DEPARTMENT OF HEALTH

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

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

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 05/04/2022

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) COMPLETE DATE
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: 38687 On 5/3/22 through 5/4/22, 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: H55961082C (MN83152) with a licensing order issued at 0830. 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 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 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: 38687 Based on interview and document review, the facility failed to ensure 1 of 1 resident (R4) was transferred with the appropriately sized mechanical lift sling, ensure nursing staff were appropriately trained to the manufactures instructions-for-use of the mechanical lift, and ensure staff followed facility policies and procedures by utilizing 2 staff for transfers. The	2 830	Corrected.	5/6/22

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2 830	Continued From page 3 deficient practice caused actual harm when R4 fell from the lift and sustained a laceration to her head and broken ribs. Findings include: R4's 2/4/22, quarterly Minimum Data Set (MDS) identified she had a severe cognition, was non-verbal and was rarely understood. R4 required total dependence of staff for transfers. R4 had diagnosis of advanced dementia. Review of the 4/29/22, initial report to the State Agency identified R4 fell out of a total mechanical lift causing head injury. R4 was taken to the local hospital. Review of the 5/3/22 12:24 p.m., 5 day report to the SA identified 2 nurse aides (NA) were transferring R4 into the bath chair. R4 reportedly pulled herself forward to scratch her buttocks and tipped out of the side of the sling. R4 landed on the floor between the legs of the lift with her head on the base. R4 was given first aide and transferred to the local hospital emergency department (ED). The nurse on duty interviewed both NA's. It was found R4 did not have the correct size sling in place. R4 had a small sling, when she should have had a medium. R4's care plan was determined to be accurate with the size of the sling needed. Both aides were not near the lift as 1 NA had gone to get the bath chair and the other NA was operating the controls. Education was reported as being provided as well as staff competencies to policies and procedures for using lifts. All residents were to be re-measured on 5/25/22 by the manufacturer representative to ensure they had the correct sized sling and to train all staff on how to operate the sling and lift. Residents who required a total mechanical lift	2 830		

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2 830	Continued From page 4 sling were measured for correct sling size. Care plans were reviewed for those residents affected. There was no mention the facility had identified staff had not been appropriately trained or retrained using manufacturer's instructions for use of the mechanical lifts. Review of a blank EZ Stand Competency Checklist identified its purpose was to assist in the proper training of operating the EZ Stand. It included a pre-operation checklist, stand operation section, and harness removal. It lacked instruction material to train staff but did note on the bottom to refer to the operator's manual that was supposed to be attached to the lift. Interview on 5/2/22 at 1:13 p.m., with the medical director (MD) identified he was notified of the incident after it had occurred. He was told 2 NA's were attempting to use the lift on R4. NA-E left to get something, and NA-D was left alone with R4 and used the mechanical lift. He reported staff told him potentially one NA "wasn't paying attention" and R4 somehow fell. R4 was sent to the ED. Staff were suspended pending the facility investigation. The MD was unaware staff were not trained to the manufacturer's instructions on the use of the mechanical lift. The MD agreed staff should have used the correct sling size and followed facility policy for use of 2 staff. The MD was also not aware staff competencies had either not been completed or had been signed off as having been completed prior to use of the lifts. Review of NA-D's employee file identified she was hired on 3/1/22. NA-D's time clock reports showed she received 18 hours of training from 3/3/22 through 3/10/22. 3/15/22 through 3/27/22 identified she received 38.25 hours of orientation to the facility. NA-D was a certified nursing	2 830		

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2 830	Continued From page 5 assistant since April 2018. NA-D's full competency checklist and job description were blank and had not been signed by either NA-D or anyone overseeing competencies prior to NA-D providing basic cares for residents. NA-D had completed online training on safe use of mechanical lifts, however, there was no indication that was from the manufacturer on the specific lifts the facility used. NA-D had never worked with EZ-Way lifts before her employment at the facility. Interview on 5/3/21 at 1:11 p.m., with the DON identified she had no lift operator's manual onsite to be used for training. She was unaware the manual included operating instructions. Interview and EZ Way lift manual review on 5/3/22 at 2:26 p.m., with NA-D identified she was hired by the facility approximately 2 months prior. NA-D was a certified nurse aide. When NA-D was hired, she completed online training to provide basics for care giving. After that, she followed a mentor for the remainder of her training. NA-D was shown the operators manual for the EZ Way lift by this surveyor and reported she had never seen that manual for the EZ lift before, or its instructions for use. Inside the manual, the manufacturer noted slings were to be color coded by size required. NA-D was unaware the slings were color-coded according to the size required for the resident. NA-D recalled the incident. She was operating the lift and had lifted R4 off the bed. While she did this, she instructed NA-E to get the bath chair that was in the hallway. NA-D proceeded to lift R4 to the highest point and use the controls to swing R4 from the bed to where the bath chair would be placed once NA-E brought it into the room. Before that could happen, NA-D saw R4 reach for her buttocks to scratch and told her to "not scratch" when R4	2 830		

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2 830	Continued From page 6 slipped from the sling approximately 4 feet, striking the floor and legs of the lift with her head and body. NA-D felt it was ok to lift a resident as high as she wanted and was unaware a resident should only be lifted enough to clear the surface she was transferring from. Observation on 5/3/22 at 2:47 p.m., of the linen closet with NA-D identified that was where residents' clean slings were kept. NA-D was unaware of how to tell the size of a sling. NA-D stated she normally "just used the sling that was in the resident's room". She indicated new labels had been placed on the outside of the laundry baskets to identify what size slings were in each basket. She recalled the sling she had used on R4 may have had gray (small) or burgundy (large) edging but was unsure what size that was. When verifying the size in each basket according to the label on the sling and color-coded edging, she indicated she had used the gray edged sling, sized small when the incident occurred. NA-D was told she should have used a medium sized sling. NA-D had grabbed a sling that was already in R4's room and had not verified the size was correct before use. NA-D also was unaware the lift had the corresponding color sizes labeled on the lift itself for easy recognition or the color-coded slings to the corresponding size. Review of NA-E's employee file identified she had been hired on 3/8/22. NA-E was not certified. NA-E had received 7.5 hours of online training and 26.5 hours of orientation. NA-E's lift competency inside her file noted her lift competency was "shown and discussed" however, there was no signature by the trainer or date of when this occurred. NA-E's main competency page was also blank and unsigned by any NA tasks she would be responsible for in	2 830		

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2 830	Continued From page 7 order to perform tasks independently or with another staff. Interview and employee file review on 5/3/22 at 4:07 p.m. with NA-E identified her lift competency was incomplete as well as her other competencies for providing basic cares to residents. NA-E reported she received about "2 weeks of training" where she followed another staff to learn "residents routines". She could not recall a nurse overseeing or completing any competencies related to her performing resident care. Interview and employee file reviews on 5/3/22 at 4:35 p.m., with the DON identified the DON and training staff used the competency checklist to train staff, and not the actual instructions listed in the manual. The DON agreed staff failed to ensure staff competencies were filled out appropriately, dated and signed. She agreed staff had not received appropriate training as there was no manual for operating instructions onsite. She was unaware NA-D and NA-E and potentially other staff had not been appropriately trained to operate the lifts safely according to the manufacturer. She identified since R4's fall, she had labeled the bins for slings in the clean linen closet. The DON agreed staff caused R4 actual harm when R4 was lifted into the air by inappropriately trained staff, fell, and received laceration to her head and multiple rib fractures. The DON agreed the facility investigation did not identify staff were not appropriately trained and she was unsure who was responsible to view employee files to ensure competencies were performed by licensed nurses to unlicensed personnel. Review of the 8/10/18, EZ Way Smart Lift	2 830		

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2 830	Continued From page 8 Operator's Instructions manual identified for safe operation of the lifts, operators should watch the training video, read through the manual, complete a competency checklist, and practice on fellow staff members before use with patients. Staff were directed to ensure accessories such as slings used with each lift were appropriate for both the patient and transferring situation and could call the EZ Way hotline if they had questions. Although it was designed to work with 1 staff, depending on the situation and facility policy, and patient condition, 2 staff may be necessary. All equipment must be maintained regularly by competent staff according to the checklist provided. Those instructions were to be kept with the lifts at all times. While lifting the resident, the were only to be lifted enough to clear the bed or surface being moved from. The sling sizing chart identified a resident between 90 to 220 pounds (lbs) was to use a beige colored medium sling. The height of the sling should be between 2 inches below the tailbone to top of a resident's shoulder line, therefore a proper fit was dependent on factors other than weight, including height and girth of a patient. Review of the current, undated Lifting Machine, Using A Mechanical policy identified at least 2 staff were needed to safely move a resident with a mechanical lift. Before using the left device, staff were to assess the resident's condition including physical and cognitive or emotional requirements. Staff were to measure for the proper sized sling and purpose according to manufacturer's guidelines. A double check of the resident's weight and sling to be used was to be obtained. Staff were to lift the resident after following manufacturer's instructions 2 inches from the surface to check the stability of attachments, the fit of the sling, and resident's	2 830		

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2 830	Continued From page 9 weight distribution. Staff were only to lift the resident as high as necessary to complete the transfer. Staff were to document in the medical record the reason for the transfers, lift used, equipment size resident's condition before and after the procedure. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to ensure staff are appropriately trained to operate mechanical lifts. The facility should ensure lift manuals are easily accessible and staff are deemed competent to operators instructions. The director of nursing or designee, should conduct random audits of the delivery of care with lift use and competencies are performed. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	2 830		

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F 000	INITIAL COMMENTS Surveyor: 38687 On 5/3/22 through 5/4/22, 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: H55961082C (MN83152) with deficiencies cited at F689. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F689 began on 4/29/22, when R4 was placed into a total body mechanical lift using the incorrect sling size by staff who were not trained to manufacturer's instructions for use or follow facility policy using 2 staff for transfer. R4 fell from the lift sling and recieved a head laceration and broken ribs. The facility administrator and director of nursing (DON) were notified of the IJ on 5/3/22 at 6:00 p.m., which was identified as a J-ISOLATED. The IJ was removed on 5/4/22 at 11:43 a.m., but non-compliance remained at the lower scope and severity of D-ISOLATED. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 5/4/22. 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	F 000		

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

Electronically Signed | 05/19/2022

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 000	Continued From page 1 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=J	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 accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 38687 Based on interview and document review, the facility failed to ensure 1 of 1 resident (R4) was transferred with the appropriately sized mechanical lift sling, ensure nursing staff were appropriately trained to the manufactures instructions-for-use of the mechanical lift, and ensure staff followed facility policies and procedures by utilizing 2 staff for transfers. The deficient practice caused actual harm when R4 fell from the lift and sustained a laceration to her head and broken ribs. The IJ began on 4/29/22, when R4 was placed into a total body mechanical lift using the incorrect sling size by staff who were not trained to manufacturer's instructions for use or follow facility policy using 2 staff for transfer. R4 fell from	F 689	F689 1. R1 returned to the facility on 05/06/2022. R1 had a new fall and pain assessment performed. R1's care plan was updated to include sling size. All other residents care plans and fall assessments were reviewed and updated as needed. Future residents who require lifting assistance will have a lift mobility, fall assessment and fall care plan initiated with the appropriate sling and other interventions initiated. 2. The Safe Lifting and Movement of Resident Policy and Procedure was reviewed with all nursing department employees and clinical leadership. Staff were also in-serviced to	5/6/22

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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
F 689	Continued From page 2 the lift sling and received a head laceration and broken ribs. The facility administrator and director of nursing (DON) were notified of the IJ on 5/3/22 at 6:00 p.m., which was identified as a J-ISOLATED. The IJ was removed on 5/4/22 at 11:43 a.m., but non-compliance remained at the lower scope and severity of D-ISOLATED. Findings include: R4's 2/4/22, quarterly Minimum Data Set (MDS) identified she had a severe cognition, was non-verbal and was rarely understood. R4 required total dependence of staff for transfers. R4 had diagnosis of advanced dementia. Review of the 4/29/22, initial report to the State Agency identified R4 fell out of a total mechanical lift causing head injury. R4 was taken to the local hospital. Review of the 5/3/22 12:24 p.m., 5 day report to the SA identified 2 nurse aides (NA) were transferring R4 into the bath chair. R4 reportedly pulled herself forward to scratch her buttocks and tipped out of the side of the sling. R4 landed on the floor between the legs of the lift with her head on the base. R4 was given first aide and transferred to the local hospital emergency department (ED). The nurse on duty interviewed both NA's. It was found R4 did not have the correct size sling in place. R4 had a small sling, when she should have had a medium. R4's care plan was determined to be accurate with the size of the sling needed. Both aides were not near the lift as 1 NA had gone to get the bath chair and the other NA was operating the controls. Education was reported as being provided as well as staff competencies to policies and procedures for	F 689	the manufacturers instructions for use per instruction manual and competencies were performed prior to staff utilizing lift. 3. No revisions were warranted to the above policy and procedure. 4. The EZ Way Stand Lift Manual was obtained for both the full and stand lifts. Both manuals were reviewed by the clinical leadership and the clinical leadership in-serviced the nursing staff on the manual location and its contents and will utilize the facility lift mobility competency for all nursing staff. In addition, the nurse aides were in-serviced on the lift sling size for each resident who use a mechanical lift and that this list will also be available in the nurse aide book and in the resident care plan. 5. Director of Nursing and/or designee is responsible for compliance. 6. Audits on safe transfer and use of the appropriate size sling for resident transfer will begin 2x daily for 2 weeks, weekly x 4 weeks then monthly x 4 to ensure compliance. Nurse aide competency will be reviewed during their annual training. 7. Audit results will be reviewed by the Administrator. The Administrator or	

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 05/04/2022

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F 689	Continued From page 3 using lifts. All residents were to be re-measured on 5/25/22 by the manufacturer representative to ensure they had the correct sized sling and to train all staff on how to operate the sling and lift. Residents who required a total mechanical lift sling were measured for correct sling size. Care plans were reviewed for those residents affected. There was no mention the facility had identified staff had not been appropriately trained or retrained using manufacturer's instructions for use of the mechanical lifts. Review of a blank EZ Stand Competency Checklist identified its purpose was to assist in the proper training of operating the EZ Stand. It included a pre-operation checklist, stand operation section, and harness removal. It lacked instruction material to train staff but did note on the bottom to refer to the operator's manual that was supposed to be attached to the lift. Interview on 5/2/22 at 1:13 p.m., with the medical director (MD) identified he was notified of the incident after it had occurred. He was told 2 NA's were attempting to use the lift on R4. NA-E left to get something, and NA-D was left alone with R4 and used the mechanical lift. He reported staff told him potentially one NA "wasn't paying attention" and R4 somehow fell. R4 was sent to the ED. Staff were suspended pending the facility investigation. The MD was unaware staff were not trained to the manufacturer's instructions on the use of the mechanical lift. The MD agreed staff should have used the correct sling size and followed facility policy for use of 2 staff. The MD was also not aware staff competencies had either not been completed or had been signed off as having been completed prior to use of the lifts.	F 689	designee will take results to QAPI for review and further recommendation. Compliance: 05/06/2022	

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F 689	Continued From page 4 Review of NA-D's employee file identified she was hired on 3/1/22. NA-D's time clock reports showed she received 18 hours of training from 3/3/22 through 3/10/22. 3/15/22 through 3/27/22 identified she received 38.25 hours of orientation to the facility. NA-D was a certified nursing assistant since April 2018. NA-D's full competency checklist and job description were blank and had not been signed by either NA-D or anyone overseeing competencies prior to NA-D providing basic cares for residents. NA-D had completed online training on safe use of mechanical lifts, however, there was no indication that was from the manufacturer on the specific lifts the facility used. NA-D had never worked with EZ-Way lifts before her employment at the facility. Interview on 5/3/21 at 1:11 p.m., with the DON identified she had no lift operator's manual onsite to be used for training. She was unaware the manual included operating instructions. Interview and EZ Way lift manual review on 5/3/22 at 2:26 p.m., with NA-D identified she was hired by the facility approximately 2 months prior. NA-D was a certified nurse aide. When NA-D was hired, she completed online training to provide basics for care giving. After that, she followed a mentor for the remainder of her training. NA-D was shown the operators manual for the EZ Way lift by this surveyor and reported she had never seen that manual for the EZ lift before, or its instructions for use. Inside the manual, the manufacturer noted slings were to be color coded by size required. NA-D was unaware the slings were color-coded according to the size required for the resident. NA-D recalled the incident. She was operating the lift and had lifted R4 off the bed. While she did this, she instructed NA-E to	F 689		

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F 689	Continued From page 5 get the bath chair that was in the hallway. NA-D proceeded to lift R4 to the highest point and use the controls to swing R4 from the bed to where the bath chair would be placed once NA-E brought it into the room. Before that could happen, NA-D saw R4 reach for her buttocks to scratch and told her to "not scratch" when R4 slipped from the sling approximately 4 feet, striking the floor and legs of the lift with her head and body. NA-D felt it was ok to lift a resident as high as she wanted and was unaware a resident should only be lifted enough to clear the surface she was transferring from. Observation on 5/3/22 at 2:47 p.m., of the linen closet with NA-D identified that was where residents' clean slings were kept. NA-D was unaware of how to tell the size of a sling. NA-D stated she normally "just used the sling that was in the resident's room". She indicated new labels had been placed on the outside of the laundry baskets to identify what size slings were in each basket. She recalled the sling she had used on R4 may have had gray (small) or burgundy (large) edging but was unsure what size that was. When verifying the size in each basket according to the label on the sling and color-coded edging, she indicated she had used the gray edged sling, sized small when the incident occurred. NA-D was told she should have used a medium sized sling. NA-D had grabbed a sling that was already in R4's room and had not verified the size was correct before use. NA-D also was unaware the lift had the corresponding color sizes labeled on the lift itself for easy recognition or the color-coded slings to the corresponding size. Review of NA-E's employee file identified she had been hired on 3/8/22. NA-E was not certified.	F 689		

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F 689	Continued From page 6 NA-E had received 7.5 hours of online training and 26.5 hours of orientation. NA-E's lift competency inside her file noted her lift competency was "shown and discussed" however, there was no signature by the trainer or date of when this occurred. NA-E's main competency page was also blank and unsigned by any NA tasks she would be responsible for in order to perform tasks independently or with another staff. Interview and employee file review on 5/3/22 at 4:07 p.m. with NA-E identified her lift competency was incomplete as well as her other competencies for providing basic cares to residents. NA-E reported she received about "2 weeks of training" where she followed another staff to learn "residents routines". She could not recall a nurse overseeing or completing any competencies related to her performing resident care. Interview and employee file reviews on 5/3/22 at 4:35 p.m., with the DON identified the DON and training staff used the competency checklist to train staff, and not the actual instructions listed in the manual. The DON agreed staff failed to ensure staff competencies were filled out appropriately, dated and signed. She agreed staff had not received appropriate training as there was no manual for operating instructions onsite. She was unaware NA-D and NA-E and potentially other staff had not been appropriately trained to operate the lifts safely according to the manufacturer. She identified since R4's fall, she had labeled the bins for slings in the clean linen closet. The DON agreed staff caused R4 actual harm when R4 was lifted into the air by inappropriately trained staff, fell, and received	F 689		

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F 689	Continued From page 7 laceration to her head and multiple rib fractures. The DON agreed the facility investigation did not identify staff were not appropriately trained and she was unsure who was responsible to view employee files to ensure competencies were performed by licensed nurses to unlicensed personnel. Review of the 8/10/18, EZ Way Smart Lift Operator's Instructions manual identified for safe operation of the lifts, operators should watch the training video, read through the manual, complete a competency checklist, and practice on fellow staff members before use with patients. Staff were directed to ensure accessories such as slings used with each lift were appropriate for both the patient and transferring situation and could call the EZ Way hotline if they had questions. Although it was designed to work with 1 staff, depending on the situation and facility policy, and patient condition, 2 staff may be necessary. All equipment must be maintained regularly by competent staff according to the checklist provided. Those instructions were to be kept with the lifts at all times. While lifting the resident, the were only to be lifted enough to clear the bed or surface being moved from. The sling sizing chart identified a resident between 90- 220 pounds (lbs) was to use a beige colored medium sling. The height of the sling should be between 2 inches below the tailbone to top of a resident's shoulder line, therefore a proper fit was dependent on factors other than weight, including height and girth of a patient. Review of the current, undated Lifting Machine, Using A Mechanical policy identified at least 2 staff were needed to safely move a resident with a mechanical lift. Before using the left device,	F 689		

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F 689	Continued From page 8 staff were to assess the resident's condition including physical and cognitive or emotional requirements. Staff were to measure for the proper sized sling and purpose according to manufacturer's guidelines. A double check of the resident's weight and sling to be used was to be obtained. Staff were to lift the resident after following manufacturer's instructions 2 inches from the surface to check the stability of attachments, the fit of the sling, and resident's weight distribution. Staff were only to lift the resident as high as necessary to complete the transfer. Staff were to document in the medical record the reason for the transfers, lift used, equipment size resident's condition before and after the procedure. The IJ was removed on 5/4/22 at 11:43 a.m., when it could be verified through observation, interview, and document review, the operators' manuals had been obtained for all lifts used in the facility and were placed in each lift per operators' instructions. All nursing staff were trained using the manual and included demonstrated competency. Staff were re-educated to correct sling size and to check the Kardex or care plan to ensure the correct size was listed. All other residents using mechanical lists were measured to ensure appropriate slings were used. Management was monitoring 2x daily and re-education would be provided until competency was attained.	F 689		

DEPARTMENT OF HEALTH

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: 5XUB11

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 May 4, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 18, 2022

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

RE: CCN: 245596
Cycle Start Date: May 4, 2022

Dear Administrator:

On April 21, 2022, we informed you of imposed enforcement remedies.

On May 4, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On May 4, 2022, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 6, 2022, will remain in effect.

This Department continues to recommend that CMS impose a 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.

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.

As we notified you in our letter of April 21, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 6, 2022.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(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 an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, South Shore Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 6, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

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

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

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

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:

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

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 (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.

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/ 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 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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 18, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: 5XUB11

Dear Administrator:

The above facility was surveyed on May 3, 2022 through May 4, 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:

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

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