indicated R20 had the following call light times greater than fifteen minutes: 7/7/18, 29 minutes; 7/9/18, 19 minutes.

During and interview by the team coordinator on 7/12/18, at 5:15 p.m. the administrator, and the regional director of clinical services (RDCS) indicated that staffing concerns and call light concerns are areas currently audited by the quality assurance performance improvement (QAPI) team. RDCS identified a need to hire additional nurses to provide consistent staffing. The administrator indicated he felt staffing "was adequate," but opportunity to redefine responsibilities during shifts could help ensure the facility reached its highest level of quality care.

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Review of the Device Activity Log from 7/3/18, to 7/10/18 identified three call light records 70 minutes or greater, seven call light records 60 minutes or greater, fourteen call light records 50 minutes of greater, eighteen call light records greater than 40 minutes, forty-five call light records greater than 30 minutes; and two call light records greater than 20 minutes.

Policy and procedure for Call Lights dated 4/2/18, indicated the purpose is to respond promptly to resident's call for assistance, to assure the call system is in proper working order, and to ensure residents can call for help when needed. Per resident council residents agreed and approved a fifteen minute call light response time, with annual review.

R287's Admission record dated 6/29/18, included diagnoses of wedge compression fracture of T11-T12 vertebra, pemphigus (a disorder of the skin), congestive heart failure, anemia, chronic pain, and atherosclerotic heart disease of coronary artery, constipation and chronic kidney disease. R287 resides on the 400 wing which is labeled as a transitional care unit (short term stay rehabilitation unit).

R287's Minimum Data Set (MDS) assessment, dated 7/6/18, reflected a BIMS score of 13 indicative of intact cognition, requires assist of one staff with transfers, bed mobility, walking in and out of room, dressing, toileting, and personal hygiene.

R287's temporary care plan dated 6/29/18, indicates R287's goal was to go home after

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F 725	Continued From page 31 rehabilitation, toilet upon rising, before and after meals, before bed, and as needed. R287 identified as a fall risk. R287's electronic medical record (EMR) printed on 7/12/18, includes a physician order for furosemide (a pill to take excess fluid away from the heart) daily at 9 a.m. Interview with R287 on 7/10/18, at 9:50 a.m., stated, "I am only incontinent of water (urine) when it takes them too long to get here". Interview with resident family member confirmed this. R287's call light response times were reviewed for 7/4/18 to 7/10/18, response times were more than 17 minutes thirteen times, and over 30 minutes seven times with the longest wait time 59 minutes and 38 seconds.	F 725		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		8/10/18

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F 755	Continued From page 32 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safeguards and systems were in place to control, account for and periodically reconcile, controlled medications to prevent loss, diversion, or accidental exposure for 1 of 1 resident (R20) reviewed for medication administration who received a controlled substance. This deficient practice had the potential to affect 5 of 43 residents receiving controlled substances. Findings include: Observation of medication storage cart used in the transitional care unit (TCU) with registered nurse (RN)-B on 7/9/18, at 7:19 p.m. identified one single-use packet labeled R281's Oxycodone 5-325 mg stored with non-controlled medications in bins in small top drawers in the medication cart. The packet was dispensed from an automated dispensing unit (ADU) and stored in an area not designated as a permanently affixed secured compartment.	F 755	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the policy of the facility in conjunction with pharmacy to establish a system of records of receipt and disposition for all controlled drugs. During observation it was noted controls and non-controlled medications were mixed together in the med cart and meds pulled by previous shift. During observation R-20's medication administration record did not reflect two licensed staff signatures at time of destruction. R-20's medication record	

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F 755	Continued From page 33 Observation of dispensing medication from the ADU and storage of meds on the C-wing med cart with (RN)-A on 7/11/18, 8:48 a.m. identified two controlled medication packets containing R20's hydrocodone 5/325 mg, and tramadol 50 mg packets dispensed from the ADU and placed in storage on the medication cart in small compartments in small top drawers of the med cart with other ADU dispensed non-controlled medications. The package label indicated to dispense R20's hydrocodone which was scheduled at noon at 3:00 p.m. During an interview on 7/9/18, at 2:56 p.m. LPN-D indicated that most medications in the facility were dispensed using an automated dispensing unit (ADU) located in the medication storage room. Controlled medications from the ADU were dispensed separately from non-controlled medications. If medications were not dispensed from the ADU, medications stored on the appropriate med cart packaged in blister-pack cards. LPN-D indicated all controlled medications in cards are stored in the locked affixed box on the medication carts. Only the duplicate cards had to be stored in the locked box on the med cart. LPN-D indicated that no Fentanyl patches were due to be changed that evening and explained the process for checking, changing, and destroying Fentanyl patches was to check for placement when the patches are changed every three days. Once removed, patches were destroyed by "smashing them up" and placing them in sharps container. LPN-D indicated that two nurses are not required to dispose of used Fentanyl patches in the sharps container. During an interview in the TCU on 7/9/18, at 7:19 p.m. (RN)-B, a pool nurse for the facility, indicated controlled medications are dispensed	F 755	was updated to indicate the fentanyl patch requires two licensed staff signatures at time of destruction. As all residents receive medications per their individualized plan of care the facility reviewed the procedure for proper destruction of fentanyl patches. All controlled medications have been secured in the narcotic lock box within the medication cart separate from non-controlled medications. An in-service was conducted on 8/14/18 and 8/15/18 to review the facility expectations with regards to proper destruction and storage of controlled medications. Audits will be conducted by the Director of Nursing with emphasis on proper destruction of fentanyl patches. Effective 8/6/18 three audits per week times three weeks, then two audits weekly times two months will be completed to ensure facility compliance. Pharmacy and the Director of Nursing will be responsible for this Plan of Correction	

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F 755	Continued From page 34 either from the ADU or the emergency dispensing unit (ADU).All medications, including controlled medications, dispensed from the ADU were stored together in the medication cart top small drawers until administered. Medications not dispensed by the ADU are in blister-pack cards. Cards containing controlled medications were stored in the affixed locked box on the med carts in each wing. RN-B indicated that no Fentanyl patches were due to be changed that p.m. The process to destroy Fentanyl patches once removed was done with 2 nurses, no record is maintained for destruction of the patches. RN-B stated "I do it for my own safety." "Every other place I work, 2 nurses must destroy Fentanyl patches." RN-B was unsure if two nurses were required to destroy patches at this facility. The removed patches are disposed of in the sharps container. During an interview on 7/11/18, at 8:48 a.m. in the TCU, RN-A indicated all controlled medications in cards, including liquids and Fentanyl patches were stored in the secured, locked box on the med carts. Controlled medications dispensed from the ADU were stored with noncontrolled medications in individual resident slots in the upper small drawers and not in the locked container on the cart because if they were stored in the locked box, everyone would forget where they were and redispense another dose of controlled medications from the ADU "It would "be a mess." RN-A indicated night shift dispensed meds from the ADU for the 8 a.m. med pass at 3:00 a.m. The day shift nurse dispensed medications for the noon and 3:00 p.m. med pass between 10:30-11:00 a.m. The p.m. shift staff started at 2:30 p.m. P.M. nurses administer 3 p.m. meds. Night-time meds were dispensed at 4:00 p.m. RN-A indicated pharmacy had no	F 755		

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F 755	Continued From page 35 guidance about appropriate times for dispensing medications. Controlled medications were allowed outside of locked containers. RN-A was unsure how controlled medications from the ADU should be stored once dispensed form the ADU. RN-A asked if storing the controlled medications outside the locked box was considered an incorrect practice. When asked what the facility policy was for storing dispensed controlled medications from the ADU, RN-A stated "I don't know." During an interview on 07/11/18 at 11:49 a.m. LPN-C identified overnight staff responsibilities included dispensing the 8:00 a.m. medications from the ADU for the a.m. shift. 8:00 a.m. medications were dispensed around 3:00 a.m. In the TCU, meds dispensed by the night shift were given by the day shift nurse around 9:00 a.m. Controlled meds in cards are stored in the lock box. ADU dispensed medications are stored in top drawers, and not in a permanently affixed, locked compartment. ADU meds are dispensed for both the noon and 3 p.m. shift by the a.m. nurse around 10 a.m. The evening shift medications for 3:00 p.m. are stored in bins in the top small drawers, including controlled medications. Meds are placed in cards are stored in labeled bins for each resident. Controlled medications in cards were stored in a locked, permanently affixed box in the med carts. Used Fentanyl patches were removed by and destroyed by one nurse, cut up put in the sharps container. During an interview on 7/10/18, 3:50 p.m. pharmacy consultant (PC)-A described the recommendations for storage of controlled medications, including tramadol, was to store them in locked compartment, permanently attached to a cart, or object. PC-A expected the	F 755		

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F 755	Continued From page 36 facility to store controlled medications in the locked compartment attached to the med cart if not administering medication with a reasonable period within the administration time frames indicated by the facility policy. A reasonable amount of time was clarified to be within one to two hours. PC-A indicated medications, especially controlled medications, should be dispensed by the person who is administering them to ensure controlled medications were readily reconciled and to deter diversion. PC-A recommended to destroy Fentanyl patches in the presence of two nurses, by either toilet flush or disposed of in a drug destroyer container, and "never" in a sharps container, because sharps containers were not secure were easily accessible and visible to staff, residents and employees. Review of the facility Medication Storage Policy dated 12/28/18 indicated "controlled medications must be stored separately from non-controlled medications." The access system (key, security codes) used to lock Schedule II medications and other medications subject to abuse, and cannot be the same access system used to obtain the nonscheduled medications. Schedule II medications and preparations must be stored in a separately locked, permanently affixed compartment. Review of the Disposal of Medications and Medication-Related Supplies Controlled Substance Disposal policy provided by Alixa RX, dated 8/2014, required two licensed nurses present when a dose of controlled medication is wasted for any reason and documented on the accountability record or book on the line representing that dose.	F 755		

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F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that	F 790		8/10/18

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F 790	Continued From page 38 led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement interventions on the person centered care plan for 1 of 1 resident (R2) reviewed for dental services. Findings include: R2 was admitted 2/21/15 with diagnoses obtained from the electronic medical record (EMR) which included: Atherosclerotic heart disease, schizophrenia, unspecified psychosis, edema, anemia in chronic kidney disease, angina, anxiety disorder, dialysis, end stage renal disease, hypertension, major depressive disorder, pain, and type 2 diabetes. During observation and interview with an interpreter on 7/09/18, at 5:44 p.m. R2 was noted to have a missing tooth on the right side of his lower denture. Via the interpreter, R2 indicated his tooth had broken about one year ago and he would like to have it repaired. R2's most recent Minimum Data Set (MDS) assessment, dated 6/20/18, did not indicate any concerns of missing teeth. Review of R2's care plan indicated R2 had upper and lower dentures, but did not indicate a missing tooth. During an interview with the licensed social worker (LSW) on 7/11/18, at 3:10 p.m. It was indicated she was not aware of R2 missing a tooth from his dentures. In addition the LSW	F 790	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Corrections is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the facility policy to promptly, within three days, refer residents with lost or damaged dentures for dental services. R-2 was noted to have a missing tooth on the right side of his lower denture. An oral/dental assessment was completed on 6/20/18 at which time no oral/dental concerns were identified and the resident declined need for dental appointment. Neither the resident or family reported to staff or the social worker of missing tooth on lower denture. On 7/17/18 the dentist office was contacted. Resident and family are aware of dental contact and agree with plan of care. Staff have been instructed to be alert for potential dental issues or concerns and the goal to find quick resolution. The facility will continue to complete the oral/dental assessment on admission, re-admit, quarterly, annually, and new onset dental discomfort. To enhance currently compliant operations all staff will be updated at an in-service on 8/14/18 and 8/15/18 about oral hygiene, oral assessments and	

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F 790	Continued From page 39 indicated registered nurse (RN)-B would have completed the oral assessment and this should have been communicated to her. RN-B was also interview at this time and indicated she had completed the assessment, but had not noticed R2 was missing a tooth in his lower dentures. The LSW further indicated the normal process followed if a resident had a problem with a tooth would be to contact the family and insurance and make anarrangement to have the resident seen by dentist if he chose to do so. During interview on 7/11/18, at 3:30 p.m. the LSW indicated she had spoken to R2 who had shown her the missing tooth from his lower dentures, and would be contacting the family and attempting to set up a dental appointment as R2 indicated he wanted his dentures repaired.	F 790	addressing dental needs timely. Effective 8/6/18 the social worker or her designated alternate will complete audits on residents with dentures to ensure proper fit and good condition of dentures. Three audit per week times three weeks, then two audits per week times two months. Any identified dental concerns will be managed in a timely manner taking into consideration availability of services. When necessary due to limitations on who will accept the work of the resident, resident may need to be placed on a cancellation list in attempt for the appointment to be performed more promptly. Audits will be shared with QAPI quarterly meeting. The QAPI Committee will review concerns and determine the need for further interventions or monitoring. The Social Service Director will be responsible for this Plan of Correction.	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facilty failed to provide food and drink	F 804	This Plan of Correction constitutes my written allegation of compliance for the	8/10/18

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F 804

Continued From page 40

that was palatable, attractive, and at a safe, appetizing temperature for 3 of 43 residents (R289, R2, & R24) observed during meal time. This had the potential to affect 13 of 43 residents who resided on the TCU unit.

Findings include:

Supper meal service on 7/09/18, at 05:30 p.m. observation identified the dietary director (DD) as the cook for the evening. Observed a prepared a plate of egg whites, bacon and cold cereal prepared for R2. R2 was going to be late for supper. The was plate was wrapped in tin foil and placed on top of other food items covered in foil on the steam table. When the resident was ready for the meal, at 5:54 p.m. DD removed the foil and placed it on the top of the steam table shelf to serve to the resident. DD was asked to identify what the temperature of the omelet and bacon, and DD indicated was unsure what the temperature was. When asked to check the temperature, DM placed a thermometer into the egg omelet and identified the temperature at 101 degrees Fahrenheit (F). DD was unsure what the proper temperature should be and indicated that the plate should have been inside the steam table to maintain a temperature above 135 degrees F.

Observation of room trays service on 7/09/18, at 6:03 p.m. identified room trays delivered to the transitional care unit (TCU) on an open rack. Lids covered the plates. No plate warmers were utilized. Liquids were served in uncovered glasses on the open cart. The cart was pushed into the TCU and staff began to pass the trays.

During an interview on 7/10/18, at 8:49 a.m. R24 stated she prefers to eat in her room, and stated

F 804

deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.
It is the policy of the facility to provide food and drink that is palatable, attractive, and at a safe, appetizing temperature.
During observation, at time of survey R-2, R-24, and R-289 food temperature did not meet expectation. Food cart arriving on the TCU was not covered and on a open rack.
Plate insulators are to be used for residents that request later meals or room trays, liquids and foods being transported will be covered and temperature checked regularly.
It was discussed with dietary manager and dietician and it is agreed that temperature monitoring is important, resident do get food that is appetizing and tasty and that meals and drinks should be covered when transported. All meals will be inspected before being served to residents and if determined not appropriate will be discarded and redone.
The policy for food temperatures and storage has been reviewed.
An in-service will be completed on 8/14/18 and 8/15/18 where food temperatures, delivering meals timely, ensuring food is covered and palatable is being reviewed. Emphasis on reminding staff that meal service is often most enjoyable social experience residents will have in a day.
The Dietary Manager or her designee will

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F 804	Continued From page 41 that meals served have not been hot lately. R24 was served oatmeal and yogurt at this time. R24 described the oatmeal as "cold and hard." During observation on 7/11/18, at 12:15 p.m., room trays for the TCU were placed on an open rack, and fluids were in uncovered glasses. The rack was transported to the TCU uncovered. A sample room tray was requested. Sample tray temperatures from the steam table were as follows: ham slice 136 degrees F, rice 136 degrees F, and carrots 163 degrees F. The sample tray was placed in the cart and transported to the upper level of the facilty. At 12:32 p.m. after trays were passed, DD measured the temperature of the tray contents. Temps were as follows: ham, 116 degrees F, rice 107 degrees F, and carrots 118 degrees F. Food was sampled. Ham, rice, and carrots were luke warm and unseasoned. During an interview on 7/12/18, at 9:45 a.m. R289 indicated that the food served is "quite often not warm." Breakfast meals are generally ok, but other meals at noon and in the evening varied a lot in temperature and flavor. Food was often on the "blah" side. During an interview on 7/12/18, at 3:58 p.m. the DD confirmed that fluids on the room trays were transported uncovered on an open rack from the kitchen to the TCU. Glasses containing liquids were uncovered on the rack. DD indicated the glasses were uncovered because the "lids don't fit." Room trays had temperature concerns identified by temperature measurement and by residents interviews. The DD was aware of temperature concerns, and stated to remedy the problem food was either reheated in the	F 804	monitor food temperatures and quality. Audits of ten residents prior to eating for the first week, then five resident per week times four weeks, then one resident times two months. Audits will be shared with the QAPI quarterly meeting. The QAPI Committee will review concerns and determine the need for further interventions or monitoring. The Dietary Manager will be responsible for this Plan of Correction.	

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F 804	Continued From page 42 microwave, or discarded and prepared upon resident request. DD was unsure of whether room trays needed to maintained at minimum holding temperatures until served. DM confirmed the sample tray tested on 7/11/18, at 12:35 p.m. containing the ham slice, rice and carrots was too cold to be palatable. DD stated the facility used hot plates in the past, but discontinued use due risk of burning residents. DM identified plate warmers on the steam tables were not being utilized during meal services. DM stated normally only one or two staff were in the kitchen to pass trays, but while state was here there were up to 6 staff including nurses and CNAs in the kitchen passing trays at one time. DM confirmed that non-dietary staff entered areas in the kitchen where hairnets should be worn. Review of the facility Food Temps and Storage policy dated 12/28/17, indicated food should be held at an acceptable temperature with methods to prevent the spread of food borne illness and reduce practices that result in food contamination or compromise food safety. Monitor temperatures at the end of serving line to assure any food items being held for future use was at acceptable temperature for product.	F 804		
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the walk-in refrigerator and freezer was maintained in good	F 908	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However submission	8/10/18

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F 908	Continued From page 43 working repair. This had the potential to affect all 43 residents currently residing in the facility. Findings include: During an initial observation of the kitchen with the DM on 7/8/19, at 2:30 p.m. the walk-in refrigerator entrance light fixture with a clear, glass, oblong, globe approximately six inches in diameter, had a large amount of water collecting at the base of the globe, touching the base of the light bulb. A water sprinkler next to the light fixture was covered in rusty debris. Observation of the walk-in freezer idenfied condensation on the window, running down the front of the door. A pry bar was sitting beside the freezer leaning against the wall. The freezer door was unable to close completely. An inch of the door margin was visible from the door frame. The dietary director (DD) had to forcibly open the door to observe the contents. The entire freezer was covered in a blanket of frost and the floor was slippery. The internal temperature was -10 degrees Fahrenheit (F). On 7/9/18, at 6:45 p.m. the walk in freezer door continued to shut inappropriately, the edge of the door remained exposed. To check the internal freezer temperature, the DD used the pry bar to open the freezer door. The DD stated a former maintenance employee provided a pry bar so staff were able open the door without having to call for to get in the freezer every time. With out it the pry bar, dietary staff were unable to open the door, especially during summer. DD stated "It never used to be like this." The freezer door was frosted shut because the central air had been broken in the kitchen for over a year. The two window air conditioning (AC) units used in the	F 908	of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the policy of the facility to ensure the walk-in refrigerator and freezer is maintained in good working repair. A temporary freezer accommodation will be utilized until walk in freezer can be repaired. In-service will be conducted on 8/14/18 and 8/15/18 to review with staff regarding freezer use, safety, and monitoring of temperatures. ED and maintenance department will develop a plan to get the freezer in compliance to ensure safety to staff that use it. The dietary manager will complete audits on freezer temperatures daily and overall of the freezer condition. Five audits the first week, then three audits for fours week, then one audit for two months to ensure compliance in this area. Audits will be shared with the QAPI quarterly meeting. The QAPI Committee will review concerns and determine the need for further interventions or monitoring. ED, maintenance, and the dietary manager will be responsible for this plan of correction.	

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F 908	Continued From page 44	F 908		

kitchen do not keep up with the moisture, so the freezer door can not close properly and freezes shut. Maintenance (M)-A, attempted to communicate the need to repair the central air conditioning in the kitchen to the corporate office, but so far, only window units had been provided to attempt to resolve the issue, and were ineffective.

On 7/10/18, at 9:17 a.m. DD reported approximately one fourth of a cup of water was emptied from the first light fixture in the walk in refrigerator in the morning. The door of the walk in freezer was observed partially open with approximately an inch the door margin exposed in the door frame. Condensation was observed running down the door, and the entire contents of the freezer including the floor was covered with frost. Foods were frozen solid, and the temperature on the thermometer on the outside of the freezer was -10 degrees F, the thermometer on the interior of the freezer indicated at temperature of -10 degrees F.

During an interview on 7/10/18, at 2:45 p.m. M-A indicated that the kitchen location next to the laundry and boiler rooms, rendered moisture and humidity hard to control. The central air conditioning unit failed in the kitchen, about a year ago, was very expensive to repair. M-A attempted to control the humidity in the kitchen with two window air conditioning units. The dishwashing room was the worst. A 20,000 BTU unit was installed first, but it was exchanged for a 25,000 BTU AC unit, but was ineffective in controlling humidity in the kitchen. Corporate recommended a dehumidifier, but one of the AC units would be removed, the dietary staff chose to keep the window AC units because it was very

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F 908	Continued From page 45 hot in the kitchen. M-A indicated to control the moisture and frosting freezer, the central air unit need to be replaced. A review of the maintenance log for the freezer door indicated the seal for the door had been replaced several times from prying the door open.	F 908		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assure call lights were maintained in working order for 1 of 43 residents (R86) reviewed during the survey. Findings include: During observation and interview with R86 on 7/09/18, at 2:58 p.m. a call light with wall box and cord attached was observed lying on the bedside table located beside the recliner in which R86 was seated. R86 indicated her call light had not worked consistently since she was admitted on 7/6/18. R86 further indicated that on Saturday night she was in bed attempting to call for help to go to the toilet. R86 indicated she had pushed the button to activate her call light and after multiple attempts pulled the call box off the wall. R86 indicated she began yelling for help and still	F 919	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the facility policy to assure that call lights are maintained in working order to promote quality of care. All residents who reside in the facility may need assistance and use the call light system to obtain assistance from staff to ensure treatment with respect and dignity and services in a manner that promotes quality of care. R-86 was found to have a call light which	8/10/18

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F 919	Continued From page 46 no one responded. As a result of not being able to self toilet and no staff response to her yelling for "help" she was incontinent in her bed and stated, "I froze because I was lying in my wet bed". R86 indicated she was not certain of the time of occurrence of the incident, or how long she remained lying in the wet bed as she did not have a clock on the wall, but she knew it was about 3:00 a.m. (because she asked) when someone came to check on her and she had been lying in her wet bed for a "long time". R86 indicated she told staff she had been attempting to call for help and staff went and obtained a different call light which was placed on the bedside table. The unidentified staff person indicated this call light did work and had been obtained from another room. R86 indicated she continued to have issues with staff not responding to her call light and she would yell out when someone passed by her room. R86 further indicated she had a TV but no remote, so she was not able to use it, and there was a clock that staff found on top of the room dresser, but it didn't have batteries and was not working. Staff did replace the batteries in the clock and laid it on the stand beside her chair (Not able to be viewed when resident was in bed.). R86 indicated she was upset over the lack of staff response to her needs and indicated she had a TV which she was not able to use as there was no remote control and she couldn't get up to operate it. Activation of R86's call light displayed on the electronic display as room 313 and R86 was located in room 108. The call light was activated at 3:26 p.m. and as of 3:30 p.m. several unidentified staff persons walked past room but no one stopped to inquire what R86 needed. After 15 minutes,a staff person was observed	F 919	was not functioning properly. When identified during the survey process that R-86 was using a call light that was not properly identifying R-86 as the resident needing assistance, (system identified another resident room) the call light was immediately corrected. To ensure that all other residents had a properly functioning call light system the facility immediately completed a call light audit on all other residents, no further identified non-functioning call lights were identified. Staff were instructed to ensure that resident call lights are functional, available and answered in a timely manner. In-service will be conducted on 8/14/18 and 8/15/18. Staff will be educated to ensure that resident call lights are functional, available, and answered in a timely manner. Staff will be provided education on how to proceed when it is identified that a call light is not functioning properly. Replacement batteries will be kept in each medication cart for call lights requiring simple battery replacement. For incidents where simple replacement of batteries is not the solution maintenance will be called to ensure that all residents have access to call lights that are in working order. On 8/1/18 the facility again conducted a full facility audit of call lights, any concerns regarding properly functioning call lights were forwarded to the maintenance department for repair. On-going audits will be conducted to ensure that the facility has properly functioning call lights for all residents. Any identified concerns with	

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	245596	A. BUILDING ______ B. WING ______	07/12/2018

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F 919	Continued From page 47 entering Room 108 and R86 requested to toilet. R86 further indicated she wanted to rest as she was tired and requested interviewer to return later. In a subsequent interview on 7/9/18, at 6:30 p.m. R86 indicated the only way she got assistance was to yell out. She further indicted she had attempted to utilize the call light, but stated, "they don't care". No one comes or checks on me unless I yell. Nursing assistant (NA)-F was interviewed on 7/09/18, at 6:41 p.m. and indicated she was not aware of the call light being changed for Room 108 or that it would display as room 313 on the electronic display. The director of nursing (DON) was subsequently interviewed on 7/09/18, at 6:41 p.m. and confirmed she was not aware of this issue until brought up by this writer and her expectation would be if a call light needed to be used from a different room it should have been clearly communicated so that staff knew where to respond. The DON further indicated staff were not aware of where to respond when the electronic display indicated 313 had been turned on and there had not been communication to update the oncoming shift of the need to change call lights for room 108. During interview on 7/9/18, at 7:15 p.m. the DON confirmed that all call lights were expected to be functioning and that a facility wide audit would be performed immediately. It was further confirmed that in the instance of a call light being changed she would expect this to be communicated so that staff were aware of the change and the solution corrected as soon as possible. In addition the DON indicated when cares were	F 919	current call lights will be corrected immediately by the maintenance department. Effective 8/6/18 five resident rooms will be audited each week times two weeks, then three resident rooms time two months. Any identified need for repairs will be completed immediately. Audits will be shared with the QAPI quarterly meeting. The QAPI Committee will review concerns and determine the need for further interventions or monitoring. Maintenance supervisor will be responsible for this plan of correction.	

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F 919	Continued From page 48 completed for a resident staff were to insure the call light was with in reach regardless of where the resident was seated.	F 919		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for staff, residenet, and the public for 2 of 2 residents (R24 & R293) that had damaged chair coverings. Findings include: During an initial interview with R24 on 7/10/18, at 8:49 a.m. the brown, vinyl recliner R24's room had a large, peeling hole on the head rest portion of the chair partially covered by a small flap of a piece of brown vinyl. Peeling vinyl fabric on the arm rests was also observed. Both areas had the vinyl fabric backing exposed. R24 indicated the chair belonged to the facility, and stated the recliner was "Pretty bad, I was not able to use a mine from home because it was covered in cat hair." A brown vinyl recliner in room 404 on 7/12/18 at 9:45 a.m. was observed. Large peeling areas of vinyl on the headrest approximately eighteen inches by twelve inches was partially covered by a brown vinyl flap.	F 921	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the facility standard of practice to provide a safe, functional, sanitary, and comfortable environment for staff, residents and the public. Any residents who were identified to have worn chairs during survey have had those chairs removed and replaced with more comfortable, safe, sanitary, and functional chairs. The facility has implemented a program to replace chairs which are worn. Chairs have arrived and a process to replace worn, uncomfortable, or unsanitary chairs have been implemented. The ED, maintenance, and the social services director will over-see this process. The ED, Social Service Director, and	8/10/18

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F 921	Continued From page 49 During an interview on 7/12/18, at 9:55 a.m. R293 sat in a brown vinyl recliner with worn arms and headrest. Fabric was exposed in the worn areas. The entire back of the recliner was covered with a sheet. R293 stated the recliner is "really bad" housekeeping staff come to just to sweep up pieces that flake off the recliner and fall onto the floor. During an interview on 7/12/18, 5:16 p.m. M-A identified twelve chairs are in use at the facility with peeling vinyl fabric on the headrests and arms. Some are covered with sheets to have a barrier between the surface and the residnets using the furniture. M-A stated "I'm trying to get new chairs because they are worn." The facility administration suggested to wrap the bad ones with material. "I am embarrassed when new residents come to the facility, covering with fabric does not fix the chairs." I was working with the previous administrator to replace the recliners because they are not longer able to be cleaned appropriately. Cost to reupholster the recliners was about four hundred dollars per chair. New chairs were also considered. Corporate office was provided with pictures and a proposal for new recliners when the previous administrator was still here, but no response was received in response to the proposal. The new administrator was updated of the need for new chairs, but has only been here a little over a week, so the process is currently on hold.	F 921	maintenance will conduct rounds of resident room to monitor comfortable environment and determine if chairs are in good condition, lighting appropriate, clock available, and TV remote working properly. Any identified concerns will be corrected immediately. Results will be shared with the QAPI quarterly meeting. The QAPI committee will review concerns and determine the need for further interventions or monitoring. The ED will be responsible for this plan of correction.	

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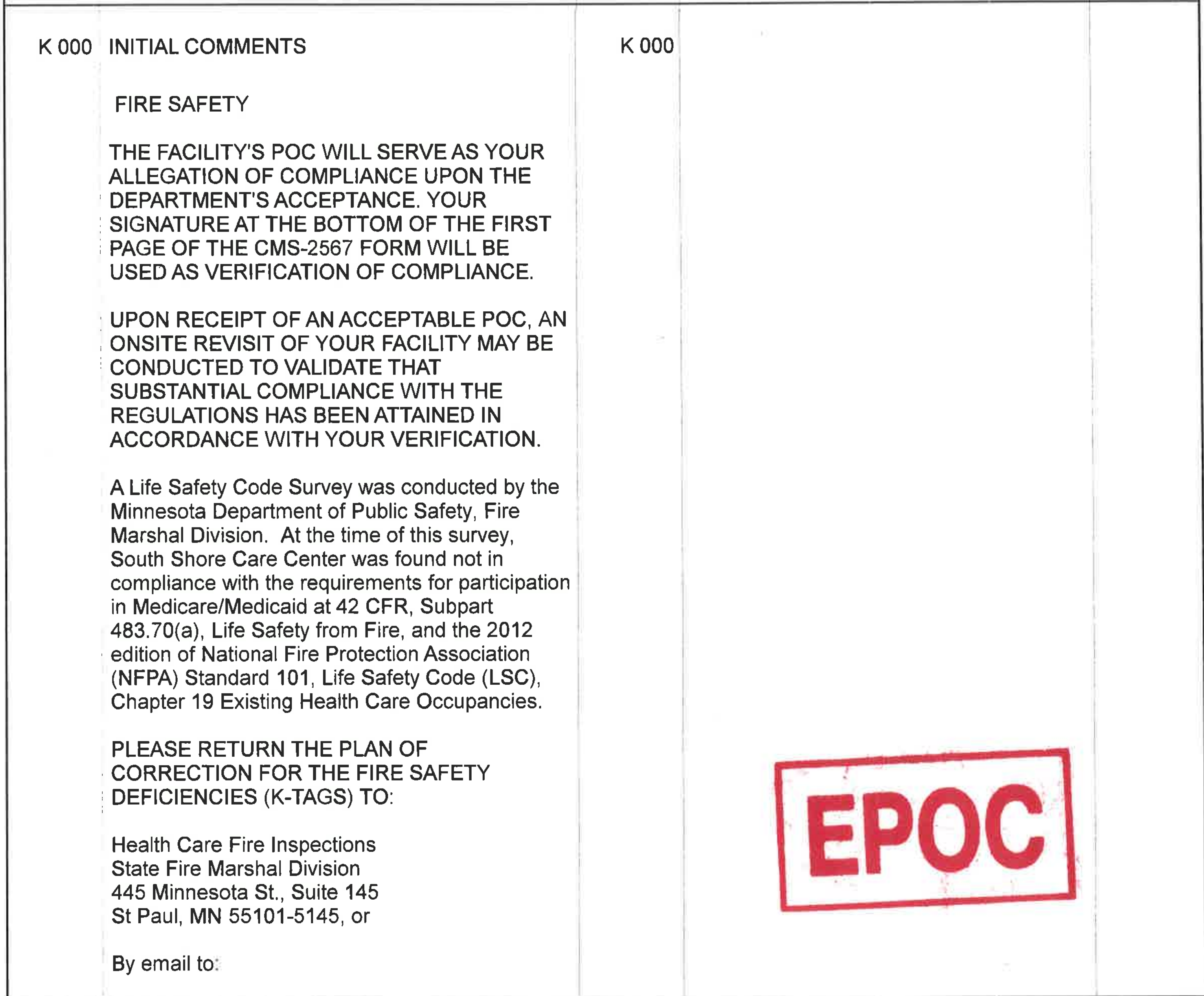

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, South Shore Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/10/2018

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. South Shore Care Center is a two-story building with partial basement. The original building was constructed in 1962, with building additions constructed in 1964 and 1968. All are fully sprinklered, and were determined to be of Type I (332) construction. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 46 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting	K 291		7/13/18

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K 291	Continued From page 2 Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain emergency lighting in accordance with 7.9. The deficient practice could affect 46 out of 46 residents. Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 FINDINGS INCLUDE: On facility tour between 11:00 AM and 1:00 PM on 07/12/2018, during the inspection, a surface mount emergency light within the Kitchen did not operate when tested. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the facility standard to ensure that emergency lighting remain functional in accordance with guidelines. During inspection a surface mount emergency light within the kitchen was found not to operate when tested. Emergency lighting will be maintained in accordance with requirements. The emergency lighting in the kitchen was replaced on 7/13/18. This was observed and verified by the Director of Maintenance and Administrator. The Maintenance Director and Administrator will be responsible to ensure facility compliance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345		7/25/18

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K 345	Continued From page 3 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. This deficient practice could effect 46 of the 46 Residents. Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25. FINDINGS INCLUDE: On facility tour between 11:00 AM and 1:00 PM on 07/12/2018, during documentation review, it was revealed that he Annual Fire Alarm Inspection had not occurred within the required time frame. The last inspection was conducted on 07/07/2017. This deficient practice was verified by the Facility Maintenance Director.	K 345	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the facility standard to comply with ensuring compliance with annual fire alarm inspection. At time of inspection it was revealed that the annual fire alarm inspection had not occurred within the required time frame. Fire alarm testing and maintenance will be completed annually. The Fire Alarm System was tested by ABC Company on 7/25/18 and documented as such. This was verified and will be monitored by the Director of Maintenance and Administrator. The Maintenance Director and Administrator will be responsible to ensure compliance.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation	K 351		8/10/18

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K 351	Continued From page 4 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to ensure that fire sprinklers were kept from obstructions that could effect the operation in accordance with NFPA 13. This deficient practice could effect 46 of 46 Residents. Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes	K 351	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the facility standard to ensure that fire sprinklers are kept free from obstruction which could effect the operation of the sprinkler. The sprinkler system will be maintained in proper working condition in accordance with requirements. The sprinkler head in the walk-in-cooler will be replaced on 8/10/18. This will be observed and verified by the Director of Maintenance	

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K 351	Continued From page 5 closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) FINDINGS INCLUDE: On facility tour between 11:00 AM and 1:00 PM on 07/12/2018, observation revealed, the sprinkler head located in the walk-in cooler was observed with rust on the deflector. This deficient practice was verified by the Facility Maintenance Director.	K 351	and Administrator and monitored by the Director of Maintenance. The Maintenance Director will be responsible to ensure facility compliance with this plan of care.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to ensure that the fire/smoke dampers were maintained according to 9.2 and in accordance with the manufacturer's specifications. The deficient practice could affect 46 out of 46 residents.	K 521	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of	9/12/18

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K 521	Continued From page 6 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 FINDINGS INCLUDE: On facility tour between 11:00 AM and 1:00 PM on 07/12/2018, documentation could not be provided that indicated the fire/smoke damper inspection had occurred within the past 4 years. This deficient practice was verified by the Facility Maintenance Director.	K 521	Correction is submitted to meet requirements established by state and federal law. It is the facility standard that fire/smoke dampers will be inspected for proper working condition every four years. Fire/smoke dampers will be inspected for proper working condition every four years as required. The fire/smoke dampers were inspected by Simplex/Grinnel Company on 7/27/18. The fire/smoke dampers will be repaired by 10/1/18. This will be verified by the Director of Maintenance and Administrator and will be monitored by the Director of Maintenance. The Maintenance Director will be responsible for this Plan of Correction.	
K 781 SS=C	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This **REQUIREMENT** is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a written and current Space Heater Policy.This deficient practice could affect 46 of 46 residents. Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except,	K 781	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and	8/10/18

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(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 781	Continued From page 7 unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 FINDINGS INCLUDE: On facility tour between 11:00 AM and 1:00 PM on 07/12/2018, documentation reviewed revealed that the Facility does not have a written Space Heater Policy that is specific to South Shore Care Center. This deficient practice was verified by the Facility Maintenance Director.	K 781	federal law. It is the facility standard to prohibit space heaters in all health care occupancies, except, unless used in non-sleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit. A new space heater policy was written and implemented on 7/13/18. All staff will be in-serviced on the revised policy per all staff in-service on 8/14/18 and 8/15/18 by the Administrator. The Maintenance Director will be responsible for this plan of correction.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or	K 914		9/12/18

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 ______	07/12/2018

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K 914	Continued From page 8 area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain electrical recepatacles in accordance with NFPA 99. The deficient practice could affect 46 out of 46 residents. Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99). FINDINGS INCLUDE: On facility tour between 11:00 AM and 1:00 PM on 07/12/2018, during documentation review, it was determined that during the electrical receptacle inspection conducted on 12/21/2017, approximately 50 electrical outlets within the	K 914	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Care is submitted to meet requirements established by state and federal law. It is the facility standard to ensure that electrical outlets within the resident rooms meet retention testing in accordance with requirements. Electrical outlets will be tested to ensure that they meet retention tests in accordance with requirements. All electrical outlets not meeting the retention test will be replaced and/or repaired between 9/1/18 and 9/30/18. This will be verified by the Director of Maintenance and Administrator and will be monitored by the Director of Maintenance. The Maintenance Director will be responsible for this Plan of Correction.	

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	245596	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**07/12/2018**

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K 914	Continued From page 9 Resident Rooms throughout the facility had failed the retention test. There was no documentation to show that these outlets have been repaired. This deficient practice was verified by the Facility Maintenance Director.	K 914		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to comply with 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8	K 920	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission	7/23/18

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K 920	Continued From page 10 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5.This deficient practice could affect 46 of the 46 residents. Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 FINDINGS INCLUDE: On facility tour between 11:00 AM and 1:00 PM on 07/12/2018, during the inspection, a CPAP Machine in Resident Room 105 was observed plugged into a power strip that was not a PCREE Rated Power Strip. This deficient practice was verified by the Facility Maintenance Director.	K 920	of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the facility standard to avoid use of power strips unless PCREE rated power strip. All power strips not meeting PCREE ratings and used for medical equipment have been removed. Power strips meeting PCREE ratings have been replaced in those areas where medical equipment is used. This was verified by the Director of Maintenance and Administrator and will be monitored by the Director of Maintenance. The Director of Maintenance will be responsible for this Plan of Correction.	

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Electronically delivered
September 13, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5596028

Dear Mr. Molgard:

This letter will replace the letter dated July 31, 2018. We have corrected the survey exit date. All remedies dates will be based of the letter from July 31, 2018.

The above facility was surveyed on July 9, 2018 through July 12, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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 Holly Kranz, Unit Supervisor at (507) 344-2742 or at holly.kranz@state.mn.us.

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
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00885	A. BUILDING: ______ B. WING ______	07/12/2018

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2 000	Initial Comments	2 000		

*****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

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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 7/9/2018, - 7/12/2018 , 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.	2 000		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to provide sufficient nursing staff to meet the toileting and safety needs of residents located on the transitional care unit (TCU). This had the potential to affect 13 of 43 residents who resided in the TCU. During an interview on 7/9/18, at 7:01 p.m. certified nursing assistant (NA)-D indicated NA-D felt more help was needed in the TCU. NA-D stated "I'm not going to lie, staffing is horrible." During a typical shift, one NA and one nurse were regularly assigned to residents in the TCU. There were twelve residents in the TCU. Additionally, the residents needs in the TCU were higher, and more complex than the rest of the facility. The nurse was regularly assigned to both the TCU and C-Wing, which was located on the upper	2 800	Corrected refer to F-725	8/10/18

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2 800	Continued From page 3	2 800		

level of the facility. At times, the NA was the only staff covering residents in the TCU. Residents in the TCU frequently require assistance of two, and presently, three residents required the use of a full body lift to toilet and transfer. NA-D indicated residents waited up to an hour to get help to toilet and transfer, almost on a daily basis and they also complained of waiting for help on a daily basis.

During an interview on 7/10/18, at 11:30 a.m. registered nurse (RN)-A, indicated the TCU had staffing issues. Residents cares were more difficult, because they require a higher level of care than residents in the other wings. "The TCU is "almost like a med-surg unit." One nurse and one NA were assigned to 12 residents. The nurse frequently worked both C-wing and TCU. The wings were on separate floors which left the NA alone in the TCU when the nurse needed to be in C-Wing. RN-A stated an assignment to both C-wing and TCU made it difficult to provide needed cares. Documentation frequently was not done, and residents missed appointments. The NAs had difficulty completing cares in a timely manner, including toileting. Residents have longer wait times with only one NA, and they complain about having to wait "all the time." Residents continent prior to admission, were incontinent in the TCU.

During an interview on 7/10/18, 12:11 p.m. NA-C indicated residents complain frequently about waiting for help. Complaints were highest in the morning when residents wanted to get up, and in the evenings when they wanted to go to bed. NA-C has observed residents in distress and tearful because they were incontinent from having to wait for help. NA-C stated sometimes "all I can do is apologize."

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2 800	Continued From page 4	2 800		

A voicemail from the ombudsman on 7/10/18, at 12:20 p.m. identified staffing was a concern for the facility. Ombudsman recommended interviewing residents and staff for information.

During the resident council meeting on 7/10/18, at 1:20 p.m. council members identified wait times for call lights that were greater than thirty minutes, especially after lunch, and longer wait times during the night when less staff were on shift. Resident (R)20 felt there were not enough staff to help meet needs, because more staff are needed when using a lift, and it takes a longer time to help them. R20 reported having to wait many times for longer than thirty minutes, and recalled being incontinent about a month ago, as a result of having to wait. R20 indicated the nurse came into the room, shut the call light off, left, and never returned. R20 indicated that the call light was put back on, but when help finally came, it was too late, "I was incontinent."

During an interview on 7/11/18, at 11:49 a.m. licensed practical nurse (LPN)-C stated the TCU was understaffed. Two NAs are working today because, "State is here." Normally, TCU had one nurse and one aid assigned to the unit. When the nurse was assigned both the TCU and the C-wing, the NA was left alone in TCU. Cares were more difficult in the TCU because residents' conditions were more acute, required more accurate documentation, and more monitoring. LPN-C felt even though resident cares were getting done, they "were not getting done well." LPN-C identified negative resident outcomes related to insufficient staffing. Recently, a newly admitted resident (R)289 fell a few times. One fall occurred on LPN-C's shift. Both staff were assisting residents and did not hear the resident

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2 800	Continued From page 5	2 800		

call for help. R293 had cognitive deficits, was unable to use the call light, and would self transfer to try to get to the bathroom. LPN-C was aware of residents who were upset and tearful when incontinent, and that upset residents occurred on a regular basis related to wait times. LPN-C stated wait times were up to forty minutes for assistance to the bathroom at times. LPN-C indicated that incontinence occurred at least three to four times per week, and stated "I am sure it is happening daily on all shifts, every shift."

During an interview on 7/12/18, at 9:54 a.m. TCU resident R293 stated was admitted to the facility in June 2018, with a broken leg and was unable bear weight on the right leg, and was unable to walk. Two staff were required to help R293 with transfers, toileting and some repositioning. R293 confirmed that wait times for assistance were regularly up to 30 minutes. R293 confirmed they were incontinent to the extent of needing a clothing change at leas three or four times since admission two weeks ago. "It's embarrassing, you know, I'm such an independent person usually, I have multiple sclerosis, but I am usually continent. I think they need more help on the floor all the time." R293 indicated before state came this week, it was really tough to get help. Getting help depended upon how many staff were working. When only one NA was working, it took twenty to thirty minutes for help after putting on the call light. R293 felt having only one NA on the floor was not fair to the patient or to the worker because everyone had to wait longer for help. R293 indicated the staff were really good, but "they just need more of them."

During a resident council follow-up interview on 7/12/18, at 10:17 a.m. R20 described the incontinent episode a month ago was

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"humiliating." R20 stated "staff make you wait because they don't want to come around because it is a lot of work." R20 indicated when staff answer call lights, they say they have to find some one else to help, then they leave. It may take up to an hour for them to return. R20 talked to the social worker last month when the call light was shut off and discussed the issue in resident council. R20 observed another resident's call light on for over an hour during the day shift. R20 routinely sat at the end of the hallway during the day and observed call lights on that "don't get answered." R20 observed staff sitting around on their cell phones, but other times observed there just was not enough help.

Review of the Facility Device Activity Report dated from 7/3/18, to 7/10/18, indicated R293 had the following call light wait times greater than fifteen minutes: 7/7/18, the call light was on for 53 minutes; 7/7/18, 28 minutes; 7/8/18, 38 minutes; 7/4/18, 36 minutes; 7/4/18, 34 minutes; 7/4/18, 32 minutes; 7/9/18, 35 minutes; 7/3/18, 32 minutes; 7/5/18, 26 minutes; 7/5/18, 24 minutes; 7/5/18, 19 minutes; 7/9/18, 18 minutes; 7/10/18, 17 minutes; and 7/6/18, 17 minutes.

Review of the Facility Device Activity Report dated 7/3/18, to 7/10/18, indicated R20 had the following call light times greater than fifteen minutes: 7/7/18, 29 minutes; 7/9/18, 19 minutes.

During and interview by the team coordinator on 7/12/18, at 5:15 p.m. the administrator, and the regional director of clinical services (RDCS) indicated that staffing concerns and call light concerns are areas currently audited by the quality assurance performance improvement (QAPI) team. RDCS identified a need to hire additional nurses to provide consistent staffing.

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The administrator indicated he felt staffing "was adequate," but opportunity to redefine responsibilities during shifts could help ensure the facility reached its highest level of quality care.

Review of the Device Activity Log from 7/3/18, to 7/10/18 identified three call light records 70 minutes or greater, seven call light records 60 minutes or greater, fourteen call light records 50 minutes of greater, eighteen call light records greater than 40 minutes, forty-five call light records greater than 30 minutes; and two call light records greater than 20 minutes.

Policy and procedure for Call Lights dated 4/2/18, indicated the purpose is to respond promptly to resident's call for assistance, to assure the call system is in proper working order, and to ensure residents can call for help when needed. Per resident council residents agreed and approved a fifteen minute call light response time, with annual review.

R287's Admission record dated 6/29/18, included diagnoses of wedge compression fracture of T11-T12 vertebra, pemphigus (a disorder of the skin), congestive heart failure, anemia, chronic pain, and atherosclerotic heart disease of coronary artery, constipation and chronic kidney disease. R287 resides on the 400 wing which is labeled as a transitional care unit (short term stay rehabilitation unit).

R287's Minimum Data Set (MDS) assessment, dated 7/6/18, reflected a BIMS score of 13 indicative of intact cognition, requires assist of one staff with transfers, bed mobility, walking in and out of room, dressing, toileting, and personal hygiene.

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R287's temporary care plan dated 6/29/18, indicates R287's goal was to go home after rehabilitation, toilet upon rising, before and after meals, before bed, and as needed. R287 identified as a fall risk.

R287's electronic medical record (EMR) printed on 7/12/18, includes a physician order for furosemide (a pill to take excess fluid away from the heart) daily at 9 a.m.

Interview with R287 on 7/10/18, at 9:50 a.m., stated, "I am only incontinent of water (urine) when it takes them too long to get here". Interview with resident family member confirmed this.

R287's call light response times were reviewed for 7/4/18 to 7/10/18, response times were more than 17 minutes thirteen times, and over 30 minutes seven times with the longest wait time 59 minutes and 38 seconds.

SUGGESTED METHOD OF CORRECTION:
The administrator, DON or designee could ensure that adequate policy and programs are developed for sufficient staffing based on the resident population so residents received safe, adequate and timely assistance with toileting, bathing, repositioning, pressure ulcer care, and eating assistance. The facility could educate staff on these policies and perform routine evaluations of resident care to ensure residents are receiving care and services for adequate staffing. The facility could report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance.

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2 800	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must 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 observation, interview and document review the facility failed to monitor 1 of 1 resident (R2) who was reviewed for dialysis services. Additionally, the facility failed to monitor and complete physician ordered treatments to skin wound for 1 of 1 resident (R288) reviewed for non-pressure related skin conditions. Findings include: R2 was admitted to the facility on 2/21/15, with diagnoses obtained from the electronic medical record (EMR)- Med Diag which included: Atherosclerotic heart disease, schizophrenia, unspecified psychosis, edema, anemia in chronic kidney disease, angina, anxiety disorder, dialysis,	2 830	Corrected see F-684	8/10/18

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end stage renal disease, hypertension, major depressive disorder, pain, and type 2 diabetes. According to the EMR R2 received dialysis services three days per week at the local hospital dialysis center.

On 7/9/18, at 3:00 p.m. R2 was observed walking in the hall with a padded, white gauze dressing on his left forearm. R2 was not able to respond to questions as to what was the reason for the dressing, but staff nurses indicated R2 had returned from his dialysis session a short time earlier. R2 ambulated into the day room and other areas of the facility at will, but no one was observed checking R2's shunt site, dressing or vital signs. Arrangements were made to obtain a Spanish speaking interpreter to allow for R2's interview.

R2 was interviewed with the assist of a Spanish speaking interpreter on 7/9/18, at 5:30 p.m. and via the interpreter indicated he went to dialysis three times a week, and felt the dialysis center and the facilty communicated regarding his care needs. R2 indicated he bled easily and if he scratches himself he would bleed for a long time. R2 indicated he let staff know when he returned from dialysis on Monday, Wednesday, and Saturday, but no one checked the dressing on his arm on a routine basis and in addition the staff at dialysis checked his vital signs frequently, but when he returned to the facility they were not usually checked. . When asked about weights R2 indicated he was not weighted before he went to dialysis and was not certain how often he was weighed, but thought it was probably with his weekly bath.

On 7/11/18, at 1:30 p.m. R2 was observed entering the building with family members in

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2 830	Continued From page 11 attendance after receiving dialysis in the morning. R2 went up to the nursing station and waved at staff, and verbalized he was back. Staff greeted resident, but made no attempt to check the dressing located on his left forearm shunt site, nor did they attempt to obtain a set of vital signs. R2 proceeded to walk to room and back and then went into the lounge area where he watched an activity taking place. During the time period of 1:30 p.m. - 2:15 p.m. R2 walked about in the facility and sat in the day room, but no staff person was observed to check the dressing covering the shunt site or take vital signs. Review of the medical record did not include documentation of shunt assessment/monitoring or checking of vital signs following R2's return from dialysis. During an interview with licensed practical nurse (LPN)-A on 7/12/18, at 1:39 p.m. it was indicated fluid restriction distributions were listed on the medication administration record (MAR) and fluid intake was adjusted according to this record. LPN-A indicated the routine for dialysis days was for R2 to be up early, the shunt site was prepared according to orders with Lidocaine and then a saran wrap covering. R2 left for dialysis at 6:00 a.m. and usually returned around 10:00 a.m. unless he was with family members then it could be later. LPN-A confirmed there were no routine checks of shunt, dressing, and vital signs following dialysis, but that staff looked at the area when R2 came to the desk, but there was no documentation and if R2 had a complaint then vital signs would be checked. On 7/12/18, at 1:39 p.m. the regional director of clinical services (RDCS) (covering for director of nursing who was out of building), confirmed there	2 830		

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was not monitoring being provided of R2's shunt or vital signs following return from dialysis and her expectation was that monitoring should be documented and care planed.

Review of the facility Dialysis Policy with the most recent review date of 4/28/18 included: The facility must develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet a resident's medical, nursing and psychosocial needs. 1.) the care plan should address: Monitor for complications, Frequency of monitoring vital signs, respiratory distress, chest pain, headache, seizure, etc.; Monitoring of shunt or access site for signs of infection, Potential for bleeding, care of the access site.

R288 was admitted to the facility on 7/2/18. BIMS (brief interview for mental status) moderately impaired cognition. Diagnoses listed on the diagnosis sheet included: venous insufficiency, arthropathy, non-pressure chronic ulcer of lower leg, diplopia, nutritional anemia, major depressive disorder, restless legs syndrome, migraine, macular degeneration, history of falling, and nondisplaced fracture of seventh cervical vertebra.

On 7/10/18, at 10:21 a. m. R288 was observed to have an open sore on her lower left leg which was open to air, a large bandage over her left elbow, along with suture area to her head. R288 stated that the sores on the leg were not healing and they (nursing staff) weren't doing much with them; further stating nurse's had not changed the dressings since arrival at the facility.

During observations on 7/10/18, at 11:48 a.m., R288 was sitting in the dining room wearing

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shorts. The open sore was visible with bloody drainage dripping down her lower leg to her ankle. Original bandage intact on left elbow.

On 7/11/18, at 8:03 a.m., resident was sitting in her recliner with the open sore visible with dried blood on her lower leg. No dressing or tubigrip on leg. Original bandage intact on left elbow.

7/12/18, at 10:19 a.m. R288 was observed in recliner with no tubigrip stockings on as ordered. R288 stated, "they couldn't find them or they were wet or something". Bandage taped to her lower leg wound with paper tape.

7/12/18, at 1:34 p.m. R288 observed sitting in recliner with no tubigrip stockings on, lower leg wound open to air.

Skin assessment done upon admission signed by LPN-B on 7/2/18, notes two areas of concern; top of scalp wound measuring 1.0 cm x 0.1 cm and left lower leg (front) bruising 10 cm x 10 cm. Details included "has healed vascular ulcers to bilateral LE (lower extremity), skin discolored to LE". The assessment did not indicate that R288 had any open areas on leg or wound on the left elbow.

Individual Resident Baseline Care Plan dated 7/2/18 and reviewed on 7/5/18, lacks any information or direction on skin or wounds.

Sanford Health Interagency Transfer Orders dated 7/2/18, direct wound care as: apply wound wash saline topically one time a day for multiple open wounds of lower leg and apply 4 x 4 gauze pad dressing one time day to ulcer of left lower extremity with fat layer exposed.

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Per progress note dated 7/5/18 at 6 p.m. by LPN-A stated normal saline and 4 x 4 pads were not in supply.

Weekly skin assessment dated 7/7/18 by LPN-E indicates overall skin is dry, warm, and pink. Left side of head has a laceration. Lower extremities bilateral have vascular insufficiency. Coccyx area has a heart shaped dressing. Assessment lacked documentation of left elbow wound and lower left leg extremity wounds.

Wound Clinic Note dated 7/9/2018, indicates the left lateral wound is 3 cm(centimeters) x 2 cm x 0.3 cm. Further indicates that the area has a moderate amount of old bloody drainage noted. Superficial debridement done and the hematoma appears fairly deep. Mepelix foam dressing applied to absorb drainage and tubigrip applied for compression. Ultrasound of the wound was ordered to assess depth of hematoma. Orders were to keep the area covered with Mepelix and tubigrip stockings to provide light compression.

Signed Doctor's Orders and Progress Notes dated 7/9/18, at 11 a.m. ordered wound care to be completed by applying Mepelix foam to open areas of left leg, change Monday, Wednesday, and Friday. Apply tubigrip from toes to knee on left leg during the day and take off at bedtime.

Interview on 7/12/18, at 9:53 a.m. revealed that RN-A had not done R288's dressing change yet that day but was not notified in report of any new orders.

At 1:47 p.m. on 7/12/18, RN-A entered R288's room to do wound care. When questioned about the wound under the bandage on R288's left elbow, RN-A stated wasn't sure what was

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2 830	Continued From page 15 underneath the dressing and not sure if there were any orders for the care of it. Interview on 7/12/18, at 1:52 p.m. with LPN-B confirmed information on the initial skin assessment on 7/2/18, but stated that DON (director of nursing) did the assessment and LPN-B only documented the data in the record. Stated had not seen the wounds and did not know of any orders except the orders received from the wound nurse orders on 7/9/18. Further stated that the skin assessment should have been done the day of admission, any skin issues faxed to the doctor but that was not done. Wound Care policy last reviewed 4/20/18, indicates the following information should be recorded in the resident medical record; type of wound care provided, the date and time the wound care was given, the position in which the resident was placed, the location of the wound, any change in the resident's condition, all assessment date (for example, wound bed color, size, drainage, etc.) obtained when inspecting the wound, how the resident tolerated the procedure, any problems or complaints made by the resident, if the resident refused the treatment and the reason why, and the signature and title of the person recording the data. There was no documentation on wound in the initial and subsequent assessments, no documentation in the Non-Pressure Skin Record in the weekly wound documentation binder which was to be done every Tuesday. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with wounds to assure they are receiving the necessary treatment/services to promote healing of wounds. The director of	2 830		

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2 830	Continued From page 16 nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facilty failed to provide food and drink that was palatable, attractive, and at a safe, appetizing temperature for 3 of 43 residents (R289, R2, & R24) observed during meal time. This had the potential to affect 13 of 43 residents who resided on the TCU unit. Supper meal service on 7/09/18, at 05:30 p.m. observation identified the dietary director (DD) as the cook for the evening. Observed a prepared a plate of egg whites, bacon and cold cereal prepared for R2. R2 was going to be late for supper. The was plate was wrapped in tin foil and placed on top of other food items covered in foil on the steam table. When the resident was ready for the meal, at 5:54 p.m. DD removed the foil and placed it on the top of the steam table shelf to serve to the resident. DD was asked to identify what the temperature of the omelet and bacon, and DD indicated was unsure what the temperature was. When asked to check the	2 960	Corrected see F-804	8/10/18

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temperature, DM placed a thermometer into the egg omelet and identified the temperature at 101 degrees Fahrenheit (F). DD was unsure what the proper temperature should be and indicated that the plate should have been inside the steam table to maintain a temperature above 135 degrees F.

Observation of room trays service on 7/09/18, at 6:03 p.m. identified room trays delivered to the transitional care unit (TCU) on an open rack. Lids covered the plates. No plate warmers were utilized. Liquids were served in uncovered glasses on the open cart. The cart was pushed into the TCU and staff began to pass the trays.

During an interview on 7/10/18, at 8:49 a.m. R24 stated she prefers to eat in her room, and stated that meals served have not been hot lately. R24 was served oatmeal and yogurt at this time. R24 described the oatmeal as "cold and hard."

During observation on 7/11/18, at 12:15 p.m., room trays for the TCU were placed on an open rack, and fluids were in uncovered glasses. The rack was transported to the TCU uncovered. A sample room tray was requested. Sample tray temperatures from the steam table were as follows: ham slice 136 degrees F, rice 136 degrees F, and carrots 163 degrees F. The sample tray was placed in the cart and transported to the upper level of the facilty. At 12:32 p.m. after trays were passed, DD measured the temperature of the tray contents. Temps were as follows: ham, 116 degrees F, rice 107 degrees F, and carrots 118 degrees F. Food was sampled. Ham, rice, and carrots were luke warm and unseasoned.

During an interview on 7/12/18, at 9:45 a.m. R289 indicated that the food served is "quite often not

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warm." Breakfast meals are generally ok, but other meals at noon and in the evening varied a lot in temperature and flavor. Food was often on the "blah" side.

During an interview on 7/12/18, at 3:58 p.m. the DD confirmed that fluids on the room trays were transported uncovered on an open rack from the kitchen to the TCU. Glasses containing liquids were uncovered on the rack. DD indicated the glasses were uncovered because the "lids don't fit." Room trays had temperature concerns identified by temperature measurement and by residents interviews. The DD was aware of temperature concerns, and stated to remedy the problem food was either reheated in the microwave, or discarded and prepared upon resident request. DD was unsure of whether room trays needed to maintained at minimum holding temperatures until served. DM confirmed the sample tray tested on 7/11/18, at 12:35 p.m. containing the ham slice, rice and carrots was too cold to be palatable. DD stated the facility used hot plates in the past, but discontinued use due risk of burning residents. DM identified plate warmers on the steam tables were not being utilized during meal services. DM stated normally only one or two staff were in the kitchen to pass trays, but while state was here there were up to 6 staff including nurses and CNAs in the kitchen passing trays at one time. DM confirmed that non-dietary staff entered areas in the kitchen where hairnets should be worn.

Review of the facility Food Temps and Storage policy dated 12/28/17, indicated food should be held at an acceptable temperature with methods to prevent the spread of food borne illness and reduce practices that result in food contamination or compromise food safety. Monitor temperatures

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2 960	Continued From page 19 at the end of serving line to assure any food items being held for future use was at acceptable temperature for product. SUGGESTED METHOD OF CORRECTION: The certified dietary manager (CDM) and/or designee could identify and develop a more palatable dining experience and could provide appropriate staff education regarding food preparation, including acceptable temperatures. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 960		
21160	MN Rule 4658.0675 Subp. 6 Mechanical Cleaning and Sanitizing; Hot Water Subp. 6. Hot water sanitization. Machines using hot water for sanitizing may be used provided that wash water and pumped rinse water are kept clean and water is maintained at not less than the temperature specified by NSF International Standard No. 3, incorporated by reference in subpart 2, under which the machine is evaluated. A pressure gauge must be installed with a valve immediately adjacent to the supply side of the control valve in the final rinse line provided that this requirement does not pertain to a dishwashing machine with a pumped final rinse. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the walk-in refrigerator and freezer was maintained in good working repair. This had the potential to affect all 43 residents currently residing in the facility.	21160	Corrected refer to F-908	8/10/18

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Findings include:

During an initial observation of the kitchen with the DM on 7/8/19, at 2:30 p.m. the walk-in refrigerator entrance light fixture with a clear, glass, oblong, globe approximately six inches in diameter, had a large amount of water collecting at the base of the globe, touching the base of the light bulb. A water sprinkler next to the light fixture was covered in rusty debris. Observation of the walk-in freezer idenfied condensation on the window, running down the front of the door. A pry bar was sitting beside the freezer leaning against the wall. The freezer door was unable to close completely. An inch of the door margin was visible from the door frame. The dietary director (DD) had to forcibly open the door to observe the contents. The entire freezer was covered in a blanket of frost and the floor was slippery. The internal temperature was -10 degrees Fahrenheit (F).

On 7/9/18, at 6:45 p.m. the walk in freezer door continued to shut inappropriately, the edge of the door remained exposed. To check the internal freezer temperature, the DD used the pry bar to open the freezer door. The DD stated a former maintenance employee provided a pry bar so staff were able open the door without having to call for to get in the freezer every time. With out it the pry bar, dietary staff were unable to open the door, especially during summer. DD stated "It never used to be like this." The freezer door was frosted shut because the central air had been broken in the kitchen for over a year. The two window air conditioning (AC) units used in the kitchen do not keep up with the moisture, so the freezer door can not close properly and freezes shut. Maintenance (M)-A, attempted to

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communicate the need to repair the central air conditioning in the kitchen to the corporate office, but so far, only window units had been provided to attempt to resolve the issue, and were ineffective.

On 7/10/18, at 9:17 a.m. DD reported approximately one fourth of a cup of water was emptied from the first light fixture in the walk in refrigerator in the morning. The door of the walk in freezer was observed partially open with approximately an inch the door margin exposed in the door frame. Condensation was observed running down the door, and the entire contents of the freezer including the floor was covered with frost. Foods were frozen solid, and the temperature on the thermometer on the outside of the freezer was -10 degrees F, the thermometer on the interior of the freezer indicated at temperature of -10 degrees F.

During an interview on 7/10/18, at 2:45 p.m. M-A indicated that the kitchen location next to the laundry and boiler rooms, rendered moisture and humidity hard to control. The central air conditioning unit failed in the kitchen, about a year ago, was very expensive to repair. M-A attempted to control the humidity in the kitchen with two window air conditioning units. The dishwashing room was the worst. A 20,000 BTU unit was installed first, but it was exchanged for a 25,000 BTU AC unit, but was ineffective in controlling humidity in the kitchen. Corporate recommended a dehumidifier, but one of the AC units would be removed, the dietary staff chose to keep the window AC units because it was very hot in the kitchen. M-A indicated to control the moisture and frosting freezer, the central air unit need to be replaced. A review of the maintenance log for the freezer door indicated the

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21160	Continued From page 22 seal for the door had been replaced several times from prying the door open. SUGGESTED METHOD OF CORRECTION: The facility maintenance director or designee could perform routine rounds to ensure all essential equipment in maintained in proper working condition, review and revise policies and educate staff how to notify maintenance of issues. The maintenance director or designee could bring results of audits to the quality assurance committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21160		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement interventions on the person centered care plan for 1 of 1 resident (R2) reviewed for	21325	Corrected refer to F-790	8/10/18

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dental services.

Findings include:

R2 was admitted 2/21/15 with diagnoses obtained from the electronic medical record (EMR) which included: Atherosclerotic heart disease, schizophrenia, unspecified psychosis, edema, anemia in chronic kidney disease, angina, anxiety disorder, dialysis, end stage renal disease, hypertension, major depressive disorder, pain, and type 2 diabetes.

During observation and interview with an interpreter on 7/09/18, at 5:44 p.m. R2 was noted to have a missing tooth on the right side of his lower denture. Via the interpreter, R2 indicated his tooth had broken about one year ago and he would like to have it repaired.

R2's most recent Minimum Data Set (MDS) assessment, dated 6/20/18, did not indicate any concerns of missing teeth.

Review of R2's care plan indicated R2 had upper and lower dentures, but did not indicate a missing tooth.

During an interview with the licensed social worker (LSW) on 7/11/18, at 3:10 p.m. It was indicated she was not aware of R2 missing a tooth from his dentures. In addition the LSW indicated registered nurse (RN)-B would have completed the oral assessment and this should have been communicated to her.
RN-B was also interview at this time and indicated she had completed the assessment, but had not noticed R2 was missing a tooth in his lower dentures. The LSW further indicated the normal process followed if a resident had a

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problem with a tooth would be to contact the family and insurance and make anarrangement to have the resident seen by dentist if he chose to do so.

During interview on 7/11/18, at 3:30 p.m. the LSW indicated she had spoken to R2 who had shown her the missing tooth from his lower dentures, and would be contacting the family and attempting to set up a dental appointment as R2 indicated he wanted his dentures repaired.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee could audit resident records for timely dental referrals and ensure audits are completed for oral condition to identify others at risk. The director of nursing or designee could report results of audits to the quality assurance committee for further recommendations to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	21426		8/10/18

(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

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21426	Continued From page 25 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 document review and interview, the facility failed to ensure all healthcare workers received tuberculosis (TB) symptom screening for 5 of 6 employees reviewed for tuberculin skin testing (LPN-D, LPN-E, Cook-A, O-E, NA-E). Findings include: Review of licensed practical nurse (LPN)-D's TB screening record indicated a hire date of 4/19/18, and included a chest X-ray dated 7/25/17, taken for a history of a positive TST. No record provided indicating LPN-D received a screen for active TB symptoms prior to employment. Review of LPN-E's personnel record indicated completion of a two-step TST outside the facility. The first step TST was dated 6/28/17 and the second -step was dated 7/12/17. LPN-E was identified by the infection preventionist as an active-status pool nurse, and the screening must have been done by the clinic. No active TB symptom screen documentation was provided to validate screening for active TB symptoms was completed. Review of nursing assistant (NA)-E's Baseline TB	21426	It is the policy of the facility to provide effective infection control program in regard to tuberculosis screening to all staff and residents per CDC guidelines. Upon state notification of 5 out of 6 employees have not had documentation on file of TB testing or had inconclusive results staff files were reviewed to ensure compliance. Because all staff are required to have necessary baseline testing, all are affected by lack of inconclusive results. Staff who demonstrated inconclusive results have been corrected. The policy on TB monitoring has been reviewed. To enhance currently compliant operations and under the Director of Nursing an in-service will be conducted on 8/14/18 and 81518 to review the appropriate procedure for two step mantoux's and screening/monitoring to ensure baseline results are on file. Training will include risk of TB and signs and symptoms of monitoring. Effective 8/6/18 a quality-assurance program was implemented under the supervision of the infection prevention nurse to monitor employee records for	

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Screening tool for Health Care Workers (HCWs) dated 5/8/18, indicated the Health Care Worker's (HCWs) History section and the TST-Second Step section were not completed. No further evidence was provided to verify a HCW history or a second-step TST were given.

Review of laundry assistant (O)-E's personal record indicated a hire date of 3/12/18. On the Baseline TB Screening Tool for Health Care Workers (HCWs) dated 3/12/18, a TST-first step was given on 3/12/18, and a TST-second step was given on 4/20/18. The measurement for induration in the TST-second step "Results" section was not completed.

Review of Cook-A's Baseline TB screening tool for Health Care Workers (HCWs) dated 2/16/18 identified a first-step TST was given on 2/16/18. The second-step TST was given on 3/2/18, and the "Results"section of the Baseline TB Screening Tool for Health Care Workers (HCWs) was not completed. A third TST was given on 3/6/18.

During an interview on 7/12/18, at 3:17 p.m. with infection preventionist LPN-B the policy for tuberculosis screening indicated all new employees were screened using the Baseline TB Screening Tool for Health Care Workers (HCWs) document from the Minnesota Department of Health (MDH) website. The document included three components: a symptom screen, a health care worker history questionnaire, and a two-step TST. O-G provided instructions to complete the form, and scheduled the first-step TST. After the first-step TST is administered, the nurse tells the employee to return to the facility within forty-eight to seventy-two hours to read the first-step TST results. When the first-step TST was read, the

compliance. The Clinical Nurse Lead or designated representative will perform systematic changes to ensure facility compliance. All staff records will be reviewed to ensure that all staff have appropriate documentation to reflect compliance with tuberculosis screening. The Infection Control Prevention nurse will be responsible to ensure facility compliance.

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nurse schedules the date of the second-step TST. the form is placed in the fax room box, and O-G records the documentation of the TB TST in Excel to help ensure completion of the second TST. If the TB screen is not completed, O-G notifies the director of nursing (DON), the facility scheduler, and the charge nurse. O-G is responsible for ensuring the pool staff have the first TST documentation completed prior to their first scheduled day of work. The expectation for the TB screening process was that nursing and O-E schedule new employees to ensure TB screening was completed within within 2 weeks of hire, and that the documentation was accurate. LPN-B stated had limited involvement in the TB screening process after becoming the infection preventionist. O-E had assumed the role of monitoring of the TB screening process. Currently no specific person was assigned to monitor TB screening, the process for TB screening process has fallen apart, documents were not completed correctly, and the system needed improvement.

On 7/12/18, at 03:46 p.m. an interview with O-E explained the process for TB screening as follows: O-E provided the new employee a Baseline TB Screening Tool for Health Care Workers (HCWs). O-E instructed new staff to complete the first half of the form, and when completed returns to O-E to place in a box in the fax room by the DON office. The new employee returns to the facilty, locates a charge nurse who finds the form, and performs the TST. When the TST is given, the first-step documented on from. The charge nurse instructs the new staff when to return to the facility between forty-eight to seventy-two to have TST results read, and places the form in a box that indicates tests to be read. O-E identified that a lot of issues were happening

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21426	Continued From page 28 with the TB screening process. Getting the second step read was difficult. Nursing staff have been educated and reminded about the importance of completing the TSTs. New staff were also provided reminders to have the TSTs read through emails, and department managers are updated about staff who have not completed the TST process. Second-steps TSTs continued to be missed. Review of the Tuberculosis, Employee Screening for Superior Healthcare Management Minnesota Region Policy Interpretation and Implementation document dated 12/27/17, indicated TB screening was required for all new employees including a two-step TST, and a symptom screening. Newly hired employees are screened for TB after an employment offer prior to duty assignment. If the first step of the two-step TST is negative, a second-step TST is performed one to two weeks after the first-step TST. If the first-step is positive, the employee was referred for a chest X-ray, and TB symptom screening must be completed prior to employment. If the chest X-ray is negative the employee health coordinator will give the employee a symptom questionnaire to complete, and if free of symptoms is considered free of active tuberculosis. SUGGESTED METHOD OF CORRECTION: The administrator and DON could read and revise the policy and procedure for TB surveillance. The administrator and DON could monitor employee screening to ensure ongoing compliance. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance.	21426		

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21426	Continued From page 29 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21520	MN Rule 4658.1300 Subp. 1-4 Medications and Pharmacy Services; Definition Subpart 1. Controlled substances. "Controlled substances" has the meaning given in Minnesota Statutes, section 152.01, subdivision 4. Subp. 2. Schedule II drugs. "Schedule II drugs" means drugs with a high potential for abuse that have established medical uses as defined in Minnesota Statutes, section 152.02, subdivision 3. Subp. 3. Pharmacy services. "Pharmacy services" means services to ensure the accurate acquiring, receiving, and administering of all drugs to meet the needs of each resident. Subp. 4. Drug regimen. "Drug regimen" means all prescribed and over-the-counter medications a resident is taking. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 1 resident (R287) reviewed for pain, received pain medications in a timely manner. This resulted in actual harm for R287 who experienced severe pain when the facility ran out of her supply of narcotic pain medication. The findings include: R287 was admitted to the facility on 6/29/18 with diagnoses including: Wedge compression	21520	Corrected refer to F-697	8/10/18

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Fracture of T11, T12 Vertebra initial encounter for closed fracture, and other chronic pain.

During interview with R287 on 7/9/18 at 6:58 p.m., she reported she'd been out of pain pills for an entire day and was in pain. R287 was crying and her posture/movements indicated she was in pain. She stated she was supposed to take a pain pill every four hours for pain control but added, "they don't always last that long." R287's family member also present during the interview, verified R287's report, "She was out of pain pills all night, the doctor had ordered 20 tablets but when they are taken every four hours they don't last that long, she went a whole day without her pills, she was very uncomfortable and crying."

During interview with licensed practical nurse (LPN)-C on 7/11/18 at 7:44 a.m., LPN-C stated, "Most of the medications come from the machine upstairs, and if it is an Oxycodone or something, the pharmacy will let us know we need a script and we will fax the doctor for a script. It usually is taken care of by the next shift."
Registered nurse (RN)-A stated during interview on 7/12/18 at 9:49 a.m., "Nursing calls the pharmacy and they will send it out on the delivery for the same night. If it is needed now, the nurses call the pharmacy from town." Although RN-A stated that the doctor had given R287 20 tablets of the pain medication and they ran out. RN-A stated they had faxed the doctor for a script but the regular doctor was on vacation, so they had to call the clinic on call. RN-A said once the pharmacy received a prescription, they would authorize it so it could be sent out.

During interview on 7/12/18, at 2:04 p.m., LPN-B stated, "[R287] has chronic and acute pain. There was some lag time between the getting the

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script from the clinic to the pharmacy. Usually the pharmacy contacts the clinic but not always, and they don't communicate it with us. We may not know until it doesn't come out of the medication administration machine. We tried Tylenol and ice for pain control [for R287] which may have given her some relief but not 100%. I don't think her quality of life was affected, she [R287] wasn't stuck in bed or anything.

Review of the electronic medical record (EMAR) indicated R287 had not received the scheduled doses of Oxycodone-Acetaminophen 5-325 mg (milligrams) on 7/3/18 at 12 a.m., 4 a.m., 8 a.m., or 12 p.m. According to the documentation, R287's pain rating was documented at a "9" on a 0-10 pain scale (0=no pain to 10=the worst pain ever) during this time frame.

A facsimile (fax) request to R287's physician dated 7/3/18, indicated: "Resident came to facility with Oxycodone-Acetaminophen tablet 5-325 mg give one tablet by mouth every 4 hours for pain control r/t (related to) wedge compression fracture of T11-T12 Vertebra. Initial encounter for closed fracture order was only for 20 doses and is completed. Gave Tylenol and ice throughout the night with little to no relief. Resident is still in constant pain and rates pain 8-10 [10 being the most severe pain] all day. Can you send a new script to pharmacy so resident can resume pain regimen." The physician's response included: "RX (prescription) sent to [Dr's name] to sign electronically."

The facility's policy Medication Orders 12/28/17, indicated staff were to reorder medications when the resident has not less than 5-7 days worth. In addition the policy indicated hard scripts must be current if not on file can in order to refill a

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21520	Continued From page 32 narcotic. "Pharmacy can try to reach physician, but facility staff are responsible for getting new order." The facility's Medication Administration policy last reviewed 5/10/18, indicated medications were to be administered within one (1) hour of their prescribed time, unless otherwise specified. The contracted pharmacy policy Unavailable Medications last revised 6/15, indicated if facility nursing staff were unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the facility medical director for orders and/or direction. The contracted pharmacy onsite formulary printed on 7/12/18, indicated Oxycodone/APAP tablet 5-325 mg were available in the automated dispensing unit (ADU) emergency supply kit. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pain to assure they are receiving the necessary treatment/services to prevent pain and have adequate narcotic medication supply on hand. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure management of pain. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21520		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings,	21685		8/10/18

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21685	Continued From page 33 systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to assure call lights were maintained in working order for1 of 43 residents (R86) reviewed during the survey. Findings include: During observation and interview with R86 on 7/09/18, at 2:58 p.m. a call light with wall box and cord attached was observed lying on the bedside table located beside the recliner in which R86 was seated. R86 indicated her call light had not worked consistently since she was admitted on 7/6/18. R86 further indicated that on Saturday night she was in bed attempting to call for help to go to the toilet. R86 indicated she had pushed the button to activate her call light and after multiple attempts pulled the call box off the wall. R86 indicated she began yelling for help and still no one responded. As a result of not being able to self toilet and no staff response to her yelling for "help" she was incontinent in her bed and stated, "I froze because I was lying in my wet bed". R86 indicated she was not certain of the time of occurrence of the incident, or how long she remained lying in the wet bed as she did not have a clock on the wall, but she knew it was about 3:00 a.m. (because she asked) when someone came to check on her and she had been lying in her wet bed for a "long time". R86 indicated she told staff she had been attempting	21685	Corrected refer to F-919	

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to call for help and staff went and obtained a different call light which was placed on the bedside table. The unidentified staff person indicated this call light did work and had been obtained from another room. R86 indicated she continued to have issues with staff not responding to her call light and she would yell out when someone passed by her room. R86 further indicated she had a TV but no remote, so she was not able to use it, and there was a clock that staff found on top of the room dresser, but it didn't have batteries and was not working. Staff did replace the batteries in the clock and laid it on the stand beside her chair (Not able to be viewed when resident was in bed.). R86 indicated she was upset over the lack of staff response to her needs and indicated she had a TV which she was not able to use as there was no remote control and she couldn't get up to operate it.

Activation of R86's call light displayed on the electronic display as room 313 and R86 was located in room 108. The call light was activated at 3:26 p.m. and as of 3:30 p.m. several unidentified staff persons walked past room but no one stopped to inquire what R86 needed. After 15 minutes,a staff person was observed entering Room 108 and R86 requested to toilet. R86 further indicated she wanted to rest as she was tired and requested interviewer to return later.

In a subsequent interview on 7/9/18, at 6:30 p.m. R86 indicated the only way she got assistance was to yell out. She further indicted she had attempted to utilize the call light, but stated, "they don't care". No one comes or checks on me unless I yell.

Nursing assistant (NA)-F was interviewed on

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7/09/18, at 6:41 p.m. and indicated she was not aware of the call light being changed for Room 108 or that it would display as room 313 on the electronic display. The director of nursing (DON) was subsequently interviewed on 7/09/18, at 6:41 p.m. and confirmed she was not aware of this issue until brought up by this writer and her expectation would be if a call light needed to be used from a different room it should have been clearly communicated so that staff knew where to respond. The DON further indicated staff were not aware of where to respond when the electronic display indicated 313 had been turned on and there had not been communication to update the oncoming shift of the need to change call lights for room 108.

During interview on 7/9/18, at 7:15 p.m. the DON confirmed that all call lights were expected to be functioning and that a facility wide audit would be performed immediately. It was further confirmed that in the instance of a call light being changed she would expect this to be communicated so that staff were aware of the change and the solution corrected as soon as possible. In addition the DON indicated when cares were completed for a resident staff were to insure the call light was with in reach regardless of where the resident was seated.

SUGGESTED METHOD OF CORRECTION:
The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis with regard to call light function. The facility could create policies and procedures, educate staff on these changes and

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21685	Continued From page 36 perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for staff, residenet, and the public for 2 of 2 residents (R24 & R293) that had damaged chair coverings. Findings include: During an initial interview with R24 on 7/10/18, at 8:49 a.m. the brown, vinyl recliner R24's room had a large, peeling hole on the head rest portion of the chair partially covered by a small flap of a piece of brown vinyl. Peeling vinyl fabric on the arm rests was also observed. Both areas had the vinyl fabric backing exposed. R24 indicated the chair belonged to the facility, and stated the	21695	Corrected refer to F-921	8/10/18

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21695	Continued From page 37 recliner was "Pretty bad, I was not able to use a mine from home because it was covered in cat hair." A brown vinyl recliner in room 404 on 7/12/18 at 9:45 a.m. was observed. Large peeling areas of vinyl on the headrest approximately eighteen inches by twelve inches was partially covered by a brown vinyl flap. During an interview on 7/12/18, at 9:55 a.m. R293 sat in a brown vinyl recliner with worn arms and headrest. Fabric was exposed in the worn areas. The entire back of the recliner was covered with a sheet. R293 stated the recliner is "really bad" housekeeping staff come to just to sweep up pieces that flake off the recliner and fall onto the floor. During an interview on 7/12/18, 5:16 p.m. M-A identified twelve chairs are in use at the facility with peeling vinyl fabric on the headrests and arms. Some are covered with sheets to have a barrier between the surface and the residnets using the furniture. M-A stated "I'm trying to get new chairs because they are worn." The facility administration suggested to wrap the bad ones with material. "I am embarrassed when new residents come to the facility, covering with fabric does not fix the chairs." I was working with the previous administrator to replace the recliners because they are not longer able to be cleaned appropriately. Cost to reupholster the recliners was about four hundred dollars per chair. New chairs were also considered. Corporate office was provided with pictures and a proposal for new recliners when the previous administrator was still here, but no response was received in response to the proposal. The new administrator was updated of the need for new chairs, but has	21695		

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21695	Continued From page 38 only been here a little over a week, so the process is currently on hold. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 2 residents (R23& R287) reviewed for dignity received assistance to the bathroom in a timely manner.	21805	Corrected refer to F-550	8/10/18

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Findings include:

R23's electronic medical record (EMR) dated 7/12/18, included diagnoses of: hypertension, hypothyroidism, chronic atrial fibrillation, psychotic disorder with delusions, heart failure, chronic kidney disease, major depressive disorder, obesity, restlessness and agitation, macular degeneration, and obstructive sleep apnea.

R23's 5 day Minimum Data Set (MDS) assessment, dated 6/28/18, indicated R23's Brief Interview for Mental Status (BIMS) score was 13, indicating cognition was intact. The MDS activities of daily living (ADL) assessment further indicated R23 required extensive assistance of two for toileting and transfers and was incontinent of bladder and occasionally incontinent of bowel.

R23's care plan, dated 5/25/18, indicated bladder incontinence and some bowel incontinence. Interventions included staff were to check R23 every two hours and assist with toileting as needed. Staff were also to provide toileting at same time each day. R23's bowel habits included toileting at the same time each day in the afternoon.

During interview on 7/10/18, at 3:34 p.m., R23 indicated she was incontinent of her bowels from waiting 45 minutes to get help after placing her call light on while her brother was here visiting. R23 further indicated this took time away from visiting with her brother and his wife while staff assisted her to get cleaned up.

During interview with nursing assistant (NA)-B on 7/12/18, at 9:17 a.m., NA-B described the function of the call light system. The NA's would

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look at the screen at the end of the hall or on the computer at the nurses station to see whose call light was on. The computer at the desk would indicate how long the call light had been on. Staff used to have beepers, however, they were no longer using them. NA-B stated, "It is hard to answer lights in the morning." NA-B stated they felt it would be helpful to have more staff available to toilet and bathe residents.

During interview on 7/12/18, at 9:27 a.m. licensed practical nurse (LPN)-A indicated everyone in the building was responsible for answering call lights in a timely manner. Any staff could page for assistance for a resident if they were not able to assist.

During interview on 7/12/18, at 1:49 p.m. regional director of clinical services (RDCS)-A indicated in 2015, call light pagers staff carried were bothersome and they "disappeared". It was every employee's job to answer call lights. A resident council meeting held at that time indicated a fifteen minute call-light response time was acceptable to memebers of the coun cil and she would expect that as timely. Facility staff had not performed any call-light audits to ensure timliness of answer, and RDCS-A acknowledged there was a problem.

During interview on 7/12/18, at 2:35 p.m., NA-A indicated it was hard to answer call lights timely after the supper meal. She felt more staff was needed to answer call lights, especially on the D wing, as those residents had experienced incontinent accidents from waiting too long for their call light to be answered.

During further interview with R23 on 7/12/18, at 3:52 p.m., R23 stated it made her feel sad as she

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does not want to have accident. Staff always say "Just a minute... I will be there in just a minute," however, it would be 30 minutes before they came back. At times, she could hear staff down the hall laughing and giggling, while R23 continued to wait for assistance. R23 stated it made her "very angry".

Review of the facility call light documentation for the dates of 7/03/18 - 7/10/18, documented R23's call light as on for 30 minutes or longer seven times during this time frame. On 7/5/18, the call light was activated at 6:30 a.m. and cleared at 7:32 a.m. (61 minutes later).

R287's Admission record dated 6/29/18, included diagnoses of wedge compression fracture of T11-T12 vertebra, pemphigus (a disorder of the skin), congestive heart failure, anemia, chronic pain, and atherosclerotic heart disease of coronary artery, constipation and chronic kidney disease. R287 resides on the 400 wing which is labeled as a transitional care unit (short term stay rehabilitation unit).

R287's Minimum Data Set (MDS) assessment, dated 7/6/18, reflected a BIMS score of 13 indicative of intact cognition, requires assist of one staff with transfers, bed mobility, walking in and out of room, dressing, toileting, and personal hygiene.

R287's temporary care plan dated 6/29/18, indicates R287's goal was to go home after rehabilitation, toilet upon rising, before and after meals, before bed, and as needed. R287 identified as a fall risk.

R287's electronic medical record (EMR), printed on 7/12/18, included a physician order for

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furosemide (a pill to take excess fluid away from the heart) daily at 9 a.m.

During interview with R287 on 7/10/18, at 9:50 a.m. R287 stated, "I am only incontinent of water (urine) when it takes them too long to get here". A subsequent interview with a family member (unidentified) confirmed this.

R287's call light response times were reviewed for 7/4/18 to 7/10/18, response times were more than 17 minutes thirteen times, and over 30 minutes seven times with the longest wait time 59 minutes and 38 seconds.

The facility call light policy/procedure last reviewed 4/2/2018, indicated staff were to respond promptly to residents' calls for assistance. Ensure call system is in proper working order. Ensure residents can call for help when needed. The policy also indicated that a15 minute response time was approved by the resident council and was reviewed yearly to determine appropriate call light response times per resident requests.

SUGGESTED METHOD OF CORRECTION:
The administrator, director of nursing (DON), or designee could revise and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures on call light response practices, educate staff on these changes, and audit periodically to ensure resident(s) dignity are maintained. Call light response time audits could be completed, and results of these audits are reviewed by the quality assessment and performance improvement (QAPI) committee could ensure compliance.

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21805	Continued From page 43 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop interventions to accommodate needs and promote independence with eating for 1 of 1 resident (R10) who had difficulty reaching the table for meals in the dining room. Findings include: R10's diagnosis report, dated July 12, 2018, indicated R10's active diagnoses of major depressive disorder, Vitamin D deficiency, hypomagnesemia, hypertension, heart failure, gastro-esophageal reflux disease, rheumatoid arthritis, arthropathy, pain, anxiety disorder, and age-related osteoporosis. R10's Minimum Data Set (MDS), dated 4/18/18, indicated a Brief Interveiw for Mental Status (BIMS) of 13, and indicated R10 was independent	21810	Corrected refer to F-558	8/10/18

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(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) COMPLETE DATE
21810	Continued From page 44	21810		

with eating after staff assistance with set up.

R10's care plan, revised on 6/14/18, indicated R10 came to the dining room for meals and was able to feed herself after her tray was set up, with encouragement to finish her food.

Occupational Therapy progress notes, dated 6/19/18, indicated R10 was fitted for a wheelchair of an 18 inch height versus 20 inches after a fall out of the wheelchair. The OT notes indicated R10's arm rests were too high, but were unable to be adjusted. The notes also indicated nursing was educated on the chair change and the location of the previous chair if R10 had complaints about the new one.

During observation on 7/10/18, at 5:23 p.m., R10 was observed sitting at the dining room table with chin below the table top reaching up to the plate, complaining to her tablemates about sitting too low in the wheelchair. R10 held soup in the left hand, had a dessert bowl on her lap, and used a spoon with the right hand to eat.

R10 was observed on 7/11/18, at 8:08 a.m., in the dining room with her chin just above the table. R10 was not able to see over the bowl she was eating out of to visualize its contents. R10 was also noted to be pulling her head up and squinting her eyes to fill out a menu. No staff came to assist R10.

During observation on 7/11/18, at 11:48 a.m., R10 was seated at the dining room table, with her chin level with table surface, bringing a fork up to her plate and down to her mouth, and had pulled a bowl off of the table and was holding the bowl with her left hand and eating with right fingers.

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 ______	07/12/2018

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During interview on 7/10/18, at 8:48 a.m., R10 stated, "My wheelchair is too low, I told them I wanted a shorter table. I complain about it to everybody and nobody ever says anything and nothing changes. It is hard for me to eat because I have to get everything up to my mouth just right."

During interview on 7/11/18, at 7:11 a.m., R10 stated, "I hate this chair, I don't like to eat in the dining room because my chair is too low". R10 further stated, "It is hard to reach my food with my chin on the table".

During interview with licensed social worker (LSW) on 7/11/18, at 1:05 p.m., the LSW stated she was aware that R10 was complaining the wheelchair was too small but was not aware of the difficulties R10 was having reaching food at the dining room table. The LSW further stated that she would make a referral to therapies.

During interview with nursing assistant (NA)-C on 7/11/18, at 12:38 p.m., NA-C stated R10 had complained about not liking the wheelchair because it was too low and would let the nurse and therapy know.

During interview with certified occupational therapy assistant (COTA) on 7/12/18 at 1:29 p.m., COTA-B confirmed that it was very difficult for R10 to eat meals and reach eating utensils because the table was too high for her chair and even her bedside table was too tall for R10 in the existing wheelchair. COTA-B further stated that R10 had kyphosis and the new wheelchair was the correct fit for her, however, needed a table of the appropriate height.

During interview on 7/12/18, at 2:09 p.m.,

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21810	Continued From page 46 licensed practical nurse (LPN)-B, stated R10 was offered to move to another table but didn't want to at that time. R10 had a family member that sat at the same table. LPN-B further stated, the height of the tables could be lowered. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could audit resident seating in the dining areas to ensure tables are at appropriate height, and work with maintenance and dietary to coordinate proper seating. The director of nursing or designee could bring results of audits to the quality assurance committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		