Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245596 | A. Building<br>B. Wing | 05/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| South Shore Care Center | 1307 South Shore Drive<br>Worthington, MN 56187 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616<br><br>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.<br><br>Findings include:<br><br>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.<br><br>R1's admission Minimum Data Set (MDS) dated [DATE], identified an admitted ,d+[DATE], severe cognitive impairment with inattention, diabetes, atherosclerotic heart disease, diverticulitis, hypertension, falls, urine retention, hyperlipidemia, disorganized thinking, daily wandering behaviors, and was on hospice.<br><br>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.<br><br>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 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.<br><br>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 .<br><br>(continued on next page) |

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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| NAME OF PROVIDER OR SUPPLIER South Shore Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1307 South Shore Drive Worthington, MN 56187 | |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>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.<br><br>The facility policy Preparing a Resident for Transfer or Discharge reviewed 1/23, identified that resident will be prepared in advance for discharge.<br><br>-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.<br><br>-nursing will obtain orders for discharge/transfer, as well as recommended discharge services and equipment |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616<br><br>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.<br><br>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.<br><br>Findings include:<br><br>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.<br><br>R1's admission Minimum Data Set (MDS) dated [DATE], identified an admitted ,d+[DATE], 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.<br><br>R1's elopement risk assessment dated [DATE], 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.<br><br>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 [DATE].<br><br>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.<br><br>R1's progress note dated 2/22/24, identified R1 did exit the front door again.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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.<br><br>R1's progress note dated 3/7/24, identified R1 attempted to open door and alarm went off so he stopped.<br><br>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.<br><br>R1's progress note dated 3/13/24, identified R1 attempted to go outside and was easily redirected.<br><br>R1's progress note dated 3/24/24, identified R1 was exiting seeking and set off the wander guard multiple times.<br><br>R1's progress note dated 3/31/24, identified R1 continued to be 1:1 visual staffing to prevent leaving the building.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>The facility elopement risk assessment dated [DATE], 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.<br><br>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.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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.<br><br>R1's progress note dated 4/20/24, identified R1 had been exit seeking after family left.<br><br>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.<br><br>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 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.<br><br>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.<br><br>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 [NAME] Street and officers stopped the vehicle on county road 33 near [NAME] 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.<br><br>The facility Elopement document dated 4/22/24, identified R1 as a wanderer, exit seeking along with confusion and impaired memory. Early 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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

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 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. 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 [NAME] 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 [DATE], 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.

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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 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.<br><br>During an interview on 5/1/24 at 1:50 p.m., family 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.<br><br>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.<br><br>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.<br><br>The facility policy titled Resident Elopement reviewed 6/22, identified that staff shall investigate and report all cases of missing residents.<br><br>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.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 4. if an employee discovers that a resident is missing from the facility, he/she shall initiate a 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.<br><br>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.<br><br>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:<br><br>-discharged R1 to a secured memory care facility on 4/22/24.<br><br>-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.<br><br>-The facility re-educated staff on response time to the door alarms, and providing adequate supervision for wandering residents on 4/23/24. |