Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 3, 2023

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

RE: CCN: 245596
Cycle Start Date: January 5, 2023

Dear Administrator:

On March 2, 2023, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Lori Hagen, Compliance Analyst
Federal Enforcement | Licensing and Certification
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 3, 2023

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

Re: Reinspection Results
Event ID: 74D512

Dear Administrator:

On March 2, 2023, 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 January 5, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 20, 2023

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

RE: CCN: 245596
Cycle Start Date: January 5, 2023

Dear Administrator:

On January 5, 2023, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 5, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 5, 2023, (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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

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

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

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

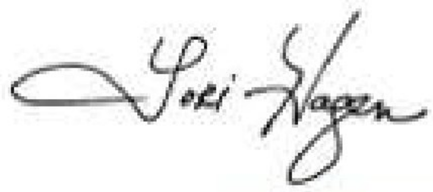
You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04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

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

Please contact me if you have questions.

Sincerely,



Lori Hagen, Compliance Analyst
Federal Enforcement | Licensing and Certification
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 20, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 74D511

Dear Administrator:

The above facility was surveyed on January 5, 2023, through January 5, 2023, 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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 contact me with any questions.

Lori Hagen, Compliance Analyst
Federal Enforcement | Licensing and Certification
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-mail: Lori.Hagen@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 01/05/2023

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 1/5/23, 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, Requirments for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H55967220C (MN89786), with a deficiency cited at (F661). 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 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with	F 661		2/3/23

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

Electronically Signed | 01/30/2023

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 661	Continued From page 1 the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to include skin care and treatment needs on a discharge summary for newly developed skin issues for 1 of 3 residents (R1) prior to discharge to another care facility. Findings include: R1 was discharged to the AL facility on 12/21/22, and the discharge paperwork was faxed to the AL prior to R1 leaving in addition to a copy being provided to R1. The discharge paperwork and orders failed to include R1's wounds on her buttocks, or treatment that had been implemented. R1's admission Minimum Data Set (MDS) assessment, dated 11/14/22 , identified R1's cognition was intact. R1's care plan identified, R1 had a potential	F 661	1. R1 has since discharged from the facility. A risk management incident will be created, and the incident will be thoroughly reviewed for root cause. The root cause identified will be implemented. All other residents with wounds, their orders were reviewed and updated as needed. Future residents who discharge will have a complete discharge summary completed and sent with the resident and/or representative. 2. Licensed nurses and facility social service designee will be in-serviced on the policy Preparing the Resident for Discharge procedure with emphasis on item #3 that the nurse is responsible for obtaining orders for discharge and the licensed nurses will be in-serviced on the Medication Treatment Order policy with focus on item #6 that all medication and	

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F 661	Continued From page 2 impairment of her skin integrity due to immobility and the intervention noted was application of barrier cream after each incontinent episode, keep skin clean and dry, application of lotion to dry skin, and a pressure relieving mattress and chair cushion. R1's therapy and progress notes reported increased strength and mobility with a goal of returning to the Assisted Living (AL) facility where she had resided prior. On 12/16/22 at 6:45 p.m., R1 called the nurse to her room and complained of soreness on her buttocks. When the area was assessed two small areas were noted. The left measured 2 centimes (cm) in diameter, and the Right-side area measured 1 cm wide (W) x 3 cm long (L). The areas appeared to be a result of R1 scratching her buttocks and scratch marks were noted around the open areas. The doctor was notified by fax and the areas were cleansed with normal saline and covered with a duoderm. On 12/18/22 a fax was sent to update the doctor, R1's wounds will be covered wish Sorbact (Surgical Dressing is a bacteria- and fungi binding wound dressing)dressing to change every 5 days and as needed until seen by the wound nurse. A fax back to the facility with the doctor's signature and dated 12/20/22. Interview on 1/4/23 at 1:25 p.m., with the AL director of nursing (DON) who admitted R1, reported she had no knowledge R1 had wounds on her buttocks until she complained of pain during her admission. The AL DON reported she had investigated and observed two open pressure ulcers one on each buttock cheek with no dressing in place. The right-side area measured approximately. 4 cm x 5 cm and the	F 661	treatment orders will be transcribed into the resident medical record. 3. Director of Nursing and/or designee is responsible for compliance. 4. Audits on Medication Transcription and discharge summary completion will begin weekly x 3 weeks then monthly to ensure sustained compliance. 5. All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendations. Compliance Date: February 3, 2023	

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F 661	Continued From page 3 left buttock area measured approximately 1 cm x 1 cm. R1 reported the areas developed in the nursing home, and she thought it was because she had liked to lie in her bed a lot. R1 reported the nursing home had been applying a cream to the area, but she did not know what it was. The AL director reported the transfer orders did not mention the wounds or contain orders for any treatment. The AL director reported she had contacted the nursing home director of nursing (DON) to ask about R1's wounds and received a reply via email that R1's sores were a result of scratches that had occurred on 12/16/22. The DON reported the treatment was collegian powder to areas and cover with a Sorbact dressing. The AL director reported she telephoned the doctor to request orders and stated treatment with Triad cream (a cream indicated for the treatment of pressure or venous ulcers) which she had on hand. An appointment was also arranged for follow up at the clinic with the doctor on 12/29/22. Interview on 1/5/23 at 1:27 p.m., with the social services designee (SSD) reported she had completed R1's discharge paperwork and recapitulation of stay by obtaining the discharge orders from therapies, including orders listed on the resident record, and the medication and treatment records. She reported she had forwarded the form to the charge nurse to review and add any additional information. Interviews on 1/5/23 at 12:58 p.m. and 3:30 p.m. with the DON identified R1 had developed two small open areas that were discovered on 12/16/22. The areas were felt to be the result of R1 scratching herself and the doctor had been updated. The initial nursing treatment was to	F 661		

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 661	Continued From page 4 cleanse the areas with saline and cover with a duoderm. This did not remain intact, and the treatment was changed to a Sorbact dressing. The doctor was faxed on 12/18/22 for the change in order and received signed on 12/20/22. R1 was scheduled to see the wound nurse on 12/22/22 but discharged on 12/21/22. The DON reported the information regarding R1's wounds and the treatment in place should have been included in the discharge paperwork sent to the AL facility and had been missed. Interview on 1/5/23 at 2:18 p.m. with R1 reported the sores on her buttocks developed while she was in the nursing home and the staff were applying a cream and dressing to the areas. R1 reported she was able to reposition herself in bed and her chair and did not need staff to assist her. Interview on 1/5/23 at 3:14 p.m. with doctors office staff, reported the doctor who had seen R1 on 12/29/22 was not available for interview at this time, but provided the notes from the visit. R1 was identified to have a superficial decubitus ulcer on her left buttock cheek. Review of the 11/30/21 policy Transfer or Discharge Documentation identified details of discharge or transfer were to be documented in the medical record and appropriate information communicated to the receiving facility or provider.	F 661		

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 01/05/2023

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 *****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 1/5/23, 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 plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H55967220 (MN89786), with a licensing order issued at S0690. 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 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 690	MN Rule 4658.0465 Subp. 3 Transfer, Discharge, and Death Subp. 3. Transfer or discharge to another facility. When a resident is transferred or discharged to another health care facility or program, the nursing home must send the discharge summary compiled according to subpart 2, and pertinent information about the resident's immediate care and sufficient information to ensure continuity of care prior to or at the time of the transfer or discharge to the other health care facility or program. Additional information not necessary for the resident's immediate care may be sent to the new health care facility or program at the time of or after the transfer or discharge. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to include skin care and treatment needs on a discharge summary for newly developed skin issues for 1 of 3 residents (R1) prior to discharge to another care facility. Findings include: R1 was discharged to the AL facility on 12/21/22, and the discharge paperwork was faxed to the AL prior to R1 leaving in addition to a copy being provided to R1. The discharge paperwork and orders failed to include R1's wounds on her buttocks, or treatment that had been implemented.	2 690	1. R1 has since discharged from the facility. A risk management incident will be created, and the incident will be thoroughly reviewed for root cause. The root cause identified will be implemented. All other residents with wounds, their orders were reviewed and updated as needed. Future residents who discharge will have a complete discharge summary completed and sent with the resident and/or representative. 2. Licensed nurses and facility social service designee will be in-serviced on the policy Preparing the Resident for	1/26/23

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	00885	A. BUILDING: _____ B. WING _____	C 01/05/2023

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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2 690	Continued From page 3 R1's admission Minimum Data Set (MDS) assessment, dated 11/14/22 , identified R1's cognition was intact. R1's care plan identified, R1 had a potential impairment of her skin integrity due to immobility and the intervention noted was application of barrier cream after each incontinent episode, keep skin clean and dry, application of lotion to dry skin, and a pressure relieving mattress and chair cushion. R1's therapy and progress notes reported increased strength and mobility with a goal of returning to the Assisted Living (AL) facility where she had resided prior. On 12/16/22 at 6:45 p.m., R1 called the nurse to her room and complained of soreness on her buttocks. When the area was assessed two small areas were noted. The left measured 2 centimes (cm) in diameter, and the Right-side area measured 1 cm wide (W) x 3 cm long (L). The areas appeared to be a result of R1 scratching her buttocks and scratch marks were noted around the open areas. The doctor was notified by fax and the areas were cleansed with normal saline and covered with a duoderm. On 12/18/22 a fax was sent to update the doctor, R1's wounds will be covered wish Sorbact (Surgical Dressing is a bacteria- and fungi binding wound dressing)dressing to change every 5 days and as needed until seen by the wound nurse. A fax back to the facility with the doctor's signature and dated 12/20/22. Interview on 1/4/23 at 1:25 p.m., with the AL director of nursing (DON) who admitted R1, reported she had no knowledge R1 had wounds on her buttocks until she complained of pain	2 690	Discharge procedure with emphasis on item #3 that the nurse is responsible for obtaining orders for discharge and the licensed nurses will be in-serviced on the Medication Treatment Order policy with focus on item #6 that all medication and treatment orders will be transcribed into the resident medical record. 3. Director of Nursing and/or designee is responsible for compliance. 4. Audits on Medication Transcription and discharge summary completion will begin weekly x 3 weeks then monthly to ensure sustained compliance. 5. All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendations. Compliance Date: February 3, 2023	

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2 690	Continued From page 4 during her admission. The AL DON reported she had investigated and observed two open pressure ulcers one on each buttock cheek with no dressing in place. The right-side area measured approximately. 4 cm x 5 cm and the left buttock area measured approximately 1 cm x 1 cm. R1 reported the areas developed in the nursing home, and she thought it was because she had liked to lie in her bed a lot. R1 reported the nursing home had been applying a cream to the area, but she did not know what it was. The AL director reported the transfer orders did not mention the wounds or contain orders for any treatment. The AL director reported she had contacted the nursing home director of nursing (DON) to ask about R1's wounds and received a reply via email that R1's sores were a result of scratches that had occurred on 12/16/22. The DON reported the treatment was collegian powder to areas and cover with a Sorbact dressing. The AL director reported she telephoned the doctor to request orders and stated treatment with Triad cream (a cream indicated for the treatment of pressure or venous ulcers) which she had on hand. An appointment was also arranged for follow up at the clinic with the doctor on 12/29/22. Interview on 1/5/23 at 1:27 p.m., with the social services designee (SSD) reported she had completed R1's discharge paperwork and recapitulation of stay by obtaining the discharge orders from therapies, including orders listed on the resident record, and the medication and treatment records. She reported she had forwarded the form to the charge nurse to review and add any additional information. Interviews on 1/5/23 at 12:58 p.m. and 3:30 p.m. with the DON identified R1 had developed two	2 690		

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2 690	Continued From page 5 small open areas that were discovered on 12/16/22. The areas were felt to be the result of R1 scratching herself and the doctor had been updated. The initial nursing treatment was to cleanse the areas with saline and cover with a duoderm. This did not remain intact, and the treatment was changed to a Sorbact dressing. The doctor was faxed on 12/18/22 for the change in order and received signed on 12/20/22. R1 was scheduled to see the wound nurse on 12/22/22 but discharged on 12/21/22. The DON reported the information regarding R1's wounds and the treatment in place should have been included in the discharge paperwork sent to the AL facility and had been missed. Interview on 1/5/23 at 2:18 p.m. with R1 reported the sores on her buttocks developed while she was in the nursing home and the staff were applying a cream and dressing to the areas. R1 reported she was able to reposition herself in bed and her chair and did not need staff to assist her. Interview on 1/5/23 at 3:14 p.m. with doctors office staff, reported the doctor who had seen R1 on 12/29/22 was not available for interview at this time, but provided the notes from the visit. R1 was identified to have a superficial decubitus ulcer on her left buttock cheek. Review of the 11/30/21 policy Transfer or Discharge Documentation identified details of discharge or transfer were to be documented in the medical record and appropriate information communicated to the receiving facility or provider. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to ensure discharge and/or	2 690		

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2 690	Continued From page 6 transfer information was complete and included all medications, wound care and follow up information to assure residents receive the necessary treatment/services following discharge. The director of nursing or designee, could conduct random audits of the discharge/transfer records to ensure appropriate care and services were included. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 690		