Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 7, 2022

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

RE: CCN: 245596
Cycle Start Date: April 7, 2022

Dear Administrator:

On April 21, 2022, we notified you a remedy was imposed. On June 1, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 25, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 6, 2022 be discontinued as of May 25, 2022. (42 CFR 488.417 (b))

In our letter of may 6, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 4, 2022. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 7, 2022

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

Re: Reinspection Results
Event ID: 6YHG11

Dear Administrator:

On June 1, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 7, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
April 21, 2022

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

RE: CCN: 245596
Cycle Start Date: April 7, 2022

Dear Administrator:

On April 7, 2022, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and 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 § 488.417(a), effective May 6, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 6, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 6, 2022.

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.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 6, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, South Shore Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 6, 2022. You will receive further information regarding this from the State agency. 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.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 - Health Regulation Division 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 Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

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 October 7, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C)

and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Electronically delivered
April 21, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: 6YHG11

Dear Administrator:

The above facility was surveyed on April 6, 2022 through April 7, 2022 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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 immediately contact:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING ______ B. WING ______	C 04/07/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 34083 On 4/6/22 through 4/7/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5596040C (MN82278), with a deficiency cited at F689. The following complaints was found to be UNSUBSTANTIATED: H5596039C (MN81971). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		4/29/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 04/21/2022

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

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F 689	Continued From page 1 accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 34083 Based on interview and document review, the facility failed to ensure interventions were developed and implemented to prevent falls for 1 of 1 resident (R2) who had a recent history of falls with fractures. R2 sustained actual harm after self transferring and ambulating without assistance of staff to the bathroom, which resulted in a fall with pelvic and hip fracture with resulting hospitalization. Findings include: Review of the 3/31/22 at 10:43 a.m., State Agency (SA) report identified R2 was found on her bathroom floor at 4:00 a.m., when she self-transferred, ambulated to the bathroom, fell and was discovered seated on the floor complaining of right-sided groin pain. R2 was transferred to the hospital by ambulance where it was determined she had sustained a fracture. R2's 3/31/22, Emergency Room (ER) provider note documented a CT scan of the abdomen pelvis identified an acute distracted(separated) comminuted (break in at least two places) right superior and inferior pubic (pelvic bone) fracture. There was also a hematoma (bruise) along the right lateral pelvic wall and a questionable bladder injury. R2 was not able to state the cause of her fall and identified her pain level at 10/10 with movement. Consultation with surgery on-call recommended R2 be transferred to a larger acute care facility for further treatment and evaluation. R2 was stabilized and transferred to higher level	F 689	R 2 returned to the facility on 4/8/2022. R 2 has several posted signs to call for assistance throughout her room. R 2 had a new pain and fall assessment completed upon admission and R2 care plan was reviewed and updated as needed. R 2 had a new bowel and bladder along with a continence evaluation completed upon readmission for which R 2 reports that there is no concern with urinary urgency nor has R 2 had an incontinent episode; but is afraid of having an incontinent episode. R 2 MD was contacted for possible medication adjustment along with request for urology consult. R 2 continues on 3 hour toileting assistance at night per R 2 preference. From survey exit until present resident fall incidents have been thoroughly investigated and their fall care plans reviewed and updated as needed. For future residents, a fall assessment, bowel and bladder screening and continence review will be completed and care plan will be created and appropriate interventions initiated. Nursing staff was in-serviced on the Fall Risk Assessment Policy with emphasis on looking for possible link for falls and review of current medications; the Fall Risk Managing policy with focus on reviewing and/or changing interventions and documentation from staff and MD on irreversible risk factors that exist and continue to be present. Director of Nursing and/or designee is	

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F 689	Continued From page 2 of care by ambulance with family in attendance. R2 was admitted to acute care following the ED evaluation for further pain management and evaluation with discharge plan for return to LTC facility. R2's 5-day admission Minimum Data Set (MDS), assessment dated 3/29/22, identified R2 had severe cognitive impairment, and required extensive assistance from 1 staff for Activities of Daily Living, which included transfers and ambulation. R2 also had pain as a result of recent fractures prior to admission involving multiple rib fractures and lumbar (lower spine) fracture as a result of two falls. R2 had diagnoses of bladder incontinence, long-term use of blood thinning medication, anxiety and depression. R2 was also receiving daily scheduled medications for her anxiety, depression, pain, and fluid retention. R2's Care Area Assessment (CAA) dated 3/29/22, identified resident was assessed as at high risk for falls, had extreme pain and required extensive assist from one staff for all transfers, toileting and ambulation. R2 was identified as frequently incontinent of bladder and used pull ups for dignity. R2 had physical performance limits of impaired balance during transitions in addition to difficulty maintaining sitting balance. She was receiving therapy services for mobility, strengthening and transfers with a discharge goal of returning to her previous living situation. R2's current undated care plan listed R2 required 1 assist and cues depending on pain level and was independent at times. The care plan for toileting identified R2 required one assist to independent depending on pain level, and transfer was listed as supervision unless having	F 689	responsible for compliance. Audits on fall care plan initiation upon admission, fall care plan intervention appropriateness and continence reviews to determine toileting program will begin 2x week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and/or designee the Administrator will take audit results to QAPI for review and further recommendation. Compliance: 4/29/2022	

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F 689	Continued From page 3 pain. However, R2's care plan did not accurately reflect therapy's current instructions for mobility which included staff assistance with use of gait belt due to balance and transfer limitation. In addition, R2's care plan failed to identify either a toileting and/or plan for monitoring when R2 was frequently discover`ed attempting to self-transfer or already in the bathroom, without requesting assistance from staff. Review of R2's progress note dated 3/25/22, identified R2 needed assistance of one staff for all ADLs, transferring and toileting, at times R2 required limited to extensive assistance depending on pain level. Cognition was also identified as fluctuating dependent on her pain medication usage. Review of R2's progress note dated 3/29/22 identified R2 required assistance of 1 staff for all ADLs, transferring and toileting. Interview on 4/7/22 at 3:00 p.m., with the MDS coordinator and director of nursing (DON) confirmed R2's current care plan and CAA. They indicated the care plan was not accurate and should have been updated to include R2's lack of safety awareness, incontinence of bladder, and need for assistance with transfer and ambulation and indicated she was frequently non compliant with staff assistance. Interview on 4/6/22 at 12:54 p.m., with the Occupational Therapist (OT) identified R2 had increased pain as a result of 2 falls with fractures that took place prior to her admission to facility. She reported R2 had difficulty moving and was	F 689		

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F 689	Continued From page 4 able to sit at the edge of her bed and transfer with assistance but was not cleared to self- transfer. The OT identified R2 had issues with safety awareness and balance that resulted in the need to have staff in attendance. The OT reported R2 told her she had gotten up independently and gone to bathroom, because she thought doing so would speed up her ability to go home. R2 was instructed she was not safe to self-transfer and ambulate without staff with her and reminded to use her call light and have staff with her. The OT identified,both physical and speech therapy, had also reminded R2 of the need to have staff with her due to balance and safety concerns. The OT reported R2 was able to understand how to use the call light but thought she also would forget at times. The OT indicated R2 was experiencing a lot of pain due to her rib and back fractures, and she was receiving a lot of pain medication which also impacted her balance and safety awareness. Interview on 4/6/22 at 3:34 p.m., with licensed practical nurse (LPN)-A identified R2 repeated attempted to self-transfer and had been instructed to use her call light, that she was not safe and she needed help. LPN-A reported when R2 was told she needed to have assistance she would respond, she knew, and she was sorry or stated she had forgotten, but continued to attempt to transfer without assistance. LPN-A reported when R2 was discovered attempting to self-transfer she was usually going to the bathroom, or at times attempting to transfer from the recliner to or from her bed. LPN-A identified she was not aware of R2 being on a toileting plan, having any posted reminders to have assistance, or other than routine checks as staff went about their duties on the hall.	F 689		

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F 689	Continued From page 5 Interview on 4/6/22 at 4:30 p.m., with LPN-B identified she had been working on the night shift when R2 had fallen. LPN-B identified the resident that shared the bathroom with R2 had turned on her call light about 1:30 a.m., and pointed to the open bathroom door where R2 was seated on the floor of the bathroom facing the toilet with her back against the wall. LPN-B noted R2 had a large skin tear on her right elbow, was able to straighten her legs, and stated the only area that hurt was her right groin when she moved. LPN-B assessed R2, and explained she was going to contact the ambulance to have her checked out at the ED. LPN-B reported R2's call light was not on and still clipped to her pillow on the bed. Staff normally checked on R2 at midnight when doing rounds, again at 2:00 a.m., and at 5:30 a.m. when residents were starting to wake up. R2 did not have any signage or reminders in her room to call for assistance before attempting to self-transfer. Staff were to make certain her call light was always within reach. Notifications to the family, provider, and DON were completed and EMS was contacted to have R2 transported to the local ED. Upon arrival of the ambulance, R2 was unable to bear weight on her right leg and was assisted from the floor to gurney and had complained of right groin pain with movement. LPN-B identified she received a phone call from the ED that R2 had a fractured pelvis and was being transferred to a regional hospital. Interview on 4/6/22 at 4:51 p.m., with nursing assistant (NA)-A identified she had been working on the night shift when R2 had fallen in the bathroom. She identified she had done rounds and R2 had been sleeping quietly in bed about 1/2 hour before her fall. NA-A identified rounds were completed every (Q) 2 hours, but staff were	F 689		

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	245596	A. BUILDING ______ B. WING ______	C 04/07/2022

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F 689	Continued From page 6 checking resident rooms about Q 1/2 hour "just to make certain everyone was alright". NA-A stated R2's bathroom light was on and the night light was on in the room, but the room lights were off. NA-A reported R2 would use her call light "sometimes" when she wanted to get up, but other times, she would just get up and go to the bathroom and staff would find her there. R2 was not on a toileting plan, and there were no signs or reminders for R2 to call for assistance before getting up. NA-A reported when R2 was reminded to use her call light she would state she was "sorry" and that she had forgotten but frequently did not remember to do so. She indicated when R2 was caught attempting to self-transfer it was usually because she wanted to use the bathroom. Interview on 4/7/22 at 9:06 a.m., with LPN-C identified R2 and she had a lot of pain and difficulty moving due to rib fractures from a previous fall at home. R2 voiced her plan to gain strength and manage her pain so she could return home. R2 was instructed to use of her call light and have staff assist her when she wanted to get up or needed something and verbalized understanding. LPN-C stated R2 felt if she was able to self-transfer, she would be able to go home sooner. R2 was reminded therapies were working with her to increase her strength and manage her pain so that she could go home, but she needed to wait until they felt it was safe for her to self-transfer. R2 verbalized understanding of the instruction. R2 was forgetful at times, and her comprehension could be considered questionable. LPN-C identified safety measures in place for R2 included her bed and room rearranged for convenience and to allow easier access to personal items. There was no formal monitoring in place, but staff would check on her	F 689		

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F 689	Continued From page 7 as they were moving about in the hall. R2 had no reminders, or interventions in place to encourage/remind to have assistance with transfers and ambulation. R2 had orders for scheduled pain medication which included alternating Tramadol and Tylenol in addition to a Lidocaine patch applied to her lower back daily. LPN-C reported R2 would use her call light at times to make a request of staff, but when she wanted to go to the bathroom or move from one surface to another, she would self- transfer and/or ambulate without using her call light to allow staff to assist her. LPN-C also reported during a conversation with R2's daughter, she was told her mother had told her, if she was able to prove her ability to be independent, she would be able to return home sooner. Interview on 4/7/22 at 10:28 a.m., with NA-B identified she had assisted R2 to and from the bathroom and utilized a gait belt to help steady her as she had some balance issues and at times complained of feeling dizzy when she got up. NA-B reported R2 would use her call light at times and allow staff to assist her with transfers and ambulation, but frequently staff would find R2 attempting to self-transfer, or already in the bathroom. She identified R2 had incontinence of bladder and wore pull ups for dignity. NA-B reported, she had to repeatedly remind R2 she needed to wait until she could apply the gait belt so she could assist her, but at times she was confused and state she did not know that or had forgotten. NA-B reported R2 was not on a toileting schedule, but when she attempted to self-transfer it was frequently because she wanted to go to the bathroom. There were no additional safety measures in place that she was aware of, and the only sign was the one posted	F 689		

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F 689	Continued From page 8 on the outside of the bathroom door, labeling it as the bathroom. Staff checked in on R2 as they were working on the unit, because they were aware she would attempt to self-transfer and not use her call light. Interview on 4/7/22 at 10:43 a.m., with the medical director identified he had not actually seen R2 due to her recent admission and then her return to the hospital after her fall. If a resident was forgetting to use the call light and had a lack of safety awareness, he would expect further investigation into the cause with assessment and implementation of additional safety measures considered. Interview on 4/7/22 at 10:55 a.m., with NA-C identified R2 required staff assistance using a gait belt and her walker to transfer and/or ambulate to the bathroom due to unsteadiness and balance issues when she got up. NA-C identified when R2 was attempting to self-transfer it was usually because she wanted to go to the bathroom and when staff would remind her she needed to have staff with her for safety, she would not reply or stated she could do it herself. NA-C reported R2 did not have additional safety measures in place and was not on a toileting schedule. Staff were aware she was a high fall risk and would check on her randomly to attempt to assist her with transfers to avoid a fall. Interview and document review on 4/7/22 at 3:49 p.m., with the DON identified R2 did not have a toileting plan or safety measures identified other than to use the call light. The DON reviewed the current care plan and agreed it failed to include the current needs for safety awareness and the need for staff assistance with transfers and	F 689		

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F 689	Continued From page 9	F 689		

ambulation. The DON agreed there should have been additional investigation and root cause anyalysis (RCA) of R2's repeated failure to comply with safety recommendations and development of a plan to implement safety measures which could have possibly helped to avoid the additional fall and resulting fracture.

Review of the 3/13/20 Falls and Fall Risk Managing policy identified based on evaluations and current data, staff would identify individualized interventions in an attempt to decrease a resident's fall risk. Staff were to monitor and re-evaluate a resident's response to interventions intended to reduce falling or fall risk factors.

Review of the 10/17/19, Care Plans-Comprehensive policy identified interventions are designed after consideration of the resident's problem areas and causes. When possible, interventions address the underlying source of the problem area, rather than only addressing symptoms or triggers.

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: Surveyor: 34083 On 4/6/22 through 4/7/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic	2 000		

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2 000	Continued From page 1 plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was found to be SUBSTANTIATED: H5596040C (MN82278) with a licensing order issued at 830. The following complaint was found to be UNSUBSTANTIATED: H5596039C (MN81971). 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 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota 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	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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		
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: Surveyor: 34083 Based on interview and document review, the facility failed to ensure interventions were developed and implemented to prevent falls for 1 of 1 resident (R2) who had a recent history of falls with fractures. R2 sustained actual harm after self transferring and ambulating without	2 830	R 2 returned to the facility on 4/8/2022. R 2 has several posted signs to call for assistance throughout her room. R 2 had a new pain and fall assessment completed upon admission and R2 care plan was reviewed and updated as needed. R 2 MD was contacted for possible medication adjustment along with urology consult.	4/29/22

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2 830	Continued From page 3 assistance of staff to the bathroom, which resulted in a fall with pelvic and hip fracture with resulting hospitalization. Findings include: Review of the 3/31/22 at 10:43 a.m., State Agency (SA) report identified R2 was found on her bathroom floor at 4:00 a.m., when she self-transferred, ambulated to the bathroom, fell and was discovered seated on the floor complaining of right-sided groin pain. R2 was transferred to the hospital by ambulance where it was determined she had sustained a fracture. R2's 3/31/22, Emergency Room (ER) provider note documented a CT scan of the abdomen pelvis identified an acute distracted(separated) comminuted (break in at least two places) right superior and inferior pubic (pelvic bone) fracture. There was also a hematoma (bruise) along the right lateral pelvic wall and a questionable bladder injury. R2 was not able to state the cause of her fall and identified her pain level at 10/10 with movement. Consultation with surgery on-call recommended R2 be transferred to a larger acute care facility for further treatment and evaluation. R2 was stabilized and transferred to higher level of care by ambulance with family in attendance. R2 was admitted to acute care following the ED evaluation for further pain management and evaluation with discharge plan for return to LTC facility. R2's 5-day admission Minimum Data Set (MDS), assessment dated 3/29/22, identified R2 had severe cognitive impairment, and required extensive assistance from 1 staff for Activities of Daily Living, which included transfers and ambulation. R2 also had pain as a result of recent	2 830	From survey exit until present resident fall incidents have been thoroughly investigated and their fall care plans reviewed and updated as needed. For future residents, a fall assessment and care plan will be created and appropriate interventions initiated. Nursing staff was in-serviced on the Fall Risk Assessment Policy with emphasis on looking for possible link for falls and review of current medications; the Fall Risk Managing policy with focus on reviewing and/or changing interventions and documentation from staff and MD on irreversible risk factors that exist and continue to be present. Director of Nursing and/or designee is responsible for compliance. Audits on fall care plan initiation and fall care plan interventions will begin 2x week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator and/or designee will take audit results to QAPI for review and further recommendation. Compliance: 4/29/2022	

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2 830	Continued From page 4	2 830		

fractures prior to admission involving multiple rib fractures and lumbar (lower spine) fracture as a result of two falls. R2 had diagnoses of bladder incontinence, long-term use of blood thinning medication, anxiety and depression. R2 was also receiving daily scheduled medications for her anxiety, depression, pain, and fluid retention.

R2's Care Area Assessment (CAA) dated 3/29/22, identified resident was assessed as at high risk for falls, had extreme pain and required extensive assist from one staff for all transfers, toileting and ambulation. R2 was identified as frequently incontinent of bladder and used pull ups for dignity. R2 had physical performance limits of impaired balance during transitions in addition to difficulty maintaining sitting balance. She was receiving therapy services for mobility, strengthening and transfers with a discharge goal of returning to her previous living situation.

R2's current undated care plan listed R2 required 1 assist and cues depending on pain level and was independent at times. The care plan for toileting identified R2 required one assist to independent depending on pain level, and transfer was listed as supervision unless having pain.

However, R2's care plan did not accurately reflect therapy's current instructions for mobility which included staff assistance with use of gait belt due to balance and transfer limitation. In addition, R2's care plan failed to identify either a toileting and/or plan for monitoring when R2 was frequently discover`ed attempting to self-transfer or already in the bathroom, without requesting assistance from staff.

Review of R2's progress note dated 3/25/22,

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2 830	Continued From page 5 identified R2 needed assistance of one staff for all ADLs, transferring and toileting, at times R2 required limited to extensive assistance depending on pain level. Cognition was also identified as fluctuating dependent on her pain medication usage. Review of R2's progress note dated 3/29/22 identified R2 required assistance of 1 staff for all ADLs, transferring and toileting. Interview on 4/7/22 at 3:00 p.m., with the MDS coordinator and director of nursing (DON) confirmed R2's current care plan and CAA. They indicated the care plan was not accurate and should have been updated to include R2's lack of safety awareness, incontinence of bladder, and need for assistance with transfer and ambulation and indicated she was frequently non compliant with staff assistance. Interview on 4/6/22 at 12:54 p.m., with the Occupational Therapist (OT) identified R2 had increased pain as a result of 2 falls with fractures that took place prior to her admission to facility. She reported R2 had difficulty moving and was able to sit at the edge of her bed and transfer with assistance but was not cleared to self- transfer. The OT identified R2 had issues with safety awareness and balance that resulted in the need to have staff in attendance. The OT reported R2 told her she had gotten up independently and gone to bathroom, because she thought doing so would speed up her ability to go home. R2 was instructed she was not safe to self-transfer and ambulate without staff with her and reminded to use her call light and have staff with her. The OT identified,both physical and speech therapy, had also reminded R2 of the need to have staff with her due to balance and safety concerns. The OT	2 830		

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2 830	Continued From page 6	2 830		

reported R2 was able to understand how to use the call light but thought she also would forget at times. The OT indicated R2 was experiencing a lot of pain due to her rib and back fractures, and she was receiving a lot of pain medication which also impacted her balance and safety awareness.

Interview on 4/6/22 at 3:34 p.m., with licensed practical nurse (LPN)-A identified R2 repeated attempted to self-transfer and had been instructed to use her call light, that she was not safe and she needed help. LPN-A reported when R2 was told she needed to have assistance she would respond, she knew, and she was sorry or stated she had forgotten, but continued to attempt to transfer without assistance. LPN-A reported when R2 was discovered attempting to self-transfer she was usually going to the bathroom, or at times attempting to transfer from the recliner to or from her bed. LPN-A identified she was not aware of R2 being on a toileting plan, having any posted reminders to have assistance, or other than routine checks as staff went about their duties on the hall.

Interview on 4/6/22 at 4:30 p.m., with LPN-B identified she had been working on the night shift when R2 had fallen. LPN-B identified the resident that shared the bathroom with R2 had turned on her call light about 1:30 a.m., and pointed to the open bathroom door where R2 was seated on the floor of the bathroom facing the toilet with her back against the wall. LPN-B noted R2 had a large skin tear on her right elbow, was able to straighten her legs, and stated the only area that hurt was her right groin when she moved. LPN-B assessed R2, and explained she was going to contact the ambulance to have her checked out at the ED. LPN-B reported R2's call light was not on and still clipped to her pillow on the bed. Staff

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2 830	Continued From page 7 normally checked on R2 at midnight when doing rounds, again at 2:00 a.m., and at 5:30 a.m. when residents were starting to wake up. R2 did not have any signage or reminders in her room to call for assistance before attempting to self-transfer. Staff were to make certain her call light was always within reach. Notifications to the family, provider, and DON were completed and EMS was contacted to have R2 transported to the local ED. Upon arrival of the ambulance, R2 was unable to bear weight on her right leg and was assisted from the floor to gurney and had complained of right groin pain with movement. LPN-B identified she received a phone call from the ED that R2 had a fractured pelvis and was being transferred to a regional hospital. Interview on 4/6/22 at 4:51 p.m., with nursing assistant (NA)-A identified she had been working on the night shift when R2 had fallen in the bathroom. She identified she had done rounds and R2 had been sleeping quietly in bed about 1/2 hour before her fall. NA-A identified rounds were completed every (Q) 2 hours, but staff were checking resident rooms about Q 1/2 hour "just to make certain everyone was alright". NA-A stated R2's bathroom light was on and the night light was on in the room, but the room lights were off. NA-A reported R2 would use her call light "sometimes" when she wanted to get up, but other times, she would just get up and go to the bathroom and staff would find her there. R2 was not on a toileting plan, and there were no signs or reminders for R2 to call for assistance before getting up. NA-A reported when R2 was reminded to use her call light she would state she was "sorry" and that she had forgotten but frequently did not remember to do so. She indicated when R2 was caught attempting to self-transfer it was usually because she wanted to use the bathroom.	2 830		

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 ______	C 04/07/2022

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

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2 830	Continued From page 8 Interview on 4/7/22 at 9:06 a.m., with LPN-C identified R2 and she had a lot of pain and difficulty moving due to rib fractures from a previous fall at home. R2 voiced her plan to gain strength and manage her pain so she could return home. R2 was instructed to use of her call light and have staff assist her when she wanted to get up or needed something and verbalized understanding. LPN-C stated R2 felt if she was able to self-transfer, she would be able to go home sooner. R2 was reminded therapies were working with her to increase her strength and manage her pain so that she could go home, but she needed to wait until they felt it was safe for her to self-transfer. R2 verbalized understanding of the instruction. R2 was forgetful at times, and her comprehension could be considered questionable. LPN-C identified safety measures in place for R2 included her bed and room rearranged for convenience and to allow easier access to personal items. There was no formal monitoring in place, but staff would check on her as they were moving about in the hall. R2 had no reminders, or interventions in place to encourage/remind to have assistance with transfers and ambulation. R2 had orders for scheduled pain medication which included alternating Tramadol and Tylenol in addition to a Lidocaine patch applied to her lower back daily. LPN-C reported R2 would use her call light at times to make a request of staff, but when she wanted to go to the bathroom or move from one surface to another, she would self- transfer and/or ambulate without using her call light to allow staff to assist her. LPN-C also reported during a conversation with R2's daughter, she was told her mother had told her, if she was able to prove her ability to be independent, she would be able to return home sooner.	2 830		

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2 830	Continued From page 9	2 830		

Interview on 4/7/22 at 10:28 a.m., with NA-B identified she had assisted R2 to and from the bathroom and utilized a gait belt to help steady her as she had some balance issues and at times complained of feeling dizzy when she got up. NA-B reported R2 would use her call light at times and allow staff to assist her with transfers and ambulation, but frequently staff would find R2 attempting to self-transfer, or already in the bathroom. She identified R2 had incontinence of bladder and wore pull ups for dignity. NA-B reported, she had to repeatedly remind R2 she needed to wait until she could apply the gait belt so she could assist her, but at times she was confused and state she did not know that or had forgotten. NA-B reported R2 was not on a toileting schedule, but when she attempted to self-transfer it was frequently because she wanted to go to the bathroom. There were no additional safety measures in place that she was aware of, and the only sign was the one posted on the outside of the bathroom door, labeling it as the bathroom. Staff checked in on R2 as they were working on the unit, because they were aware she would attempt to self-transfer and not use her call light.

Interview on 4/7/22 at 10:43 a.m., with the medical director identified he had not actually seen R2 due to her recent admission and then her return to the hospital after her fall. If a resident was forgetting to use the call light and had a lack of safety awareness, he would expect further investigation into the cause with assessment and implementation of additional safety measures considered.

Interview on 4/7/22 at 10:55 a.m., with NA-C identified R2 required staff assistance using a gait

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2 830	Continued From page 10 belt and her walker to transfer and/or ambulate to the bathroom due to unsteadiness and balance issues when she got up. NA-C identified when R2 was attempting to self-transfer it was usually because she wanted to go to the bathroom and when staff would remind her she needed to have staff with her for safety, she would not reply or stated she could do it herself. NA-C reported R2 did not have additional safety measures in place and was not on a toileting schedule. Staff were aware she was a high fall risk and would check on her randomly to attempt to assist her with transfers to avoid a fall. Interview and document review on 4/7/22 at 3:49 p.m., with the DON identified R2 did not have a toileting plan or safety measures identified other than to use the call light. The DON reviewed the current care plan and agreed it failed to include the current needs for safety awareness and the need for staff assistance with transfers and ambulation. The DON agreed there should have been additional investigation and root cause anyalysis (RCA) of R2's repeated failure to comply with safety recommendations and development of a plan to implement safety measures which could have possibly helped to avoid the additional fall and resulting fracture. Review of the 3/13/20 Falls and Fall Risk Managing policy identified based on evaluations and current data, staff would identify individualized interventions in an attempt to decrease a resident's fall risk. Staff were to monitor and re-evaluate a resident's response to interventions intended to reduce falling or fall risk factors. Review of the 10/17/19, Care Plans-Comprehensive policy identified	2 830		

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2 830	Continued From page 11 interventions are designed after consideration of the resident's problem areas and causes. When possible, interventions address the underlying source of the problem area, rather than only addressing symptoms or triggers. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. The DON or designee could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		