Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 12, 2024

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

RE: CCN: 245596
Cycle Start Date: May 1, 2024

Dear Administrator:

On May 13, 2024, we notified you a remedy was imposed. On June 5, 2024 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 21, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 1, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 13, 2024, 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 1, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location 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
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 12, 2024

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

Re: Reinspection Results
Event ID: 0I0T12

Dear Administrator:

On June 5, 2024 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 1, 2024. 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
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 13, 2024

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

RE: CCN: 245596
Cycle Start Date: May 1, 2024

Dear Administrator:

On May 1, 2024, 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 immediate jeopardy (Level J), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D),whereby corrections were required.

REMOVAL OF IMMEDIATE JEOPARDY

On April 23, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 1, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective August 1, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 1, 2024.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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

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 1, 2024. 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.

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:

Lisa Krebs, Rapid Response Supervisor
Licensing and Certification Program

Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

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 November 1, 2024 (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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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://forms.web.health.state.mn.us/form/NHDisputeResolution

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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 13, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 0I0T11

Dear Administrator:

The above facility was surveyed on April 30, 2024 through May 1, 2024 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:

Lisa Krebs, Rapid Response Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@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 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	**1307 SOUTH SHORE DRIVE 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 On 4/30/24 and 5/1/24, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed H55963358C (MN00102732) and a deficiency was issued at F689 at PAST NON-COMPLIANCE. Deficiency were also issued at F623. 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 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State	F 623		5/21/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 05/29/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 1	F 623		

Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;

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F 623	Continued From page 2 (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure	F 623		

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F 623	Continued From page 3 to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide timely discharge notification in writing to the resident/resident representative, and the Ombudsman for 1 of 1 residents (R1) reviewed for discharge. Findings include: R1's face sheet printed 5/1/24, identified diagnoses of Alzheimer's, dementia, and senile degeneration (mental deterioration associated with age) of the brain. R1's admission Minimum Data Set (MDS) dated 2/21/24, identified an admission date of 2/24, severe cognitive impairment with inattention, diabetes, atherosclerotic heart disease, diverticulitis, hypertension, falls, urine retention, hyperlipidemia, disorganized thinking, daily wandering behaviors, and was on hospice. R1's care plan dated 2/16/24, identified a focus that R1 chose to remain at the facility for long-term care cognitive impairment/hospice care. R1's progress note dated 4/22/24 at 8:18 p.m., identified that R1's son was called and R1 would be admitted to a dementia unit. Son stated that he would rather R1 stay at the facility. Informed that since he left, we no longer have a say in the	F 623	R1 was transferred to a secured unit on 4/26/2024. There were no ill effects experienced with this emergency transfer. All current and future residents who discharge from the facility, a 30-day discharge notice will be provided, and the area ombudsman will be notified per facility policy. IDT and licensed nurses will be in-serviced on the Emergency Transfer/Discharge policy with emphasis on item #4 that the physician will be notified, notify the receiving facility and family/representative and for planned discharges the IDT and licensed nurses will be in-serviced on the Transfer or Discharge, Preparing the Resident policy that residents will be prepared in advance for pending discharges. Social Services and/or designee is responsible for compliance. Audits on resident discharge notification to resident/resident representative, ombudsman notification, discharge orders and post discharge documentation will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audits will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation.	

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F 623	Continued From page 4 matter, and we have to make sure to ensure R1's safety. Son stated "that is too bad." At 9:02 p.m., R1 was transported to the other facility via staff car with some personal belongings sent with. At 9:10 p.m., call placed to R1's daughter to update on course of events. Daughter is very upset that resident was moved. Ensured that they could move him to any facility that they want but the dementia unit is secure and tonight he demonstrated what he was capable of, and we are fortunate that no further incidents occurred that could have been tragic. Daughter stated not understanding how this could happen, he moved like a turtle. Reassured daughter that "I do not want to argue the facts, but I want her to know that her father is safe and the plan of action for the night." During an interview on 5/1/24 at 1:50 p.m., family member (FM)-A stated that R1 loved the facility and they did not want him to leave. FM-A indicated the facility had not notified her of discharge in writing on 4/22/23, and given no opportunity to appeal the discharge prior to R1 being discharged. During an interview on 5/1/24 at 2:09 p.m., with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), and Social Service Director (SSD), the DON stated that they were able to provide for all of R1's needs except more involvement with different departments and structured to what R1 likes. The facility provided a lot of distraction, 1:1 supervision, getting R1 more involved in activities. The DON stated that they have taken care of residents with needs like R1 that ambulated, wandered, participated in activities, and were redirectable. We were usually able to redirect and distract. The SSD stated that	F 623	Compliance: 05/21/2024	

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SOUTH SHORE CARE CENTER	**1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187**

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F 623	Continued From page 5	F 623		

they did not follow the 30-day discharge notice per corporate, for his safety, and the safety of other residents.

During an interview on 5/2/24 at 10:42 a.m., Ombudsman (O)-A stated that she was at the facility on 4/26/24 was verbally told that they had moved R1 "because corporate told us we couldn't keep him so he moved to the other facility." The facility told O-A that the family did not want R1 to move. O-A explained to the facility that they needed to notify the Ombudsman with discharge information along with family and that it needed to be sent. They have a right to appeal and remain at the facility during the process. O-A stated that this was an unauthorized discharge. O-A stated they told me about R1's elopement and how he drove on the narrow road with the lake on both sides. O-A asked about what was in care plan to keep R1 safe and individualizing it to meet R1's needs and the DON and SSD "stared at me with deer in the headlights." O-A stated she still has not received the notice of discharge to another facility for R1.

The facility policy Preparing a Resident for Transfer or Discharge reviewed 1/23, identified that resident will be prepared in advance for discharge.
-A post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident, and/or his or her family, at least twenty-four hours before the residents discharge or transfer from the facility.
-nursing will obtain orders for discharge/transfer, as well as recommended discharge services and equipment

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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: Based on interview and record review the facility failed to comprehensively assess and implement interventions to provide adequate supervision for 1 of 1 residents (R1) who had a history of exit seeking behaviors. R1's elopement from the facility in an unlocked motor vehicle, resulted in an immediate jeopardy (IJ). The facility implemented immediate corrective action and was issued as past non-compliance. The immediate Jeopardy (IJ) began on 4/22/24, when R1 exited the facility and staff did not respond timely to the activation of a door alarm by R1's WanderGuard bracelet. R1 got into an unlocked vehicle and drove around the city for 1.5 hours until police stopped him. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Social Service Designee (SSD), were notified of the IJ on 5/1/24 at 5:30 p.m. The facility implemented immediate corrective action on 4/23/23, and the IJ was issued at past non compliance. Findings include: R1's face sheet printed 5/1/24, identified	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 7 diagnoses of Alzheimer's, dementia, and senile degeneration (mental deterioration associated with age) of the brain. R1's admission Minimum Data Set (MDS) dated 2/21/24, identified an admission date of 2/24, indicated R1 had severe cognitive impairment with inattention, diabetes, disorganized thinking and daily wandering behaviors. R1 was independent walking throughout the facility. R1 had adequate vision and hearing and was able to make self understood and understood others. R1's elopement risk assessment dated 2/15/24, identified R1's risk factors for elopement included R1 was ambulatory, and habits of wandering and exit seeking. Additional risk factors included R1 had eloped from this setting or a previous one, family voiced concerns R1 may tend to exit seek or elope, and R1 was taking medications that may cause confusion. Analysis concluded that R1 was at risk for elopement and interventions included a personal safety alarm, frequent monitoring (was not defined), and staff aware of elopement risk. R1's care plan dated 2/15/24, identified R1 was a high risk for elopement and wandering related to senile dementia and history of elopement attempts. Interventions included, assess elopement status quarterly and as needed. Distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, book (western preference). Wander guard (personal safety alarm that alerts staff if resident attempts to leave the facility) to right lower ankle. The careplan did not include intervention of frequent monitoring as per the elopement assessment dated 2/15/24.	F 689		

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R1's progress notes between 2/22/24 to 4/14/24 identified R1 had multiple documented occurrences where R1 had attempted to leave the facility and/or had exit seeking behaviors without further assessment and revisions to R1's individualized care plan to continuously manage R1's exit seeking behaviors in order to prevent and/or mitigate the risk of elopement from the facility.

R1's progress note dated 2/22/24, identified R1 did exit the front door again.

R1's progress note dated 2/25/24, identified R1 was found exiting the door by A-wing. Wander guard alarmed and he was found near the nursing assistant supply room at the top of the ramp by the ice machine. R1 was easily redirected back to room.

R1's progress note dated 3/7/24, identified R1 attempted to open door and alarm went off so he stopped.

R1's progress note dated 3/10/24, identified R1 was walking towards the exit door, managed to get outside the facility and was easily redirected in at 3:21 p.m. At 9:47 p.m., R1 walked out of the facility and staff brought him back in immediately.

R1's progress note dated 3/13/24, identified R1 attempted to go outside and was easily redirected.

R1's progress note dated 3/24/24, identified R1 was exiting seeking and set off the wander guard multiple times.

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R1's progress note dated 3/31/24, identified R1 continued to be 1:1 visual staffing to prevent leaving the building.

R1's progress note dated 4/3/24, identified R1 attempting to open emergency door on B-wing. The alarm scared him, and he walked away.

R1's progress note dated 4/9/24, identified R1 was wandering facility, 1:1 provided. Nurse followed R1 as he exited the building and was able to easily redirect back into the facility.

R1's progress note dated 4/11/24, identified staff saw R1 walk out of the exit door and managed to get out and staff brought him back in. Another time R1 did not exit the building but did open the door and walked back in the facility by himself.

A facility reported incident submitted to the State Agency dated 4/14/24, identified R1 had exited the building and went to the front patio/fence area. Returned to facility without difficulty. The summary identified the facility would include an order to check the wander guard every shift for placement and functioning, will continue to discuss with family about potential different placement, and R1's care plan updated with activity of choice as R1 had been a gardener. The care plan 2/15/24 was not updated to reflect the activity intervention.

The facility elopement risk assessment dated 4/14/24, identified the same information from the 2/15/24 assessment but concluded with interventions of exit alarm, secure unit placement, visual barriers (stop sign, ribbon, tape, etc.), staff aware of elopement risk, and personalization of room. No changes were made to the care plan.

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During an interview on 5/1/24 at 9:02 a.m., registered nurse (RN)-A stated an awareness of R1's behaviors, R1 frequently wandered around the building and exit seek. R1 was independent with walking around the facility. R1 could sometimes walk very fast however, other times he would walk very slowly. When it was cold R1 would go into the entry way and return to the building without assistance. R1 could be distracted from wandering with food, following nurses around during medication passes, and watching sports or the lake. RN-A would always tell R1 at the beginning of the shift to not leave without her. R1 would not be safe to drive a car.

During an interview on 5/1/24 at 9:18 a.m., housekeeper (H)-A stated R1 would always try to go outside so every time she worked, she would look for R1 to make sure he was safe inside the facility.

R1's progress note dated 4/20/24, identified R1 had been exit seeking after family left.

R1's medication administration record (MAR) for April 2024, identified on 4/22/24 R1 received Seroquel (antipsychotic) 25 milligrams (mg) at 1:00 p.m., and haloperidol (antipsychotic) 2 mg was given at 6:13 p.m., morphine 0.5 mL was given at 6:13 p.m.

R1's progress note dated 4/22/24, identified R1 had attempted to leave the building twice. Nurse gave as needed medication of Haldol and morphine to calm R1. At 6:41 p.m., wander guard alarm sounded and at 6:42 p.m., staff opened the front door and did not see anyone but saw a vehicle drive away from the facility. Staff began a

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search for R1. A staff member realized his car was missing during the search and police were notified of missing resident and motor vehicle. Police returned R1 to facility at 8:15 p.m. R1 was transferred to a locked memory unit. Progress note identified R1 was driving a car around the city of Worthington, Minnesota for almost 1.5 hours without a drivers license and medication that could impair mental status, vision, and reaction time.

During observation on 5/1/24 at 4:52 p.m., the distance from the front door to where the staff members vehicle was parked was approximate 120 feet. The facility is located across the street from a lake off a road that in one direction runs along the lake shore with a stretch of road that has the lake on both sides. If one were to turn right out of the facility the road either goes along the side of the lake or leads to highway 60 after a couple of turns.

The police record dated 4/22/24, case 2024002271 identified they received two calls at 6:58 p.m. the first call reported a missing vehicle and the second call reported a missing resident. Officers arrived on scene and determined the incidents were related. At approximately 7:45 vehicle owner reported he found the vehicle being driven east on Oxford Street and officers stopped the vehicle on county road 33 near Sundberg Avenue, according to Google maps was approximately 3.7 miles from the facility. The vehicle was returned to the owner and the resident was transferred back to the facility.

The facility Elopement document dated 4/22/24, identified R1 as a wanderer, exit seeking along with confusion and impaired memory. Early

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afternoon and late evening the day of the event, there were a lot of visitors and other resident in and out of the facility prior to the incident. R1 had been restless prior to occurrence.

A facility reported incident submitted to the State Agency dated 4/25/24, identified an alarm sounded at 6:41 p.m. Upon staff going outside to locate R1 they saw a motor vehicle leaving the premise. 911 was notified and staff searched the premise and did not locate R1. Sheriff returned R1 to the facility at 8:15 p.m. (1.5 hours after the documented time R1 had left the facility). The summary identified R1 had wanted to go home. R1 was transferred to a sister facility upon return.

During an interview on 5/1/24 at 1:20 p.m., trained medication aide (TMA) indicated she had worked the evening shift on 4/22/24. TMA stated right before R1 left the facility around 6:45 p.m., R1 had been in a recliner by the window in view of the nursing station with licensed practical nurse (LPN)-A. TMA had left the area and went to Hall-C to use the restroom. She had heard the alarm, returned to the area, however R1 was not there. TMA went outside to the right, and LPN-A went to the left, but could not find R1 so she returned to building to alert all staff to begin the search.

During an interview on 4/30/24 at 3:11 p.m., nursing assistant (NA)-A stated staff had to always watch R1 because he would try to leave, mainly through the front door. R1 wore a WanderGuard that would activate an alarm if he tried to exit the facility however, the WanderGuard did not lock the doors. NA-A worked the evening shift of 4/22/24, when R1 went missing sometime after supper, she could

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F 689	Continued From page 13 not remember what time it was. NA-A had last seen R1 sitting in a recliner by the window in the dining room. NA-A explained she and NA-B had been in a resident's room with the door closed so she did not hear the door alarm sounding until she came out of the room at which point they went to the front door. NA-A did not know how long the alarm had been sounding before hearing it. NA-B told NA-A he was going to drive around to look for R1 but found his car missing from the parking lot. During a phone interview on 5/1/24 at 10:50 a.m., NA-B stated the evening of 4/22/24 he was in a room with NA-A so they did not hear the alarm until they left the resident's room. NA-B did not know how long the alarm had been sounding but LPN-A was already outside looking for R1 when he got outside. NA-B walked toward the lake across the street from the facility because he was worried R1 had got in and drowned. As NA-B walked he passed a few people and asked them if they had seen R1. The group of ladies told NA-B they saw an older man walking down the path. That is when NA-B decided to return to the facility to get his car to search. When NA-B returned to the facility he found his car missing. NA-B and LPN-A got in a vehicle and drove around looking for R1. NA-B stated when they got to highway 60, approximately two miles from the facility, they saw R1 in the car going the opposite direction so they made a U-turn to follow him. NA-B called the police back to tell them they located R1 driving NA-B's car. The police advised them to follow R1 and not attempt to get him to stop, the police would intervene and pull R1 over. NA-B said R1 was really speeding but driving "nice" by himself. NA-B was worried R1 would get in an accident and hurt himself or someone else.	F 689		

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NA-B stated he did not realize he had left his keys in the car when he had been on break. NA-B was surprised R1 knew how to start his vehicle, "I had to have instructions from Honda to learn."

During an interview on 5/1/24 at 12:52 p.m., NA-C stated the evening on 4/22/24 she did hear the alarm but was with a resident and could not immediately respond. NA-C did not know how long the alarm had been sounding prior to being shut off. After she completed cares with the resident, NA-C headed toward the front door and met NA-A and NA-B also going outside. NA-C went toward the lake and asked two ladies walking if they saw R1 which they had not. When NA-C walked back toward the facility, that is when we noticed NA-B's vehicle missing. NA-C went back into the building and that is when R2 told her that R1 had got in a vehicle and drove away. NA-C went back to helping residents in the facility

During an interview on 5/1/24 at 10:05 a.m., R2 who had moderate cognitive impairment according to the quarterly MDS dated 2/24/24, stated from his window he watched R1 walk really fast out of the building and got into a vehicle. R1 backed up, made a U-turn, and drove off. R2 saw staff outside the building looking for R1, but was not sure if it was before or after R1 was in the vehicle.

During an interview on 5/1/24 at 9:24 a.m., LPN-A stated on 4/22/24, R1 attempted to leave two times on his shift prior to the incident. After R1's first attempt to get out of the facility, he was redirected to sit in a chair in the dining room. After R1's second attempt he was assisted to sit in the recliner by the window to look at the lake and because R1 was restless and agitated LPN-A

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F 689	Continued From page 15 gave him morphine and haloperidol at 6:15 p.m. After 20 minutes R1 continued to sit in the chair awake and appeared calm so LPN-A left the nurses station to go downstairs. LPN-A heard the door alarming at approximately 6:41 p.m. LPN-A went outside and saw a car turning left out of the parking lot. LPN-A did not think much of it because he did not think R1 would drive a car. When LPN-A came back into the building he met NA-B who reported his car was missing. After the notifications to family, facility, and 911 were made NA-B and LPN-A took LPN-A's vehicle and began the search by turning left out of the facility parking lot. LPN-A drove down the road and there was a stop sign to go left or right and he took a right. LPN-A and NA-B passed two stop lights and then saw NA-B's car. They called the police while following R1 so they could stop him. R1 was going a minimum of 35 miles per hour. R1 went on a roundabout that led to a gravel road and that is when the police pulled him over. R1 got out of NA-B's car smiling. LPN-A reported he was surprised R1 had been driving good, he stopped at the stoplights but R1 should not have been driving especially after taking morphine and haloperidol. R1 was always exit seeking, he would try to escape the facility any chance he got. R1 should have had 1:1 supervision but there was not enough staff scheduled to provide that, instead R1 had the wander guard that alerted staff as he was exiting the building. In response to R1's exit seeking behaviors the direction and interventions were always to educate R1 not to leave, keep an eye on him, and provide him with medication. LPN-A was unaware of any other interventions that were utilized to prevent R1 from exit seeking or leaving the facility. During an interview on 5/1/24 at 1:50 p.m., family	F 689		

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member (FM)-A stated R1 was an outdoors person and loved the outside view at the facility. FM-A wished the facility had doors that locked. FM-A stated when she was told R1 was driving a vehicle she was terrified that R1 would hurt himself, or "if some little kid was out and [R1] mistook the gas for the brake."

During an interview on 5124 at 2:09 p.m., director of nursing (DON) and assistant director of nursing (ADON) stated their expectations when a resident was exit seeking was to stay with the resident, divert, redirect, find out what the resident was seeking, distract them and see when the last time their needs were addressed. DON stated it would be hard to say what would have stopped R1 from exit seeking on 4/22/24. ADON stated there was a lot of business in the facility that day and that always seemed to be a trigger for R1.

The facility policy titled Wander Management System updated 6/22, identified a wander management alarm system may be used on a resident who is deemed unsafe through the nursing assessment and documented on the resident's care plan that the resident was at risk for elopement. The wander management system should be checked every shift for placement and weekly for function.

The facility policy titled Resident Elopement reviewed 6/22, identified that staff shall investigate and report all cases of missing residents.
1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the charge nurse or DON.
4. if an employee discovers that a resident is missing from the facility, he/she shall initiate a

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search of the building and premise, if not located, notifications made to Administrator, DON, resident representative, physician, law enforcement, volunteer agencies, state agency. Proved search teams with resident identification information, initiate an extensive search of the surrounding area.
5. when resident returns to the facility examine the resident for injuries, contact the physician, notify resident representative, notify search teams, apply wander guard bracelet with MD order as needed, complete and file a risk management incident, report to the state agency and update care plan accordingly. Document relevant information in the resident's medical record.

The past non-compliance IJ began on 4/22/23. The IJ was removed, and the deficient practice corrected on 4/23/24 when it was verified the facility had implemented corrective action that included:
-Discharged R1 to a secured memory care facility on 4/22/24.
-The facility developed a new protocol to have staff always present in the area of the door leading out of the facility on 4/23/24.
-The facility re-educated staff on response time to the door alarms, and providing adequate supervision for wandering residents on 4/23/24.

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	00885	A. BUILDING: ______ B. WING ______	C 05/01/2024

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

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2 000	Initial Comments	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:
On 4/30/24 and 5/1/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H55963358C (MN00102732) with a licensing order issued at 1925. 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 not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 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		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21925	Corrected	5/21/24

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facility failed to provide timely discharge notification in writing to the resident/resident representative and the Ombudsman for 1 of 1 residents (R1) reviewed for discharge.

Findings include:

R1's face sheet printed 5/1/24, identified diagnoses of Alzheimer's, dementia, and senile degeneration (mental deterioration associated with age) of the brain.

R1's admission Minimum Data Set (MDS) dated 2/21/24, identified an admission date of 2/24, severe cognitive impairment with inattention, diabetes, atherosclerotic heart disease, diverticulitis, hypertension, falls, urine retention, hyperlipidemia, disorganized thinking, daily wandering behaviors, and was on hospice.

R1's care plan dated 2/16/24, identified a focus that R1 chose to remain at the facility for long-term care cognitive impairment/hospice care.

R1's progress note dated 4/22/24 at 8:18 p.m., identified that R1's son was called and R1 would be admitted to a dementia unit. Son stated that he would rather R1 stay at the facility. Informed that since he left, we no longer have a say in the matter, and we have to make sure to ensure R1's safety. Son stated "that is too bad." At 9:02 p.m., R1 was transported to the other facility via staff car with some personal belongings sent with. At 9:10 p.m., call placed to R1's daughter to update on course of events. Daughter is very upset that resident was moved. Ensured that they could move him to any facility that they want but the dementia unit is secure and tonight he demonstrated what he was capable of, and we

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are fortunate that no further incidents occurred that could have been tragic. Daughter stated not understanding how this could happen, he moved like a turtle. Reassured daughter that "I do not want to argue the facts, but I want her to know that her father is safe and the plan of action for the night."

During an interview on 5/1/24 at 1:50 p.m., family member (FM)-A stated that R1 loved the facility and they did not want him to leave. FM-A indicated the facility had not notified her of discharge in writing on 4/22/23, and given no opportunity to appeal the discharge prior to R1 being discharged.

During an interview on 5/1/24 at 2:09 p.m., with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), and Social Service Director (SSD), the DON stated that they were able to provide for all of R1's needs except more involvement with different departments and structured to what R1 likes. The facility provided a lot of distraction, 1:1 supervision, getting R1 more involved in activities. The DON stated that they have taken care of residents with needs like R1 that ambulated, wandered, participated in activities, and were redirectable. We were usually able to redirect and distract. The SSD stated that they did not follow the 30-day discharge notice per corporate, for his safety, and the safety of other residents.

During an interview on 5/2/24 at 10:42 a.m., Ombudsman (O)-A stated that she was at the facility on 4/26/24 was verbally told that they had moved R1 "because corporate told us we couldn't keep him so he moved to the other facility." The facility told O-A that the family did not want R1 to move. O-A explained to the facility that they

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needed to notify the Ombudsman with discharge information along with family and that it needed to be sent. They have a right to appeal and remain at the facility during the process. O-A stated that this was an unauthorized discharge. O-A stated they told me about R1's elopement and how he drove on the narrow road with the lake on both sides. O-A asked about what was in care plan to keep R1 safe and individualizing it to meet R1's needs and the DON and SSD "stared at me with deer in the headlights." O-A stated she still has not received the notice of discharge to another facility for R1.

The facility policy Preparing a Resident for Transfer or Discharge reviewed 1/23, identified that resident will be prepared in advance for discharge.
-A post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident, and/or his or her family, at least twenty-four hours before the residents discharge or transfer from the facility.
-nursing will obtain orders for discharge/transfer, as well as recommended discharge services and equipment

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures that written notification was provided to the resident and their representative before a transfer. The facility could educate staff on these policies and audit periodically. The results of these audits will be reviewed by the quality assessment committee to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty One (21) days

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