

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER Southside Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2644 Aldrich Avenue South Minneapolis, MN 55408	

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)
<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617</p> <p>Based on interview and document review, the facility failed to ensure the comprehensive assessment was completed and implemented using the Resident Assessment Instrument (RAI) process as specified by CMS for 1 of 3 (R7) residents reviewed for trauma-informed care in addition to 1 of 5 residents (R7) reviewed for psychotropic medications.</p> <p>Findings include:</p> <p>R7's admission Minimum Data Set (MDS) dated [DATE], indicated she had intact cognition and no hallucinations or delusions with no reported behavioral symptoms. The MDS reported diagnoses including depression and alcohol dependence, however, did not identify a post-traumatic stress disorder (PTSD) diagnosis. The MDS reported R7 took antidepressant medications and antipsychotic medications on a routine basis only.</p> <p>R7's Care Area Assessment (CAA) for psychosocial well-being dated 11/7/24, indicated R7 reported feeling lonely and that her mood and/or behavior impacted her interpersonal relationships or arose from social isolation. The CAA identified R7 took psychotropic medications mirtazapine and fluoxetine (antidepressants) to treat depression. Additionally, the CAA identified she utilized non-pharmacologic interventions such as crafting activities, sitting outside on the front porch, smoking cigarettes, and minimal socializing to manage anxiety symptoms. The CAA indicated R7's psychosocial well-being would be addressed in her care plan and lacked documentation if a referral was warranted to another discipline.</p> <p>R7's CAA for mood state dated 11/7/24, identified her psychiatric disorder(s) and use of psychotropic medications. The CAA also identified her scheduled use of the antipsychotic medication olanzapine at bedtime to treat her insomnia (a sleeping disorder), however, lacked documentation of her PRN use of olanzapine as well as her history of trauma. The CAA indicated her mood state would be addressed in her care plan but lacked documentation if a referral was warranted to another discipline.</p> <p>R7's CAA for activities dated 11/7/24, was triggered but lacked documentation. The CAA indicated activities would be addressed in her care plan and did not address if a referral to another discipline was warranted.</p> <p>(continued on next page)</p>

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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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A biopsychosocial intake diagnostic assessment dated [DATE], indicated R7 reported a history of trauma. The admission paperwork reported, she was in an abusive marriage for [AGE] years which included physical, emotional and sexual abuse by her husband.</p> <p>An undated admission record printed 1/30/25, indicated R7 admitted to the facility on [DATE] and identified diagnoses of depression and alcohol dependence. The admission record lacked documentation of a PTSD diagnosis.</p> <p>A comprehensive trauma informed care assessment dated [DATE], identified triggers such as loud male voices, yelling, and angry voices, thrown objects. The assessment included target symptoms of depression under control. On bipolar spectrum. Depression more related to bipolar not actual depression. The assessment identified psychotropic medication management as well as non-pharmacologic interventions and indicated her needs would be addressed in the care plan.</p> <p>R7's signed order summary was requested but not received.</p> <p>R7's medication administration record (MAR) dated 1/25 reflected the following active physician orders:</p> <ul style="list-style-type: none"> - fluoxetine 80 milligram (mg) (Prozac), total 1 x daily by mouth (total 80mg) for depression, dated 11/14/24. - hydroxyzine hydrochloride (HCl) 50mg tablet (hydroxyzine HCl) 1-2 (50-100mg) by mouth three times daily as needed, dated 11/4/24. - lamotrigine 100mg tabs (Lamictal), Take 300mg by mouth every bedtime for depression dated 1/14/25. - mirtazapine 15mg tablet (Remeron), Take 1 tab by mouth at bedtime for insomnia dated 11/4/24. - olanzapine 15mg (Zyprexa), Take 3 tab by mouth twice daily for anxiety/agitation dated 11/29/24. - olanzapine 10mg (Zyprexa), Take 1/2 tab (5mg) by mouth daily as needed for anxiety/agitation dated 11/04/24. <p>R7's MAR reflected the PRN olanzapine was administered on 1/6/25, 1/7/25, 1/10/25, 1/14/25, 1/18/25, 1/19/25, 1/21/25, 1/22/25, and 1/28/25.</p> <p>R7's care plan dated 11/1/24, identified her depression diagnosis and directed staff to administer medications as ordered and monitor for and report side effects. Furthermore, her care plan, revised 11/24/24, directed staff to her behavioral management care plan and comprehensive behavioral assessment. The care plan lacked documentation regarding her history of trauma as well as her use of a PRN antipsychotic (olanzapine).</p> <p>(continued on next page)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A behavioral management care plan dated 11/24/24, indicated R7's behavioral triggers included sleep apnea and insomnia, and reported she often stayed awake throughout the night smoking and did experience sleep apnea. Additionally, the triggers identified on the care plan included stress related to medical appointments and getting the medications she needs prescribed to her, and her personal struggles with pain and addiction create a tremendous amount of stress for her. The care plan identified R7's target behavioral monitoring of chain-smoking cigarettes related to her insomnia and her addiction to food and eating between meals. Interventions included on the care plan were managing her medical appointments, setting up a sleep study consultation, assistance in managing her PRN medications and assessing her anxiety levels, and encouraging non-pharmacological solutions for anxiety management. The care plan lacked documentation of R7's history of trauma and related triggers.</p> <p>A facility referral form dated 12/17/24, indicated R7 was referred out for a psychiatry visit. The referral form revealed under the information from: side; diagnosis depression and PTSD.</p> <p>Per interview on 1/29/25 at 9:14 a.m., registered nurse (RN)-B confirmed completing R7's admission MDS dated [DATE] and reported being onsite 2-3 days per week. RN-B indicated when completing an MDS assessment onsite, the process was to review the binder with the paper assessments in it and work through those to build the MDS and then submit it through PointClickCare (PCC). RN-B stated, I get the information from staff and residents, in addition to chart review, and reported information from residents was often corroborated with staff interview because, I sometimes have to take what they say with a grain of salt, if a resident is being interviewed about medications or behaviors. RN-B stated when building the care plan, I definitely look at their history, and reported building the care plan from scratch if a resident was a new admission, like R7. RN-B reported collecting resident assessment information from a resident's history and physical (H&P) or whatever documents they send to us from the referral. RN-B confirmed reviewing R7's admission paperwork from her discharging facility and stated the information utilized to build her admission MDS, CAA worksheets, and care plan were based on true diagnoses that are in the diagnosis list but not necessarily what is being alluded to in other paperwork. RN-B stated being hesitant about reporting a PTSD diagnosis under section I of the MDS if it was not listed under the primary diagnosis or secondary diagnosis list of R7's admission or referral paperwork. RN-B verbalized being unaware of the RAI utilization guidelines (the instructions on how and when to use) to determine a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified. RN-B stated it was important to capture accurate MDS assessments because that is how the facility was reimbursed for their care.</p> <p>During interview on 1/29/25 at 12:03 p.m., health unit coordinator (HUC)-A, who also identified as the facility's social services director and activities director, reported there were several people in the facility with PTSD. HUC-A stated residents with triggers related to their PTSD were assessed upon admission if staff were aware of their diagnosis. HUC-A stated if a resident was struggling with PTSD or substance abuse, staff could offer a walk outside during the summer months or call management during off-hours for assistance. HUC-A reported it was important to give residents what they needed to succeed, like medication management, medical appointment referrals and transportation arrangements, to provide for their psychosocial well-being and mental health needs.</p> <p>(continued on next page)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 1/31/25 at 9:59 a.m., R7 stated there hasn't been a conversation yet here about my triggers or my past trauma. She reported there had been past events that were triggering for her and stated, there's one lady here that keeps asking for cigarettes. R7 shared the other unidentified female resident would ask for more cigarettes until she owed R7 money, which was a trigger for her because, that's not fair for me or her really. She endorsed reporting the events to RN-A, also identified as the facility's director of nursing (DON) and administrator, and believed RN-A spoke to the unidentified resident.</p> <p>Per interview on 1/31/25 at 9:45 a.m., treatment director (TD)-K confirmed working with R7 on her admission to the facility and recalled R7 reporting a history of trauma and that having an impact on her mental health. TD-K stated R7's trauma history included abuse and there was also some history of financial abuse with a previous partner of hers. TD-K stated R7 was assessed for trauma prior to discharge from their facility but I don't think she met full criteria to get the PTSD diagnosis in our diagnostic assessment, however, stated the referral would note if the resident had trauma. TD-K stated, from my recollection it is noted on there, her assessment and her history of trauma. But with her other concerns and wishes to want to be sober, her history of substance use, it made more sense to get those other diagnoses on her admission.</p> <p>During interview on 2/3/25 at 12:51 p.m., nurse practitioner (NP)-J verified working with R7 for a number of years and confirmed her PTSD diagnosis. NP-J further confirmed responsibility for R7's psychotropic medication management, including her PRN antipsychotic medication olanzapine.</p> <p>During interview on 2/3/25 at 1:37 p.m., RN-A stated, I think the care planning is appropriate for the new admissions, including R7. RN-A reported the trauma-informed care plan and assessment for R7 was completed due to a complaint survey and was kept in a separate survey binder and stated, no, I didn't capture that on the first day they were here. I should have done it before day 7, I think you get 7 days for the MDS. But I do expect that if we assess a resident for trauma, like we did, then it should be identified in the MDS. And that's maybe something I should have gone over more with our MDS nurse. RN-A stated if there was a second nurse available to help during the facility's new admissions, I could have helped RN-B more, I could have made it [the training] more robust.</p> <p>A comprehensive care plan policy was requested but not received.</p> <p>A policy pertaining to MDS or RAI was requested but not received.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617</p> <p>Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded for 5 of 7 residents (R1, R6, R7, R10, R11) reviewed for inaccurate MDS assessments.</p> <p>Findings include:</p> <p>R1 - Activity Preferences</p> <p>R1's annual Minimum Data Set (MDS) dated [DATE], reflected a Brief Interview for Mental Status (BIMS, or an assessment to determine a person's mental status) score of 11, indicating mild cognitive impairment. Additionally, the MDS indicated she had clear speech with the ability to make herself understood and was able to understand others. The MDS reported the interview for daily and activity preferences should not be conducted because R1 was rarely/never understood and family/significant other was not available. The MDS indicated staff assessed R1 regarding her daily and activities preferences and identified R1 preferred participating in her favorite activities and doing things in groups of people. The MDS identified diagnoses of anxiety, bipolar disorder (a chronic mental health disorder characterized by extreme mood swings between extreme periods of elevated moods, or mania, and extreme low moods, or depression), schizophrenia (a chronic mental health illness that affects a person's thoughts, perceptions, emotions, and behaviors), and mild intellectual disabilities (a developmental disorder that affects a person's abstract thinking and learning and problem-solving skills).</p> <p>R1's Care Area Assessment (CAA) for activities dated 12/12/24, indicated R1 slept in every morning and refused to get out of bed in the morning. Furthermore, the CAA indicated R1 has little interest in doing activities other than her word find book. Sometimes likes to listen to music with the Activities Director, however, likes to take naps mostly during the morning and has a history of not going to medical appointments, because she doesn't feel like doing anything except word find puzzles. The CAA indicated activities would be addressed in R1's care plan to slow or minimize decline and maintain her current level of functioning.</p> <p>An activities assessment was requested for the annual MDS dated [DATE], but was not received.</p> <p>During interview on 1/29/25 at 9:48 a.m., registered nurse (RN)-B verified R1 was not interviewed about her activity preferences to complete section F during her annual MDS dated [DATE]. RN-B stated she sometimes gathered the MDS data from interviewing staff, and depending on the situation, I will engage the resident and ask about what they liked to do prior to admission. RN-B stated, I don't care for the questions themselves; I think they are silly questions. The question set is geared towards different [population] set than ours. RN-B confirmed R1 did not have an activities care plan focus and stated, it mostly discusses her behaviors, I don't see anything for activities. I think that maybe is a gap in my understanding.</p> <p>Per facility policy titled Activities Policy updated 11/18/24, staff were directed to get to know a resident's history, preferences, dreams, and hopes to provide a variety of engaging resident programs while incorporating resident preferences.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R6 - Level II PASARR (Preadmission screening and resident review)</p> <p>R6's modification of annual Minimum Data Set (MDS) dated [DATE], indicated she had intact cognition, did not exhibit physical or verbal behaviors directed towards herself or others, but did report she experienced hallucinations and delusions during the lookback period. R6's MDS included diagnoses of schizophrenia (a chronic mental health illness that affects a person's thoughts, perceptions, emotions, and behaviors), alcohol dependence in remission, insomnia (a sleeping disorder), history of cocaine abuse, and encephalopathy (a medical condition that disrupts brain function, causing memory loss, confusion, seizures, changes in personality, muscle spasms or coma). Furthermore, the MDS reported R6 was not currently considered by the state to have serious mental illness and/or intellectual disability or a related condition.</p> <p>Senior LinkAge Line initial Pre-Admission Screening (PAS) Results dated 1/20/21, was reviewed on 1/27/25 at 2:13 p.m. The PAS indicated R6 met the criteria for mental illness and was referred to a lead agency and case manager for further evaluation (level II PASARR). Furthermore, the results of the level I were forward to a managed care program, identified as Special Care Basic Needs (SNBC). The report identified R6's lead agency and case manager for the level II PASARR.</p> <p>A request for information (ROI) was made on 1/30/25 at 9:02 a.m., for R6's records from the lead agency but was not received.</p> <p>A request for interview was made on 1/30/25 at 3:30 p.m., from the lead agency's case manager but was not received.</p> <p>R6's care plan updated 11/28/24, lacked documentation indicating services recommended under her level II PASARR were included.</p> <p>A review of R6's medical record on 1/30/25, revealed a lack of documentation regarding the services recommended under the level II PASARR evaluation.</p> <p>Per interview on 1/29/25 at 9:59 a.m., registered nurse (RN)-B confirmed R6's annual MDS dated [DATE], was coded inaccurately for question A1500 regarding her level II PASARR, stating, it looks like 'no'.</p> <p>Per interview on 2/3/25 at 1:37 p.m., RN-A was unable to identify what services were recommended under R6's level II PASARR, stating, I'm not sure, as far as what services should have been provided to her, I can't answer that. I never really read it until you guys brought it up, I never really thought to look it up. The PASARR thing, I don't necessarily know how to read them if I'm being honest.</p> <p>R7 - PRN Antipsychotic Medication, PASARR</p> <p>R7's admission Minimum Data Set (MDS) dated [DATE], indicated she had intact cognition and no hallucinations or delusions with no reported behavioral symptoms. The MDS reported diagnoses including depression and alcohol dependence. The MDS reported R7 took antidepressant medications and antipsychotic medications on a routine basis only. Additionally, the MDS reported R7 was not currently considered by the state level II preadmission screening and resident review (PASRR) process to have serious mental illness and/or intellectual disability or a related condition.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R7's CAA for psychotropic drug use dated 11/7/24, identified her use of antidepressants and a mood stabilizer (lamotrigine) as well as her routine (scheduled) use of the antipsychotic medication olanzapine at bedtime to treat her insomnia (a sleeping disorder), however, lacked documentation of her PRN use of olanzapine. The CAA indicated the psychotropic drug use would be addressed in the care plan.</p> <p>R7's Minnesota Senior Linkage Line preadmission screening results dated 11/21/24, identified a Level II assessment for mental illness was required prior to her admission to the facility. The results identified a lead agency and provided contact information.</p> <p>R7's medical record was reviewed on 1/27/25 and lacked documentation of results of a Level II assessment.</p> <p>R7's signed order summary was requested but not received.</p> <p>R7's medication administration record (MAR) dated 1/25 reflected the following active physician orders:</p> <ul style="list-style-type: none"> - olanzapine 15mg (Zyprexa), Take 3 tab by mouth twice daily for anxiety/agitation dated 11/29/24. - olanzapine 10mg (Zyprexa), Take 1/2 tab (5mg) by mouth daily as needed for anxiety/agitation dated 11/04/24. <p>R7's MAR reflected the PRN olanzapine was administered on 1/6/25, 1/7/25, 1/10/25, 1/14/25, 1/18/25, 1/19/25, 1/21/25, 1/22/25, and 1/28/25.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Per interview on 1/29/25 at 9:14 a.m., registered nurse (RN)-B confirmed completing R7's admission MDS dated [DATE]. RN-B stated, I get the information from staff and residents, in addition to chart review, and reported information from residents was often corroborated with staff interview because, I sometimes have to take what they say with a grain of salt, if a resident was being interviewed about medications or behaviors. RN-B stated medications were reviewed and reconciled against the chart. RN-B reported collecting resident assessment information from a resident's history and physical (H&P) or whatever documents they send to us from the referral. RN-B confirmed reviewing R7's admission paperwork from her discharging facility and stated the information utilized to build her admission MDS, CAA worksheets, and care plan were based on true diagnoses that are in the diagnosis list but not necessarily what is being alluded to in other paperwork. RN-B reviewed R7's admission MDS and verified it reported she was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. RN-B believed the PASARR was completed by RN-A and stated, I usually just ask him, it was my understanding that he was completing those so I was taking him on his word for it. I wouldn't even know what I was looking for if I was to go through her chart for that [PASARR] anyway. RN-B confirmed not interviewing R7 regarding her activity preferences and stated, depending on the situation, I will engage the resident and ask about what they liked to do prior to admission. RN-B recalled R7 admitted to the facility freshly sober and had a lot of anxiety, that she talked about having non-pharmacologic interventions to address. RN-B stated, I thought if I clicked 'not assessed' it would trigger on the care plan, it would trigger something on the CAA. RN-B stated, I don't care for the questions themselves; I think they are silly questions. The question set is geared towards different [population] set than ours. RN-B stated it was important to capture accurate MDS assessments because that is how the facility was reimbursed for their care.</p> <p>During interview on 2/3/25 at 12:51 p.m., nurse practitioner (NP)-J verified working with R7 for a number of years and confirmed her PTSD diagnosis. NP-J further confirmed responsibility for R7's psychotropic medication management, including her PRN antipsychotic medication olanzapine.</p> <p>During interview on 1/28/25 at 2:46 p.m., the Hennepin County supervisor (HCS)-L for Health and Human Services for adult access explained they were the contact person for the mental illness level II PASARR for the county. HCS-L stated a person should not be admitted to a facility without having the level II PASARR completed to ensure whatever services the individual was assessed to need are in place once the individual admits the facility. HCS-L confirmed receiving a level II PASARR for R7 and stated, I don't see a note that is was completed, but I see the referral came to us in October.</p> <p>Per follow-up interview on 1/28/25 at 4:44 p.m., HCS-L stated after many attempted contacts with the facility, the assessor assigned to R7's level II PASARR was not able to obtain the needed documentation to complete the assessment. HCS-L stated, Clearly we have a disjunct here, which sometimes happens when a nursing facility admission is done without an assessment and the facility isn't clear about what is required in this situation.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview on 2/3/25 at 1:37 p.m., RN-A stated, I think the care planning is appropriate for the new admissions, including R7. RN-A reported the trauma-informed care plan and assessment for R7 was completed due to a complaint survey and was kept in a separate survey binder and stated, no, I didn't capture that on the first day they were here. I should have done it before day 7, I think you get 7 days for the MDS. But I do expect that if we assess a resident for trauma, like we did, then it should be identified in the MDS. And that's maybe something I should have gone over more with our MDS nurse. RN-A stated if there was a second nurse available to help during the facility's new admissions, I could have helped RN-B more, I could have made it [the training] more robust.</p> <p>48299</p> <p>R10 - PASARR, medication</p> <p>R10's admission Minimum Data Set (MDS) dated [DATE], indicated R10 admitted to the facility on [DATE], had intact cognition, delusions, and diagnoses of bipolar disease and post-traumatic stress disorder. Item A1500 inquired had the resident been evaluated by level II PASARR and determined to have a serious mental illness and/or mental retardation or a related condition, and the MDS indicated no. The MDS indicated R10 received antipsychotic medication.</p> <p>R10's preadmission screening (PAS) dated 11/20/24, indicated the following preadmission screening result:</p> <p>-OBRA [Omnibus Budget Reconciliation Act; nursing home reform act to protect people from abuse in nursing homes]: Before this person admits to a nursing facility, an OBRA Level II assessment for mental illness is required.</p> <p>R10's letter sent with the PAS dated 11/20/24, indicated Senior Linkage Line made a referral for mental illness OBRA level II to lead agency Hennepin and indicated a name and phone number.</p> <p>R10's documents did not reflect a completed OBRA level II.</p> <p>Centers for Medicare and Medicaid Services' (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual dated 10/1/24, indicated to code no if any of the following apply:</p> <p>-PASARR level I screening did not result in an referral for level II screening, or</p> <p>-Level II screening determined the resident does not have a serious mental illness and/or ID/DD (intellectual disability and/or developmental disability) or related conditions, or</p> <p>-PASARR screening is not required because the resident was admitted from a hospital after requiring acute inpatient care, is receiving services for the condition for which they received care in the hospital, and the attending physician has certified before admission the resident is likely to require less than 30 days of nursing home care.</p> <p>CMS' RAI manual dated 10/1/24, indicated to code yes if PASARR level II screening determined the resident has a serious mental illness and/or ID/DD or related condition, and continue to item A1510, Level II PASARR conditions.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R10's discharge/admission medications signed 11/15/24, indicated R10 received medication which included buspirone (an antianxiety medication) for mood disorder and gabapentin (an anticonvulsant) for mood disorder.</p> <p>R11 - PASARR, medication</p> <p>R11's admission MDS dated [DATE], indicated R11 admitted to the facility on [DATE], had intact cognition, moderate depression, and diagnoses of anxiety disorder and post-traumatic stress disorder. Item A1500 inquired had the resident been evaluated by level II PASARR and determined to have a serious mental illness and/or mental retardation or a related condition, and the MDS indicated no. The MDS indicated R11 received antianxiety and antidepressant medication.</p> <p>R11's PAS dated 12/19/24, indicated R11 required an OBRA level II assessment for mental illness before admission to a nursing facility.</p> <p>R11's Level II PAS dated 12/20/24, indicated R11's admission was approved, had a documented mental illness, needed specialized mental health services, and mental health services were recommended to support R11 in their management of mental health symptoms.</p> <p>R11's medication administration record for the month of January 2025, identified R11 had medications which included gabapentin (an anticonvulsant) for nerve pain, with a start date of 12/7/24, and methadone (an opioid) for opioid dependence, with a start date of 12/3/24.</p> <p>When interviewed on 1/29/25 at 10:03 a.m., registered nurse (RN)-B stated they did not review PASARRs and asked RN-A, who was the facility administrator and director of nursing, how to answer A1500 section of the MDS and was told to answer no for R10 and R11. RN-B stated they answered the high-risk drug classes section of the MDS after they reviewed R10 and R11's discharge and admission paperwork. RN-B verified the MDS did not reflect R10's antianxiety and anticonvulsant medications, and R10 admitted with buspirone and gabapentin. RN-B verified R11's MDS did not reflect opioid and anticonvulsant medications, and R11 admitted with methadone and gabapentin.</p> <p>When interviewed on 2/3/25 at 9:54 a.m., RN-A stated accurate MDS assessments were important to develop residents' care plans, which informed staff how to care for the residents.</p> <p>A policy pertaining to MDS accuracy was requested but not received.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617</p> <p>Based on interview and document review, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program by incorporating recommendations from the PASARR level II determination and the PASARR evaluation report into the care plan for 1 of 6 (R6) reviewed for PASARRs.</p> <p>Findings include:</p> <p>R6's modification of annual Minimum Data Set (MDS) dated [DATE], indicated she was not currently considered by the state to have serious mental illness and/or intellectual disability or a related condition. The MDS indicated she had intact cognition, did not exhibit physical or verbal behaviors directed towards herself or others, but did report hallucinations and delusions during the lookback period. R6's MDS included diagnoses of schizophrenia (a chronic mental health illness that affects a person's thoughts, perceptions, emotions, and behaviors), alcohol dependence in remission, insomnia (a sleeping disorder), history of cocaine abuse, and encephalopathy (a medical condition that disrupts brain function, causing memory loss, confusion, seizures, changes in personality, muscle spasms or coma).</p> <p>R6's Care Area Assessments (CAAs) dated 10/25/24, were triggered for visual function, psychosocial well-being, mood state, activities, falls, nutritional status, dental status, and psychotropic drug use. The CAAs lacked documentation if referrals to another discipline were warranted.</p> <p>A transfer/discharge report printed 1/30/25, indicated R6's admitted to the facility was 2/01/21.</p> <p>Senior LinkAge Line initial Pre-Admission Screening (PAS) Results dated 1/20/21 was reviewed on 1/27/25 at 2:13 p.m. The PAS indicated R6 met the criteria for mental illness and was referred to a lead agency and case manager for further evaluation (level II PASARR). Furthermore, the results of the level I were forward to a managed care program, identified as Special Care Basic Needs (SNBC). The report identified R6's lead agency and case manager for the level II PASARR.</p> <p>A request for information (ROI) was made on 1/30/25 at 9:02 a.m. for R6's records from the lead agency but was not received.</p> <p>A request for interview was made on 1/30/25 at 3:30 p.m. from the lead agency's case manager but not received.</p> <p>R6's care plan dated 11/24/24, directed staff to see her behavioral management care plan in the medication administration record (MAR) for detailed information about her behavioral management care plan and comprehensive behavioral assessment.</p> <p>R6's behavioral management care plan updated 11/28/24, lacked documentation indicating services recommended under her level II PASARR were included.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of R6's medical record on 1/30/25 revealed a lack of documentation regarding the services recommended under the level II PASARR evaluation.</p> <p>Per interview on 1/29/25 at 9:59 a.m., registered nurse (RN)-B confirmed R6's annual MDS dated [DATE], was coded inaccurately for question A1500 regarding her level II PASARR, stating, it looks like 'no'. RN-B stated, I'm fairly new to MDS and indicated they were trained by RN-A, who was also identified as the facility's director of nursing (DON) and administrator. RN-B believed the PASARR was completed by RN-A, so I usually just ask him. It was my understanding RN-A was completing those, so I was taking RN-A's word for it. RN-B verbalized being unaware of what a PASARR was and stated, I wouldn't even know what I was looking for it I was to go through her chart for that.</p> <p>Per interview on 2/3/25 at 1:37 p.m., RN-A was unable to identify what services were recommended under R6's level II PASARR, stating, I'm not sure, as far as what services should have been provided to her, I can't answer that. I never really read it until you guys brought it up, I never really thought to look it up. The PASARR thing, I don't necessarily know how to read them if I'm being honest. RN-A stated the intended use of PASARRs was to ensure individuals with intellectual disabilities and developmental disabilities don't end up in the nursing home. RN-A stated R6 fell right into the [NAME] of what the facility specializes in and believed she was receiving good and appropriate care.</p> <p>A PASARR policy was requested but not received.</p> <p>A policy pertaining to MDS accuracy was requested but not received.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617</p> <p>Based on interview and document review, the facility failed to ensure a level II pre-admission screen and resident review (PASARR) was completed prior to admission for 4 of 5 residents (R7, R9, R10, R11) reviewed who required a level II PASARR screening for mental illness.</p> <p>Findings include:</p> <p>R7:</p> <p>R7's admission Minimum Data Set (MDS) dated [DATE], indicated she had intact cognition and no hallucinations or delusions with no reported behavioral symptoms. The MDS reported diagnoses including depression and alcohol dependence. Additionally, the MDS reported R7 was not currently considered by the state level II preadmission screening and resident review (PASARR) process to have serious mental illness and/or intellectual disability or a related condition.</p> <p>An admission record dated 11/13/24, indicated R7 admitted to the facility on [DATE].</p> <p>R7's Minnesota Senior Linkage Line preadmission screening results dated 11/21/24, identified a Level II assessment for mental illness was required prior to her admission to the facility. The results identified a lead agency and provided contact information.</p> <p>R7's medical record was reviewed on 1/27/25 and lacked documentation of results of a Level II assessment.</p> <p>During interview on 1/28/25 at 2:46 p.m., the Hennepin County supervisor (HCS)-L for Health and Human Services for adult access explained they were the contact person for the mental illness level II PASRR for the county. HCS-L stated a person should not be admitted to a facility without having the level II PASRR completed to ensure whatever services the individual was assessed to need are in place once the individual admits the facility. HCS-L confirmed receiving a level II PASRR for R7 and stated, I don't see a note that is was completed, but I see the referral came to us in October.</p> <p>Per follow-up interview on 1/28/25 at 4:44 p.m., HCS-L stated after many attempted contacts with the facility, the assessor assigned to R7's level II PASRR was not able to obtain the needed documentation to complete the assessment. HCS-L stated, Clearly we have a disjunct here, which sometimes happens when a nursing facility admission is done without an assessment and the facility isn't clear about what is required in this situation.</p> <p>Per interview on 1/29/25 at 9:14 a.m., registered nurse (RN)-B confirmed completing R7's admission MDS dated [DATE], and verified answering no to question A1500 regarding the level II PASSRR. RN-B stated, I'm fairly new to MDS and indicated being trained by RN-A, who also identified as the facility's director of nursing (DON) and administrator. RN-B believed the PASRR was completed by RN-A, so I usually just ask him. It was my understanding RN-A was completing those, so I was taking RN-A's word for it. RN-B verbalized being unaware of what a PASARR was and stated, I wouldn't even know what I was looking for it I was to go through her chart for that.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Per interview on 2/3/25 at 1:37 p.m., RN-A stated, The PASARR thing, I don't necessarily know how to read them if I'm being honest. RN-A stated the intended use of PASARRs was to ensure individuals with intellectual disabilities and developmental disabilities don't end up in the nursing home. RN-A confirmed training RN-B on the MDS process and stated, it could have been better. RN-A stated if there was a second nurse available to help during the facility's new admissions, I could have helped RN-B more, I could have made it [the training] more robust. RN-A stated if there was more time, I could have been more available.</p> <p>51577</p> <p>R9:</p> <p>R9's admission Minimum Data Set (MDS) dated [DATE], indicated (BIMS) of 13, intact cognition, and a admitted [DATE].</p> <p>R9's Transfer/Discharge Report, indicated R9 was admitted to the facility with a primary diagnosis of bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration that can make it difficult to carry out day-to-day tasks.) and secondary diagnoses of other stimulant dependence.</p> <p>R9's preadmission screening results (PAS) dated 11/20/24, indicated a referral for mental illness OBRA level II was made. The letter indicated a lead agency and phone number to follow up with. It also stated before this person was admitted to a facility the level II assessment was required.</p> <p>01/27/25 06:23 p.m., director of nursing, (DON) stated the PASARR II was something that fell through the cracks with new admissions. Previously, the facility had a nurse who completed this information, however they recently retired.</p> <p>R9's medical record lacked evidence a PASARR Level II assessment was completed to ensure R9's mental health care needs were met.</p> <p>48299</p> <p>R10: -level I done after admission and no level II completed</p> <p>R10's admission Minimum Data Set (MDS) dated [DATE], indicated R10 admitted to the facility on [DATE], had intact cognition, delusions, and diagnoses of bipolar disease and post-traumatic stress disorder.</p> <p>R10's Biopsychosocial Intake from The Landing (facility which provided short-term, intensive support and stabilization for clients experiencing acute psychological or emotional crises) dated 8/23/24, indicated R10 had the following diagnoses:</p> <p>-8/23/24, bipolar I disorder, with psychotic features</p> <p>-8/23/24, posttraumatic stress disorder</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R10's preadmission screening (PAS) dated 11/20/24, indicated the following preadmission screening results:</p> <p>-OBRA [Omnibus Budget Reconciliation Act; nursing home reform act to protect people from abuse in nursing homes]: Before this person admits to a nursing facility, an OBRA Level II assessment for mental illness is required.</p> <p>R10's letter sent with the PAS dated 11/20/24, indicated Senior Linkage Line made a referral for mental illness OBRA level II to lead agency Hennepin and indicated a name and phone number.</p> <p>During interview on 2/3/25 at 9:54 a.m., RN-A looked at R10's PAS and stated they thought the process was completed and verified they did not have a OBRA level II for R10.</p> <p>R11: - level I and II done after admission</p> <p>R11's admission MDS dated [DATE], indicated R11 admitted to the facility on [DATE], had intact cognition, moderate depression, and diagnoses of anxiety disorder and post-traumatic stress disorder.</p> <p>R11's Biopsychosocial Intake from The Landing dated 9/11/24, indicated R11 had the following diagnoses:</p> <p>-9/11/24, panic disorder</p> <p>-9/11/24, posttraumatic stress disorder</p> <p>R11's PAS dated 12/19/24, indicated R11 required an OBRA level II assessment for mental illness before admission to a nursing facility.</p> <p>R11's Level II PAS dated 12/20/24, indicated persons referred for level II screening for a mental illness may not be admitted to a nursing facility until the form was completed and the level II screener approved the admission. The Level II PAS indicated R11's admission was approved, had a documented mental illness, needed specialized mental health services, and mental health services were recommended to support R11 in their management of mental health symptoms.</p> <p>During interview on 1/28/25 at 3:07 p.m., registered nurse (RN)-A, who was the facility administrator and director of nursing, stated PASARRs were completed prior to admissions. RN-A stated the hospital social workers usually initiated the PASRR process but found with their new admissions, which included R10 and R11, the facility previously did not initiate the PASRR process.</p> <p>During interview on 1/30/25 at 8:39 a.m., health unit coordinator (HUC)-A, who also facilitated activities and was the social services director, stated RN-A handled the PASRR part of the admission process, and HUC-A reviewed referrals and completed the therapeutic recreation assessment form with new admissions.</p> <p>During interview on 2/3/25 at 9:54 a.m., RN-A verified R11's PASARR process was initiated after admission and agreed PASARRs were important to have completed prior to admission to know what additional services residents needed.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A facility policy was requested and not received.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617</p> <p>Based on interview and document review, the facility failed to review and revise the activities care plan with input from the resident and/or resident representative for 1 of 1 residents (R1) reviewed for activities.</p> <p>Findings include:</p> <p>R1's annual Minimum Data Set (MDS) dated [DATE], reflected a Brief Interview for Mental Status (BIMS, or an assessment to determine a person's mental status) score of 11, indicating mild cognitive impairment. Additionally, the MDS indicated she had clear speech with the ability to make herself understood and was able to understand others. The MDS reported the interview for daily and activity preferences should not be conducted because R1 was rarely/never understood and family/significant other was not available. The MDS indicated staff assessed R1 regarding her daily and activities preferences and identified R1 preferred participating in her favorite activities and doing things in groups of people. The MDS identified diagnoses of anxiety, bipolar disorder (a chronic mental health disorder characterized by extreme mood swings between extreme periods of elevated moods, or mania, and extreme low moods, or depression), schizophrenia (a chronic mental health illness that affects a person's thoughts, perceptions, emotions, and behaviors), and mild intellectual disabilities (a developmental disorder that affects a person's abstract thinking and learning and problem-solving skills).</p> <p>R1's Care Area Assessment (CAA) for activities dated 12/12/24, indicated R1 slept in every morning and refused to get out of bed in the morning. Furthermore, the CAA indicated R1 has little interest in doing activities other than her word find book. Sometimes likes to listen to music with the Activities Director, however, likes to take naps mostly during the morning and has a history of not going to medical appointments because she doesn't feel like doing anything except word find puzzles. The CAA indicated activities would be addressed in R1's care plan to slow or minimize decline and maintain her current level of functioning.</p> <p>R1's CAA for mood state dated 12/12/24, indicated R1 slept in every morning, refuses to get out of bed, has little interest in doing activities other than her word find book. Sometimes likes to listen to music with the activities director, however, likes to take naps mostly during the morning and has a history of not going to medical appointments because she doesn't feel like doing anything except her word find puzzles. Mental Health: BIMS score 15, residents score can vary every time she is asked to perform this assessment. The CAA indicated R1's mood state - functional status would be addressed in the care plan.</p> <p>An activities assessment was requested for the annual MDS dated [DATE], but was not received.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's care plan revised 4/18/20, identified her risk for not meeting emotional, intellectual, physical and social needs related to her cognitive deficits, schizophrenia, and physical limitations. The goal of care was to maintain involvement in cognitive stimulation and social activities as desired. The care plan directed staff to invite R1 to activities and ensure activities she attended were compatible with physical and mental capabilities, compatible with known interests and preferences, adapted as needed, compatible with her needs and abilities, were age appropriate. The care plan lacked documentation of R1's activity preferences, either facility-sponsored or independent activities.</p> <p>During interview on 1/29/25 at 9:48 a.m., registered nurse (RN)-B confirmed completing the MDS assessments and stated R1 was tricky because she would sometimes say things not based in fact. RN-B verified not interviewing R1 for the MDS dated [DATE] about section F regarding her activity preferences. RN-B stated, I don't care for the questions themselves; I think. I think they are silly questions themselves. The question set is geared towards a different population set than ours. RN-B stated she sometimes gathered the MDS data from interviewing staff, and depending on the situation, I will engage the resident and ask about what they liked to do prior to admission. RN-B confirmed R1 did not have an activities care plan focus and stated, it mostly discusses her behaviors, I don't see anything for activities. I think that maybe is a gap in my understanding.</p> <p>Per interview on 2/3/25 at 1:37 p.m., RN-A, also identified as the facility's director of nursing (DON) and administrator, confirmed training RN-B on the MDS process and stated, it could have been better. RN-A stated if was a second nurse available to help during the facility's new admissions, I could have helped RN-B more, I could have made it [the training] more robust. RN-A stated if there was more time, I could have been more available.</p> <p>Per facility policy titled Activities Policy updated 11/18/24, staff were directed to get to know a resident's history, preferences, dreams and hopes to provide a variety of engaging resident programs while incorporating resident preferences.</p> <p>A comprehensive care plan policy was requested but not received.</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299</p> <p>Based on interview and document review, the facility failed to evaluate a resident's discharge needs or develop a discharge plan to ensure an appropriate discharge location could accommodate resident medical, mental health, oncology, cancer care, and medication needs for 1 of 1 residents (R12) who was discharged to a location where it was unknown if they could meet R12's needs.</p> <p>Findings include:</p> <p>R12's discharge return not anticipated Minimum Data Set (MDS) dated [DATE], indicated R12 had a planned discharge to a home/community setting, had intact cognition, mild depression, no behaviors, and was independent with activities of daily living. The MDS identified diagnoses of major depressive disorder, alcohol dependence, adjustment disorder with depressed mood, history of suicide attempt, and a history of other psychoactive substance abuse. The MDS indicated antipsychotic and antibiotic medication use. The MDS indicated there was not an active discharge plan in place for R12 to return to the community, and R12 did not want a referral to a local contact agency.</p> <p>R12's care plan 8/11/24, did not identify discharge planning, and indicated R12 required pain management, assistance from social services and nursing to schedule medical appointments, transportation, and needed follow-up and communication with oncology staff at cancer institute. R12 attended a day program for alcohol abuse treatment, addiction treatment program, and had little or no activity involvement. R12 had potential for dehydration or potential for fluid deficit related to nausea, poor intake, use and/or side effects of medication, and swallowing problem. R12 had depression and psychosocial well-being problem related to anxiety, cancer, dependent behavior, disease process, inability to concentrate, family discord, inability to problem solve, ineffective coping, lack of motivation, recent admission, and social isolation.</p> <p>R12's interdisciplinary notes indicated the following events:</p> <p>-8/15/24, R12 approved for treatment program for alcohol abuse and would be escorted by social services director.</p> <p>-9/12/24, R12 made a false report about two roommates and steps were taken to move R12 to a private room.</p> <p>-10/10/24, R12 wanted money for chewing tobacco and stated they would call social services and get the building in trouble if the facility did not give R12 money.</p> <p>-10/21/24, registered nurse (RN)-A discussed with R12 about respecting staff and R12 stated they should not have to be respectful to staff.</p> <p>-11/4/24, RN-A called Hennepin County Nurse hotline to request an appointment and scheduler stated R12 was a no call, no show for two appointments. RN-A indicated nursing had arranged transportation for the appointments, and R12 had called to have cab ride back to the facility. RN-A indicated the facility social worker would escort R12 for all appointments.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Southside Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2644 Aldrich Avenue South Minneapolis, MN 55408	
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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-11/5/24, R12 was discharged [DATE] around noon to a different setting and named the facility. R12 was discharged with all medications, and staff dropped R12 off at the listed address.</p> <p>R12's providers order dated 11/11/24, six days after the discharge took place, indicated R12 was okay to discharge with medications to a group home living environment.</p> <p>R12's documents lacked a discharge summary.</p> <p>When interviewed on 1/28/25 at 12:32 p.m., registered nurse (RN)-A, who was the facility administrator and director of nursing, stated when discharging residents, the facility got a discharge order from the provider and sent discharging residents with a copy of their medication administration record and medications depending on where they were going. RN-A stated they completed discharge summaries in residents' progress notes. RN-A stated R12's discharge was self-directed, and the health unit coordinator (HUC)-A, who also facilitated activities and was the social services director, drove R12 to the group home. RN-A stated they did not remember if they had R12 sign any discharge paperwork, because R12 got to the point where R12 did not want to work with the facility on their discharge.</p> <p>On 1/28/25 at 12:39 p.m., writer called two numbers for R12 and both numbers were changed, disconnected, or no longer in service.</p> <p>When further interviewed on 1/28/25 at 1:17 p.m., RN-A stated R12 was at the facility for cancer treatment and was cured a year. RN-A stated R12 was in counseling for drinking problems and met people at the treatment program who R12 wanted to move in with, and did not tell RN-A where the location was. RN-A stated R12 was safe to make their own decisions, and R12 gave the facility notice of their wishes to discharge a day or two before the discharge was set to occur. RN-A stated they packed R12's medications, got a provider's order for discharge, and moved R12 to their new residence. RN-A stated they normally filled out a discharge summary and had the resident sign it and would look for R12's. RN-A stated R12 discharged on [DATE], and verified the providers order for discharge was obtained 11-11-24. RN-A stated orders were delayed at times when providers were contacted. RN-A stated R12 started to be belligerent with staff, and RN-A had thoughts of discharging R12 or calling the police. RN-A reviewed progress notes which indicated R12 was educated to be kinder to staff and manipulated staff for money.</p> <p>When interviewed on 1/28/25 at 1:58 p.m., RN-A stated they could not find a discharge summary for R12 and stated R12 left quickly, and RN-A provided a blank Discharge Summary they would normally fill out for discharging residents. The blank Discharge Summary form had a spot for name, admission and discharge date, discharge location, condition on discharge, admitting diagnosis, course of treatment, and an area for a signature and date. The bottom half of the form had spots for information about discharge diagnosis, prognosis, disposition of medication, provider signature and date.</p> <p>When interviewed on 1/29/25 at 11:49 a.m., certified physician assistant (CPA)-B stated staff sent messages through their portal for discharge recommendations. The facility was not a locked unit, and residents could leave without guidance or provider approval. CPA-B stated they got a message 11/11/24, about R12 wanting to transfer to a group home and indicated R12 was okay to discharge with medications to group home living. CPA-B verified they were aware of the discharge later than the discharge date. CPA-B stated R12 discharged on their own accord and was able to make such decisions and did not have concerns about knowing about R12's facility discharge at a later date.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/30/25 at 9:19 a.m., writer attempted to call the facility R12 was discharged to, and the number was no longer working.</p> <p>On 1/30/25 at 9:32 a.m., an overarching program number was called, and the representative stated the facility closed a year ago and did not have R12 in their records.</p> <p>When interviewed on 1/30/25 at 9:37 a.m., HUC-A stated RN-A handled discharges from the facility, and they had not previously had discharges in which the resident said they wanted to leave within 24 hours. HUC-A stated HUC-A and DON usually called the receiving facility to communicate about resident needs, spent time with the staff at the receiving facility when bringing residents to new locations, and would call the facility afterward to ask how the resident was and inquire if they needed anything else. HUC-A stated R12 planned their own discharge with an unknown social worker, stated they were moving out, and did not tell the facility details about the social worker helping with the discharge or discharge location. HUC-A stated R12 mentioned they were moving out a week prior to discharge but did not give a timeline of when the discharge would be, and HUC-A did not know if R12 was truthful. HUC-A stated R12 left on bad terms and was agitated and upset with everyone. When R12's self-planned ride fell through on 11/5/24, HUC-A drove the resident to the unknown facility location using directions provided by R12, however HUC-A stated R12 did not want HUC-A to enter the new facility. HUC-A wrote down the address upon arrival and looked up the address and phone number when HUC-A returned to the facility, however, HUC-A stated they never called the receiving facility number they found. The phone number and facility name were the same as the writer attempted to reach which had closed several months prior to discharge.</p> <p>When interviewed on 1/30/25 at 10:36 a.m., after conversing about closure of the identified receiving facility, CPA-B stated the facility was responsible for safe discharge, especially if dropping the resident off. CPA-B expected a report to be made if the facility did not know where the resident was discharging to and left against medical advice. CPA-B stated R12 was not cognitively impaired, did not have dementia, and was independent with decisions and activities of daily living.</p> <p>When interviewed on 1/30/25 at 10:47 a.m., RN-A stated R12 did not leave against medical advice and was a safe discharge, since R12 reported he was working with an unknown social worker. R12 was sent with medications and a copy of medication administration record, HUC-A drove R12 to their destination, and R12 had a support system and was independent. RN-A stated the social worker was from R12's drinking rehabilitation group, but RN-A did not know who the social worker was, since R12 did not provide the name or number of the social worker. RN-A tried to call the three numbers the writer called, and the calls failed. RN-A stated R12 had mentioned discharge but did not give a timeline, and then suddenly R12 stated they were discharging. RN-A stated it happened faster than they would have wanted it to happen, but a process was in place.</p> <p>When interviewed on 1/30/25 at 11:00 a.m., RN-D stated R12 did not want staff to know where they were going and just told staff they were leaving. RN-D stated HUC-A dropped R12 off to the place R12 was going. RN-D ended the call prior to interview end.</p> <p>When interviewed on 1/30/25 at 11:22 a.m., R12's psychiatry office representative stated R12 had a psychiatric prescriber and therapist through them, was seen 4/11/24, and missed appointments on 5/9/24, and 6/14/24. The representative stated they did not have a phone number or address for R12 so they were waiting for R12 to reach out to them. The representative stated they had record of the facility reaching out for medication refills in November of 2024.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When interviewed on 1/30/25 at 12:51 p.m., R12's chemical counselor stated R12 completed an intensive residential outpatient treatment program but would not have resumed care of R12's at discharge.</p> <p>When interviewed on 1/30/25 at 3:40 p.m., RN-A stated they spoke to their boss, who was going to check on R12 and thought the facility R12 discharged to changed names and ownership. RN-A stated R12 was tired of being at Southside and was ready to leave and thought it was safe for R12 to discharge. RN-A considered filing a report but thought that would have upset R12.</p> <p>The facility provided a new phone number for R12.</p> <p>When interviewed on 1/31/25 at 12:22 p.m., R12 stated they were at the facility for cancer treatment and were in remission. R12 stated their discharge was self-initiated and R12 was trying to get back to work and regular daily life. R12 stated the social worker at the treatment center put R12 into contact with people who helped R12 into a group home where R12 could work. R12 stated they were discharged with their belongings, medications, and a couple of folders of paperwork but did not recall what the paperwork was. R12 stated they had no disruptions with their medications or care.</p> <p>When interviewed on 2/3/25 at 10:01 a.m., RN-A stated they did not have proof and did not make a copy of the summary they sent with R12 at the time of discharge. RN-A stated they did not have an active role in R12's discharge planning and did not have a nurse to hand off report to about R12, since R12 was private about their discharge plans and coordinated their discharge with an outside social worker.</p> <p>A policy related to discharge was requested but not received.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617</p> <p>Based on observation, interview and document review, the facility failed to ensure individualized activities were provided for 1 of 1 residents (R1) reviewed for activities.</p> <p>Findings include:</p> <p>R1's annual Minimum Data Set (MDS) dated [DATE], reflected a Brief Interview for Mental Status (BIMS, or an assessment to determine a person's mental status) score of 11, indicating mild cognitive impairment. Additionally, the MDS indicated she had clear speech with the ability to make herself understood and was able to understand others. The MDS reported the interview for daily and activity preferences should not be conducted because R1 was rarely/never understood and family/significant other was not available. The MDS indicated staff assessed R1 regarding her daily and activities preferences and identified R1 preferred participating in her favorite activities and doing things in groups of people. The MDS identified diagnoses of anxiety, bipolar disorder (a chronic mental health disorder characterized by extreme mood swings between extreme periods of elevated moods, or mania, and extreme low moods, or depression), schizophrenia (a chronic mental health illness that affects a person's thoughts, perceptions, emotions, and behaviors), and mild intellectual disabilities (a developmental disorder that affects a person's abstract thinking and learning and problem-solving skills).</p> <p>R1's Care Area Assessment (CAA) for activities dated 12/12/24, was triggered due to the symptom of presence of little interest or pleasure in doing things. The CAA indicated the problem was actual, however lacked documentation of the nature of the problem or condition. The CAA indicated R1 slept in every morning and refused to get out of bed in the morning. Furthermore, the CAA indicated R1 has little interest in doing activities other than her word find book. Sometimes likes to listen to music with the Activities Director, however, likes to take naps mostly during the morning and has a history of not going to medical appointments, because she doesn't feel like doing anything except word find puzzles. The CAA indicated activities would be addressed in R1's care plan to slow or minimize decline and maintain her current level of functioning.</p> <p>R1's CAA for mood state dated 12/12/24, indicated R1 slept in every morning, refuses to get out of bed, has little interest in doing activities other than her word find book. Sometimes likes to listen to music with the activities director, however, likes to take naps mostly during the morning and has a history of not going to medical appointments because she doesn't feel like doing anything except her word find puzzles. Mental Health: BIMS score 15, residents score can vary every time she is asked to perform this assessment. The CAA indicated R1's mood state - functional status would be addressed in the care plan.</p> <p>An activities assessment was requested for the annual MDS dated [DATE], but was not received.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's care plan revised 4/18/20, identified her risk for not meeting emotional, intellectual, physical and social needs related to her cognitive deficits, schizophrenia, and physical limitations. The goal of care was to maintain involvement in cognitive stimulation and social activities as desired. The care plan directed staff to invite R1 to activities and ensure activities she attended were compatible with physical and mental capabilities, compatible with known interests and preferences, adapted as needed, compatible with her needs and abilities, were age appropriate. The care plan lacked documentation of R1's activity preferences, either facility-sponsored or independent activities.</p> <p>A care conference record dated 4/6/24, indicated her preferred activities included, begging for food, pop, chewing gum. Word find book, watching TV, bingo, group activities, sing alongs, music, will make needs known.</p> <p>An activities participation log dated 9/24 included activities such as morning visit in room, crossword puzzles in dayroom, socialize with others, outside for fresh air, one-to-one visits, outing to clinic for doctor's visit, TV, and Bingo. The monthly participation log lacked documentation if arts or crafts were offered to R1. Furthermore, the log lacked documentation of refusals to participate in activities.</p> <p>An activities participation log dated 10/24 included activities such as sleeping in, morning visit in room, crossword puzzles in dayroom, socialize with others, outside for fresh air or to smoke, one-to-one visits, outing to clinic for doctor's visit, TV, music, napping, and Bingo. The monthly participation log lacked documentation if arts or crafts were offered to R1. Furthermore, the log lacked documentation of refusals to participate in activities.</p> <p>An activities participation log dated 11/24 included activities such as morning visit in room, crossword puzzles in dayroom, socialize with others, outside for fresh air, one-to-one visits, independent activity, went shopping for her at Target, TV, and Bingo. The monthly participation log lacked documentation if arts or crafts were offered to R1. Furthermore, the log lacked documentation of refusals to participate in activities.</p> <p>An activities participation log dated 12/24 included activities such as morning visit in room, crossword puzzles in dayroom, socialize with others, outside to smoke, morning visits, independent activity, TV, and Bingo. The monthly participation log lacked documentation if arts or crafts were offered to R1. Furthermore, the log lacked documentation of refusals to participate in activities.</p> <p>An activities participation log dated 1/25 included activities such as morning visit in room, crossword puzzles in dayroom, socialize with others, outside to smoke, morning visit, independent activity, New Years Day social, listen to the radio, TV, and Bingo. On 1/9/25, R1 was reported to have participated in arts and craft painting.</p> <p>An activities calendar dated 12/16/24 - 12/22/24 lacked an arts and craft activity offering.</p> <p>An activities calendar dated 12/23/24 - 1/5/25 lacked an arts and craft activity offering.</p> <p>An activities calendar dated 1/20/25 - 1/26/25 included the following activities:</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Monday: Breakfast, Current Events - Morning News, Independent Resident Outings, Morning Visits, Assist Res [sic, Resident] with Needs, Lunch, Western Classics, 11:30 Lunch, Table Games, Coffee Time, TV Viewing, 4:30 Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>- Tuesday: Breakfast, Current Events - Morning News, Independent Resident Outings, Res [sic, Resident] Outing, Ind [sic, independent] Activity, Lunch, Western Classics, 11:30 Lunch, Arts and Craft Group, Social Hour, 4:30 Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>- Wednesday: Breakfast, Current Events - Morning News, Independent Resident Outings, News Hour, Crossword Puzzles, Lunch, Western Classics, 11:30 Lunch, Music Listening, Reading Group, TV Time, 4:30 Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>- Thursday: Breakfast, Current Events - Morning News, Independent Resident Outings, Current Events, Assist Residents, Lunch, Western Classics, 11:30 Lunch, 1:00 Bingo, 2:00 Discussion Group, 4:30 Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>- Friday: Breakfast, Current Events - Morning News, Independent Resident Outings, Morning News, 10:00 Ind [sic, independent] Activity, Lunch, Western Classics, 11:30 Lunch, Ind [sic, independent] Activity, Ind [sic, independent] Activity, Ind [sic, independent] Activity, 4:30 Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>- Saturday: Breakfast, Current Events - Morning News, Independent Resident Outings, News Hour, Ind [sic, independent] Activity, Lunch, Western Classics, 11:30 Lunch, Ind [sic, independent] Activity, Ind [sic, independent] Activity, Ind [sic, independent] Activity, 4:30 Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>- Sunday: Breakfast, Current Events - Morning News, Independent Resident Outings, Sunday Morning Church Programs in Main Dining Room, Religious Program on TV, Lunch, Western Classics, 10:00 Ind [sic, independent] Activity, 11:30 Lunch, Ind [sic, independent] Activity, Ind [sic, independent] Activity, 4:30 Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>An activities calendar dated 1/13/25 - 1/19/25 included the following activities:</p> <p>- Monday: Breakfast, Current Events - Morning News, Independent Resident Outings, Morning News, Room Visits, Lunch, Western Classics, Crossword Puzzles, Music Listening, TV Time, Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>- Tuesday: Breakfast, Current Events - Morning News, Independent Resident Outings, Current Events, Res [sic, Resident] Outing, Lunch, Western Classics, 11:30 Lunch, Table [NAME], Social Hour, Supper, [blank space], Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>- Wednesday: Breakfast, Current Events - Morning News, Independent Resident Outings, News Hour, Morning Stretch, Lunch, Western Classics, 11:30 Lunch, Bingo, Activities Continue, 4:30 Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>- Thursday: Breakfast, Current Events - Morning News, Independent Resident Outings, One to One Visits, Res [sic, Resident] Outing, Lunch, Western Classics, 11:30 Lunch, 1:00 Arts and Craft, Activity, 4:30 Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Friday: Breakfast, Current Events - Morning News, Independent Resident Outings, Catch Up With the News, Ind [sic, independent] Activity, Lunch, Western Classics, 11:30 Lunch, Ind [sic, independent] Activity, Ind [sic, independent] Activity, Ind [sic, independent] Activity, Ind [sic, independent] Activity, 4:30 Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>- Saturday: Breakfast, Current Events - Morning News, Independent Resident Outings, News Hour, Ind [sic, independent] Activity, Lunch, Western Classics, 11:30 Lunch, Ind [sic, independent] Activity, Ind [sic, independent] Activity, Ind [sic, independent] Activity, Ind [sic, independent] Activity, 4:30 Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>- Sunday: Breakfast, Current Events - Morning News, Independent Resident Outings, Sunday Morning Church Programs in Main Dining Room, Religious Program on TV, Lunch, Western Classics, 10:00 Ind [sic, independent] Activity, 11:30 Lunch, Ind [sic, independent] Activity, Ind [sic, independent] Activity, 4:30 Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>An activities calendar dated 1/27/25 - 2/7/25 included the following activities:</p> <p>- Monday: Breakfast, Current Events - Morning News, Independent Resident Outings, Morning Visits, Res [sic, Resident] Outing, Lunch, Western Classics, 11:30 Lunch, Table Game, 2:30 Social Hour, 4:30 Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>- Tuesday: Breakfast, Current Events - Morning News, Independent Resident Outings, Res [sic, Resident] Outing, Ind [sic, Independent] Activity, Lunch, Western Classics, 11:30 Lunch, 1:00 Arts and Craft Group, [blank space], 4:30 Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>- Wednesday: Breakfast, Current Events - Morning News, Independent Resident Outings, 9:00 News Hour, 10:00 One to One Visits, Lunch, Western Classics, 11:30 Lunch, 1:00 Reading Group, 2:00 Social Hour, 4:30 Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>- Thursday: Breakfast, Current Events - Morning News, Independent Resident Outings, 9:00 Resident Council, 11:30 Lunch, Western Classics, 1:00 Bingo, 3:00 Coffee Time, 4:30 Supper, [blank space], Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>- Friday: Breakfast, Current Events - Morning News, Independent Resident Outings, 9:00 Morning News, Ind [sic, independent] Activity, Lunch, Western Classics, 11:30 Lunch, Ind [sic, independent] Activity, Ind [sic, independent] Activity, Ind [sic, independent] Activity, Ind [sic, independent] Activity, 4:30 Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>- Saturday: Breakfast, Current Events - Morning News, Independent Resident Outings, 9:00 News Hour, [blank space], Lunch, Western Classics, 11:30 Lunch, Ind [sic, independent] Activity, Ind [sic, independent] Activity, Ind [sic, independent] Activity, Ind [sic, independent] Activity, 4:30 Supper, Evening Meal/Dinner, - Evening News, Snack Time, Resident Social Time.</p> <p>- Sunday: Breakfast, Current Events - Morning News, Independent Resident Outings, Sunday Morning Church Programs in Main Dining Room, Religious Program on TV, Lunch, Western Classics, 10:00 Ind [sic, independent] Activity, 11:30 Lunch, Ind [sic, independent] Activity, Ind [sic, independent] Activity, 4:30 Supper, Evening Meal/Dinner, Evening News, Snack Time, Resident Social Time.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation and interview on 1/27/25 at 2:58 p.m., R1 was in her room and sitting on her bed. She had multiple crossword puzzle books around her room and stated she wished the facility had more arts and crafts because, that's what I like to do. R1 stated the facility did not have activities on the weekends. She stated she enjoyed working independently on puzzle books and did not have trouble getting books to work on as well as arts and crafts but stated when she and other residents would ask for more supplies, staff responded there was no money for that. R1 stated she would accept either structured group activities and independent options, such as a craft bucket where she could independently pick her own activities and supplies at any time. Additionally, R1 stated staff did not ask residents for their input about activities but wished they would.</p> <p>During observation on 1/28/25 at 8:06 a.m., R1 was in the dining room at the table eating breakfast. Behind the table is a white bookshelf with four shelves and various books, board games, coloring supplies and beads. The top shelf held a Jenga game, coloring and cookbooks, a travel to [NAME] book, literature, puzzles, a Cranium board game, a bible, and plain English book. The second shelf had two Yahtzee board games, a Reminiscing board game, two Monopoly board games, and dominoes. The third shelf had puzzles, a Cranium board game, and a game of trivia. The bottom shelf had a plastic container with various beads and thread, construction paper and coloring pencils. There was no bucket observed in the bookshelf with crafts. There was an activities calendar dated 1/27/25 - 2/7/25, posted in the hallway between the dining room and the front door to the facility. At 8:48 a.m., R1 walked through the dining room and conversed with another resident, laughing and joking.</p> <p>At 10:59 a.m., R1 sat in the dining room working on her crossword puzzle book. Licensed practical nurse (LPN)-A talked with her about her crossword puzzle and TV shows. R1 used the remote control to change the channel on the TV in the corner of the room to a MeTV program.</p> <p>During a continuous observation on 1/28/25 between 12:58 p.m. and 1:56 p.m., the following was observed:</p> <ul style="list-style-type: none"> - 12:56 p.m. The health unit coordinator (HUC)-A, also identified as the facility's activities and social services director, sat in the dining room at the table with resident charts out. LPN-A sat in the dining room as well. The activities calendar posted identified an activity of arts and crafts at 1:00 p.m. There were no residents in the dining room and no activities occurring. - 1:15 p.m. R2 sat down in the dining room at a table and asked LPN-A, what should we do? - 1:25 p.m. There was no ongoing activity or arts and crafts per the posted activity calendar. LPN-A walked to the bookshelf and offered puzzles or board games. R2 declined the puzzles. LPN-A offered to play a DVD movie and R2 stated the DVD player did not work. LPN-A attempted to play the movie and put a DVD into the player and pushed some buttons on the device. LPN-A stated, I think you're right; I don't think this works. Sorry, I tried. LPN-A walked away from the DVD player and sat down at the table and stated, maybe we can find something cool to watch on TV. - 1:29 p.m. R1 walked in the dining room from outside and asked LPN-A what they were watching. LPN-A told her they were watching a cartoon, Frozen, and invited R1 to watch the movie. R1 sat down to watch the movie before leaving the dining room at 1:37 p.m. <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Southside Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2644 Aldrich Avenue South Minneapolis, MN 55408	
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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 1:56 p.m. R1 returned to the dining room table with her crossword puzzle book. She sat down and began to work on the puzzles. There was no offering of arts and crafts per the posted activities calendar.</p> <p>During observation on 1/29/25 at 12:59 p.m., R1 was participating in Bingo in the dining room. She stated, I am really good at winning at Bingo, I always win.</p> <p>Per interview on 1/29/25 at 12:03 p.m., HUC-A described their role at the facility, including setting up appointments, arranging transportation, escorting residents to appointments, filling in for activities when the activities person was out, picking up supplies for activities and residents, managing resident council, bookwork and answering the phones. HUC-A stated, every morning I go straight to the desk to handle the books and phones and deal with the appointments and transportation. I have become RN-A's right hand. HUC-A stated, even if it gets overwhelming, we improvise and we make it work. HUC-A reported most of the residents were independent with their activities but confirmed assisting some residents with their personal shopping needs and providing the supplies craft activities. HUC-A confirmed having independent craft buckets for one of the residents previously and stated, one of the gals liked crafts, so I went out and got supplies for painting and tracing and she came with one time and picked out some supplies. HUC-A confirmed the craft bucket was not for R1 and stated she liked word puzzles. HUC-A stated residents were assessed for their activity preferences upon admission and R1's preferences hadn't really changed except when she quit smoking and started to eat more food and chewing the gum. HUC-A confirmed not asking R1 about activity preferences recently and stated someone else was completing the required MDS assessments about activity preferences. HUC-A reviewed R1's activity log and stated, she loves Bingo, she loves her puzzle books. When she's out, I go get more.</p> <p>During interview on 1/29/25 at 9:48 a.m., registered nurse (RN)-B confirmed completing the MDS assessments and stated R1 was tricky because she would sometimes say things not based in fact. RN-B verified not interviewing R1 for the MDS dated [DATE], about section F regarding her activity preferences. RN-B stated, I don't care for the questions themselves; I think. I think they are silly questions themselves. The question set is geared towards a different population set than ours. RN-B stated she sometimes gathered the MDS data from interviewing staff, and depending on the situation, I will engage the resident and ask about what they liked to do prior to admission. RN-B confirmed R1 did not have an activities care plan focus and stated, it mostly discusses her behaviors, I don't see anything for activities. I think that maybe is a gap in my understanding.</p> <p>During interview on 1/29/25 at 4:56 p.m., R1's medical doctor (MD)-D and psychiatrist was aware R1 enjoyed crafts and believed it was important for her to stay busy. MD-D stated activities were extremely important for R1, whether they were busy activities like light walking or raking or fun activities like coloring because they could be distracting from the voices and can improve the mood. MD-D stated activities helped R1 not to focus on the psychosis and prevented her from sitting around, listening to those voices.</p> <p>Per interview on 2/3/25 at 1:37 p.m., RN-A, also identified as the facility's director of nursing (DON) and administrator, confirmed training RN-B on the MDS process and stated, it could have been better. RN-A stated if was a second nurse available to help during the facility's new admissions, I could have helped RN-B more, I could have made it [the training] more robust. RN-A stated if there was more time, I could have been more available. RN-A stated a belief the residents in the facility were all happy.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Southside Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2644 Aldrich Avenue South Minneapolis, MN 55408	

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was requested from the facility's medical director was requested but not received.</p> <p>Per facility policy titled Activities Policy updated 11/18/24, the purpose of the activities program was to maximize independence and focus on residents' remaining strengths and abilities. The policy directed staff to get to know a resident's history, preferences, dreams and hopes to provide a variety of engaging resident programs while incorporating resident preferences. Furthermore, the policy directed staff to provide the necessary resources for independent resident interests and hobbies and encourage resident participation with personal invites to group activities.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299</p> <p>Based on observation, interview, and document review, the facility failed to ensure appropriate blood pressure monitoring and order was in place for 1 of 5 residents (R3) observed during morning medication administration.</p> <p>Findings include:</p> <p>R3's annual Minimum Data Set (MDS) dated [DATE], indicated R3 had intact cognition, delusions, and no behaviors or rejection of care. The MDS indicated R3 was independent with activities of daily living, had diagnoses of orthostatic hypotension (drop in blood pressure when standing up or sitting down), hyperlipidemia (condition where there are high levels of fats in the blood), depression, and schizophrenia, and medications included antipsychotics and antidepressants.</p> <p>R3's medication and treatment administration record for January 2025, indicated R3 had the following orders:</p> <p>-9/13/23, Midodrine HCL 2.5 milligram (mg) tablet and instructed staff to give [ONE] [TABLET] BY MOUTH TWICE DAILY - HOLD FOR B/P [blood pressure] 110 MMHG [MILLIMETERS OF MERCURY] BUT GIVE IF [R3] IS HAVING SYMPTOMS (DX: HYPOTENSION [low blood pressure]).</p> <p>-8/7/23, take blood pressure daily.</p> <p>R3's Consultation Report dated 1/13/25, directed the facility to clarify if R3's midodrine entry should say hold for blood pressure greater than 110 mmHg. Another clarification indicated blood pressure and pulse were recorded daily and midodrine was twice daily, so please clarify how often blood pressure should be assessed and recorded due to hold parameter on midodrine entry. The Consultation Report had a written reply dated 1/26/25, which indicated sometimes blood pressure was taken after medication given to see effectiveness. The other written reply indicated R3's blood pressure was consistently hypotensive.</p> <p>During medication observation on 1/29/25 at 7:48 a.m., RN-A prepared medication for R3. Three tablets were prepared with one tablet of midodrine 2.5 milligram (mg). RN-A gave R3 medication, and R3 took medication. RN-A did not check R3's blood pressure before administration of medication.</p> <p>When interviewed on 1/29/25 at 8:05 a.m., RN-A verified they did not check R3's blood pressure prior to medication administration and stated they normally checked R3's blood pressure before and about forty-five minutes after medication administration to check medication effectiveness.</p> <p>During observation and interview on 1/29/25 at 8:12 a.m., RN-A checked R3's blood pressure, which was 98/74 mmhg.</p> <p>When interviewed on 1/31/25 at 12:54 p.m., licensed practical nurse (LPN)-A stated blood pressure should be taken before administration of blood pressure medication with parameters to know if the medication needed to be held or okay to give.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When interviewed on 2/3/25 at 8:37 a.m., consultant pharmacist (CP)-C stated they indicated to the facility in November 2023 R3 received blood pressure medication twice a day and blood pressure checked once a day. CP-C did not have a copy of the facility reply but had made a note to indicate blood pressure was monitored for R3 once a day. CP-C was not sure if R3 was resistive to getting blood pressure checked twice a day or if the provider clarified to check once a day. CP-C stated they indicated in their pharmacy review dated 1/13/25, to clarify if the R3's midodrine order should say hold for blood pressure greater than 110 mmhg and inquired about whether blood pressure should be checked once or twice a day since midodrine was given twice a day. CP-C had not returned to the facility yet so did not know the facility's reply to their recommendation.</p> <p>When interviewed on 2/3/25 at 9:05 a.m., certified physician assistant (CPA)-B expected nursing to check blood pressure prior to administering a blood pressure medication with hold parameters. If a blood pressure medication with parameters was given twice a day, nursing should check blood pressure twice a day before administration. CPA-B stated they previously discussed hold parameters for blood pressure greater than 120 mmhg but 110 mmhg was okay. CPA-B stated if R3 was stable on current dosing then it may be okay to check R3's blood pressure once a day, but nursing should clarify with the provider first. CPA-B did not recall nursing discussing the pharmacy recommendations directly with them. CPA-B stated it was important to follow orders with hold parameters, because if blood pressure was too high, midodrine could raise blood pressure further and cause problems.</p> <p>When interviewed on 2/3/25 at 9:56 a.m., RN-A, who was the administrator and director of nursing, stated R3's blood pressure had not been 110 mmhg or above and verified they should clarify with the provider if the order should read to hold midodrine for blood pressure equal to or greater than 110 mmhg. RN-A stated they should check R3's blood pressure twice daily.</p> <p>A policy pertaining to blood pressure monitoring and/or administering blood pressure medication was requested but not received.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617</p> <p>Based on interview and document review, the facility failed to identify triggers to avoid potential re-traumatization and failed to develop and implement the comprehensive care plan to include individualized trauma-informed approaches for 1 of 2 resident (R7) who had a history of trauma.</p> <p>Findings include:</p> <p>R7's admission Minimum Data Set (MDS) dated [DATE], indicated she had intact cognition and no hallucinations or delusions with no reported behavioral symptoms. The MDS reported diagnoses including depression and alcohol dependence, however, did not identify a post-traumatic stress disorder (PTSD) diagnosis.</p> <p>R7's Care Area Assessment (CAA) for psychosocial well-being dated 11/7/24, identified R7 took psychotropic medications mirtazapine and fluoxetine (antidepressants) to treat depression. Additionally, the CAA identified she utilized non-pharmacologic interventions such as crafting activities, sitting outside on the front porch, smoking cigarettes, and minimal socializing to manage anxiety symptoms. The CAA indicated R7's psychosocial well-being would be addressed in her care plan and lacked documentation if a referral was warranted to another discipline, and lacked identification of triggers.</p> <p>R7's CAA for mood state dated 11/7/24, identified her non-specific psychiatric disorder(s) and use of psychotropic medications. The CAA indicated her mood state would be addressed in her care plan but lacked documentation if a referral was warranted to another discipline, and lacked identification of triggers.</p> <p>A biopsychosocial intake diagnostic assessment dated [DATE], indicated R7 reported a history of trauma. The admission paperwork reported, she was in an abusive marriage for [AGE] years which included physical, emotional and sexual abuse by her husband.</p> <p>A comprehensive trauma informed care assessment dated [DATE], identified triggers such as loud male voices, yelling, and angry voices, thrown objects. The assessment included target symptoms of depression under control. On bipolar spectrum. Depression more related to bipolar not actual depression. The assessment identified psychotropic medication management as well as non-pharmacologic interventions and indicated her needs would be addressed in the care plan.</p> <p>R7's care plan revised 11/24/24, directed staff to her behavioral management care plan and comprehensive behavioral assessment. The care plan lacked documentation of R7's history of trauma and potential triggers.</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A behavioral management care plan dated 11/24/24, indicated R7's behavioral triggers included sleep apnea and insomnia, and reported she often stayed awake throughout the night smoking and did experience sleep apnea. Additionally, the triggers identified on the care plan included stress related to medical appointments and getting the medications she needs prescribed to her, and her personal struggles with pain and addiction create a tremendous amount of stress for her. The care plan identified R7's target behavioral monitoring of chain-smoking cigarettes related to her insomnia and her addiction to food and eating between meals. Interventions included on the care plan were managing her medical appointments, setting up a sleep study consultation, assistance in managing her PRN (as needed) medications and assessing her anxiety levels, and encouraging non-pharmacological solutions for anxiety management. The care plan lacked documentation of R7's history of trauma and related triggers.</p> <p>A facility referral form dated 12/17/24, indicated R7 was referred out for a psychiatry visit. The referral form revealed under the information from: side; diagnosis depression and PTSD.</p> <p>During interview on 1/29/25 at 12:03 p.m., health unit coordinator (HUC)-A, who also identified as the facility's social services director and activities director, reported there were several people in the facility with PTSD. HUC-A stated residents with triggers related to their PTSD were assessed upon admission if staff were aware of their diagnosis. HUC-A stated if a resident was struggling with PTSD or substance abuse, staff could offer a walk outside during the summer months or call management during off-hours for assistance. HUC-A reported it was important to give residents what they needed to succeed, like medication management, medical appointment referrals and transportation arrangement, to provide for their psychosocial well-being and mental health needs.</p> <p>During interview on 1/31/25 at 9:59 a.m., R7 stated there hasn't been a conversation yet here about my triggers or my past trauma. She reported there had been past events at the facility that were triggering for her and stated, there's one lady here that keeps asking for cigarettes. R7 shared the other unidentified female resident would ask for more cigarettes until she owed R7 money, which was a trigger for her because, that's not fair for me or her really. She endorsed reporting the events to RN-A, also identified as the facility's director of nursing (DON) and administrator, and believed RN-A spoke to the unidentified resident.</p> <p>Per interview on 1/31/25 at 9:45 a.m., treatment director (TD)-K confirmed working with R7 on her admission to the facility and recalled R7 reporting a history of trauma and that having an impact on her mental health. TD-K stated R7's trauma history included abuse and there was also some history of financial abuse with a previous partner of hers. TD-K stated R7 was assessed for trauma prior to discharge from their facility but I don't think she met full criteria to get the PTSD diagnosis in our diagnostic assessment, however, stated the referral would note if the resident had trauma. TD-K stated, from my recollection it is noted on there, her assessment and her history of trauma. But with her other concerns and wishes to want to be sober, her history of substance use, it made more sense to get those other diagnoses on her admission.</p> <p>During interview on 2/3/25 at 12:51 p.m., nurse practitioner (NP)-J verified working with R7 for a number of years and confirmed her PTSD diagnosis. NP-J further confirmed responsibility for R7's psychotropic medication management, including her PRN antipsychotic medication olanzapine.</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 2/3/25 at 1:37 p.m., RN-A stated, R7, I know the least amount about her, but I know she sees a trauma center. I think the care planning is appropriate. RN-A reported the trauma-informed care plan and assessment for R7 was completed but was kept separately from her behavioral management care plan. RN-A explained the trauma assessments and care plans for residents were kept in a separate survey binder because the facility had gone through a complaint survey and RN-A thought they were supposed to keep all related documents together in a separate binder. RN-A confirmed, no, I didn't capture that on the first day they were here. I should have done it before day 7, I think you get 7 days for the MDS. But I do expect that if we assess a resident for trauma, like we did, then it should be identified in the MDS.</p> <p>A facility policy titled Trauma Informed Care dated 11/8/24, indicated the facility would ensure to assess a resident who had a history of trauma and/or PTSD and facilitate appropriate treatment and services to manage the assessed problem to attain the highest practicable mental and psychological well-being. The policy directed staff to complete the comprehensive trauma informed care assessment upon admission, quarterly, annually and with a significant change. The assessment included an interview of the resident and/or representative and if available a review of the resident's medical or psychosocial history regarding any serious or traumatic life events, to aid in identifying any possible trauma history. The policy indicated the facility would collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, and other healthcare professions to develop and implement individualized interventions. The policy instructed trauma-specific interventions should recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety.</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>49617</p> <p>Based on interview and document review, the facility failed to ensure the posted nurse staffing information accurately displayed the total number/actual hours worked by the licensed staff for each shift on a daily basis. This had the potential to affect all 11 residents or visitors who wished to review the information.</p> <p>Findings include:</p> <p>A weekly staffing post dated 1/1/25 - 1/7/25 included the facility's name, the date, census and total hours for registered nurses (RNs), licensed practical nurses (LPNs), and trained medication assistants (TMAs). The post lacked actual worked hours for RNs and LPNs.</p> <p>A weekly staffing post dated 1/8/25 - 1/14/25 included the facility's name, the date, census and total hours for registered nurses (RNs), licensed practical nurses (LPNs), and trained medication assistants (TMAs). The post lacked actual worked hours for RNs and LPNs.</p> <p>A weekly staffing post dated 1/15/25 - 1/21/25 included the facility's name, the date, census and total hours for registered nurses (RNs), licensed practical nurses (LPNs), and trained medication assistants (TMAs). The post lacked actual worked hours for RNs and LPNs.</p> <p>A weekly staffing post dated 1/22/25 - 1/28/25, included the facility's name, the date, census and total hours for registered nurses (RNs), licensed practical nurses (LPNs), and trained medication assistants (TMAs). The post lacked actual worked hours for RNs and LPNs.</p> <p>A facility schedule dated 1/1/25 - 1/15/25, indicated the actual hours worked per shift contradicted the total hours posted on the weekly staffing post.</p> <p>A facility schedule dated 1/16/25 - 1/31/25, indicated the actual hours worked per shift contradicted the total hours posted on the weekly staffing post.</p> <p>During interview on 1/27/25 at 1:17 p.m., RN-A, who also identified as the facility's director of nursing (DON) and administrator, verified responsibility for the weekly staffing posts and the staffing schedule. RN-A asked if the daily staff posts were the ones with the ratios? before providing the requested documents on 1/28/25 at 12:24 p.m.</p> <p>During subsequent interview on 2/3/25 at 1:37 p.m., RN-A confirmed the facility schedules as accurate working hours.</p> <p>A request for a policy pertaining to staffing posts was requested but not received.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617</p> <p>Based on interview and document review, the facility failed to ensure a PRN (as needed) psychotropic medication order included an end date or a documented clinical rationale for 1 of 1 residents (R7) reviewed for PRN psychotropic medications.</p> <p>Findings include:</p> <p>R7's admission Minimum Data Set (MDS) dated [DATE], indicated she had intact cognition and no hallucinations or delusions with no reported behavioral symptoms. The MDS reported diagnoses including depression and alcohol dependence. The MDS reported R7 took antidepressant medications and took antipsychotic medications on a routine basis only.</p> <p>R7's Care Area Assessment (CAA) for psychotropic drug use dated 11/7/24, identified she took an antidepressant, a mood stabilizer, and scheduled antipsychotic medication, however, lacked documentation of her as needed (PRN) antipsychotic medication.</p> <p>R7's signed order summary was requested but not received.</p> <p>R7's medication administration record (MAR) dated 1/25 reflected the following active physician orders:</p> <ul style="list-style-type: none"> - fluoxetine 80 milligram (mg) (Prozac), total 1 x daily by mouth (total 80mg) for depression, dated 11/14/24. - hydroxyzine hydrochloride (HCl) 50mg tablet (hydroxyzine HCl) 1-2 (50-100mg) by mouth three times daily as needed, dated 11/4/24. - lamotrigine 100mg tabs (Lamictal), Take 300mg by mouth every bedtime for depression dated 1/14/25. - mirtazapine 15mg tablet (Remeron), Take 1 tab by mouth at bedtime for insomnia dated 11/4/24. - olanzapine 15mg (Zyprexa), Take 3 tab by mouth twice daily for anxiety/agitation dated 11/29/24. - olanzapine 10mg (Zyprexa), Take 1/2 tab (5mg) by mouth daily as needed for anxiety/agitation dated 11/04/24. <p>R7's MAR reflected the PRN olanzapine was administered on 1/6/25, 1/7/25, 1/10/25, 1/14/25, 1/18/25, 1/19/25, 1/21/25, 1/22/25, and 1/28/25.</p> <p>R7's MARs dated 11/24, and 12/24, were requested but not received.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER Southside Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2644 Aldrich Avenue South Minneapolis, MN 55408	
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 1/31/25 at 10:51 a.m., consultant pharmacist (CP)-C reported the importance of limiting antipsychotic medications, like olanzapine, to 14 days was because we want to make sure they are used appropriately and to ensure they are monitored for adverse effects. CP-C stated if those medications were being utilized frequently and a resident was having a regular occurrence of behaviors, we could look at scheduled meds and see if that would be more appropriate, and discuss a risk versus benefits.</p> <p>During interview on 2/3/25 at 9:05 a.m., certified physician assistant (CPA)-B, who also identified as the facility's medial director's designee, expected PRN psychotropic medications to have a stop date after 14 days and if not, to have a clinical rationale. CPA-B stated there should be an effort to get ahold of the resident's psychiatrist to obtain the clinical rationale to extend the PRN order beyond 14 days, and if staff were unable to reach the resident's psychiatrist, CPA-B expected staff to reach out to either a resident's provider or the facility's medical director. CPA-B stated it was important to follow the regulation regarding 14-day limits with such medications because they could affect brain function and capacity.</p> <p>During interview on 2/3/25 at 12:51 p.m., nurse practitioner (NP)-J verified working with R7 for a number of years and confirmed responsibility for R7's psychotropic medication management, including her PRN antipsychotic medication olanzapine. NP-J confirmed the PRN olanzapine order did not have an end date and confirmed not receiving a request for a clinical rationale to extend the order beyond 14 days. NP-J voiced familiarity with such requests and stated, the only form we've gotten was a medication list, but no communication about those PRN medications or needing a rationale to go beyond the 14 days. NP-J verbalized a belief R7 was on an appropriate dose of olanzapine and stated had the facility requested a clinical rationale to extend the PRN beyond 14-day limit, I believe what she is currently on is appropriate. I would have provided a clinical rationale as to why it was necessary for her to go beyond that timeframe.</p> <p>A request for a policy pertaining to psychotropic drug use was requested but not received.</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>48299</p> <p>Based on interview and document review, the facility failed to employ a registered dietician or other active qualified clinical nutrition professional to carry out the functions of a facility registered dietician. This had potential to affect 11 of 11 residents who received food from the kitchen.</p> <p>Findings include:</p> <p>When interviewed on 1/27/25 at 12:07 p.m., cook (C)-B, who was the head cook, stated eggs were on the menu every day, but they did not serve eggs every day. C-B stated other cooks did not follow the menu which made ordering and using items before perishing more difficult. C-B stated they had one resident who was a vegetarian; otherwise, the other residents were on a regular house diet. When asked about the registered dietician's involvement, C-B stated they thought the registered dietician quit and did not come to the facility anymore.</p> <p>When interviewed on 1/27/25 at 1:24 p.m., registered nurse (RN)-A, who was the facility administrator and director of nursing, stated they had a newly-hired dietician, and the new dietician had not been as involved as the previous one. RN-A stated the facility needed to get the new dietician dialed in.</p> <p>When interviewed on 1/27/25 at 3:21 p.m., C-A stated they asked what residents wanted for supper and made sure the meals had a protein, starch, and vegetable.</p> <p>When interviewed on 1/28/25 at 11:26 a.m., C-A stated they did not always follow the menu and did not have to discuss menu changes with anyone.</p> <p>When interviewed on 1/29/25 at 2:33 p.m., RN-A stated the dietician their boss hired indicated they would come to the facility, but now indicated they were not going to take the facility assignment. RN-A stated they were now between dieticians, since the last one retired and/or resigned and would provide the last time the residents were reviewed by a dietician. RN-A stated they were going to contract a dietician.</p> <p>Per email correspondence on 1/31/25 at 5:47 a.m., RN-A indicated the previous registered dietician's last day with the facility was 5/31/24.</p> <p>When interviewed on 2/3/25 at 9:05 a.m., certified physician assistant (CPA)-B stated they were not involved with the facility's nutritional assessments or diet orders.</p> <p>When interviewed on 2/3/25 at 10:09 a.m., RN-A stated the facility did not have a lot of special diets and nursing completed nutritional assessments in the absence of a registered dietician. RN-A stated C-B made changes to the menu as needed and cycled the menus by season. RN-A stated staff followed items on the menu but served items on days which differed from the menu. RN-A stated they will get organized once they have a new dietician.</p> <p>Facility policy Resident's Care Supervised by a Physician dated 12/31/24, indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A resident's attending physician may delegate the task of writing dietary orders, consistent with 483.60, to a qualified dietitian or other clinically qualified nutrition professional who is acting within the scope of practice as defined by State law; and is under the supervision of the physician.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299</p> <p>Based on observation, interview, and document review, the facility failed to serve food according to a menu, and review changes to a menu with a qualified dietician or other qualified nutrition professional. In addition, the facility failed to ensure the menu met the nutritional needs of residents with a cardiac diet and other diets for 5 of 5 residents (R1, R2, R3, R5, R10) reviewed for dietary recommendations.</p> <p>Findings include:</p> <p>R1's annual Minimum Data Set (MDS) dated [DATE], indicated R1 had mild cognitive impairment. The MDS identified diagnoses of diabetes mellitus, hyperlipidemia (condition where there are high levels of fats in the blood), anxiety, bipolar disorder (a chronic mental health disorder characterized by extreme mood swings between extreme periods of elevated moods, or mania, and extreme low moods, or depression), schizophrenia (a chronic mental health illness that affects a person's thoughts, perceptions, emotions, and behaviors), and mild intellectual disabilities (a developmental disorder that affects abstract thinking and learning and problem-solving skills).</p> <p>R1's medication and treatment administration record and diabetic flowsheet for January 2025, indicated R1's diet as no concentrated sweets (a diet which limits added sugar and helps control blood sugar levels).</p> <p>R1's Behavior Sheet dated 12/26/24, indicated R1 believes [they] need more food all day.</p> <p>R1's Behavior Sheet dated 1/11/25, indicated R1 did not stick to diet.</p> <p>R2's annual MDS dated [DATE], indicated R2 had intact cognition, diagnoses of atrial fibrillation (condition which causes irregular and rapid heartbeat) or other dysrhythmias (abnormal heartbeat), hypertension (high blood pressure), diabetes mellitus, thyroid disorder, depression, and psychotic disorder (severe mental illness which causes a person to lose touch with reality). The MDS did not indicate R2 had a therapeutic diet.</p> <p>R2's medication and treatment administration record for January 2025, indicated R2's diet as cardiac, consistent carbohydrate diet (dietary plan which involved consuming a consistent amount of carbohydrates at each meal and snack).</p> <p>R3's annual Minimum Data Set (MDS) dated [DATE], indicated R3 had intact cognition, delusions, and no behaviors or rejection of care. The MDS indicated R3 was independent with activities of daily living, had diagnoses of orthostatic hypotension (drop in blood pressure when standing up or sitting down), hyperlipidemia (condition where there are high levels of fats in the blood), depression, and schizophrenia, and medications included antipsychotics and antidepressants.</p> <p>R3's medication and treatment administration recorded, indicated R3 had a regular diet with increase sodium.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R5's annual MDS dated [DATE], indicated R5 had intact cognition, diagnoses of diabetes mellitus, hyperlipidemia, bipolar disease, and schizophrenia.</p> <p>R5's medication and treatment administration record for January 2025, indicated R5's diet as no concentrated sweets.</p> <p>R10's admission Minimum Data Set (MDS) dated [DATE], indicated R10 admitted to the facility on [DATE], had intact cognition, delusions, and diagnoses of malnutrition or at risk for malnutrition, bipolar disease, and post-traumatic stress disorder</p> <p>R10's medication and treatment administration record for January 2025, indicated R10's diet as regular.</p> <p>When interviewed on 1/27/25 at 12:07 p.m., cook (C)-B, who was the head cook, stated eggs were on the menu every day, but they did not serve eggs every day. C-B stated other cooks did not follow the menu which made ordering and using items before perishing more difficult. C-B stated they had one resident who was a vegetarian; otherwise, the other residents were on a regular house diet. When asked about the registered dietician's involvement, C-B stated they thought the registered dietician quit and did not come to the facility anymore.</p> <p>When interviewed on 1/27/25 at 1:24 p.m., registered nurse (RN)-A, who was the facility administrator and director of nursing, stated they had a newly-hired dietician, and the new dietician had not been as involved as the previous one. RN-A stated the facility needed to get the new dietician dialed in.</p> <p>When interviewed on 1/27/25 at 3:21 p.m., C-A asked R10 what they wanted for their evening meal, and R10 stated spaghetti. C-A stated they asked what residents wanted for supper and made sure the meals had a protein, starch, and vegetable.</p> <p>When interviewed on 1/27/25 at 6:12 p.m., C-A stated R10 had a vegetarian diet and there were no other residents with a different diet. C-A stated they were thawing meat for chili the following day, 1/28/25.</p> <p>During observation and interview on 1/28/25 at 8:15 a.m., C-A served pancakes, scrambled eggs, bananas, and resident choice of juice and coffee, and C-A verified the items served.</p> <p>The menu indicated choice of juice, pancakes and syrup, hard boiled eggs, sausage, choice of milk, and coffee/tea/water.</p> <p>During observation and interview on 1/28/25 at 11:26 a.m., C-A served chili, cornbread, cheese, and sour cream. C-A stated they made chili since there was a lot of ground beef downstairs. C-A stated they did not always follow the menu. C-A stated the residents used to bring back full trays of food after mealtime when C-A followed the menu but eat more when C-A made what the residents wanted. C-A stated they do not have to discuss menu changes with anyone. A cake was on the counter in a pan, and C-A stated the cake was for snack tonight.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The menu indicated beef goulash, peas, applesauce, bread and margarine, choice of milk, and coffee/tea/water. The menu indicated the PM [evening] Snack was peanut butter sandwich and choice of fruit. The menu for Friday supper indicated chili con carne, cornbread, baby carrots, oatmeal cookie, diced pears, choice of milk, and coffee/tea/water.</p> <p>When interviewed on 1/28/25 at 2:59 a.m., C-A stated they were preparing tomato soup and grilled cheese for the evening meal and was not sure what fruit would be served yet.</p> <p>The menu indicated potato chips and diced pears would be served with tomato soup and grilled cheese on wheat.</p> <p>When interviewed on 1/29/25 at 2:17 p.m., RN-A stated R1 and R2 should technically be on a diabetic diet, but the residents did not follow the diet. RN-A stated everyone else was on the regular house diet.</p> <p>When interviewed on 1/29/25 at 2:33 p.m., RN-A stated the dietician their boss hired indicated they would come to the facility, but now indicated they were not going to take the facility assignment. RN-A stated they were now between dieticians since the last one retired and/or resigned and would provide the last time the residents were reviewed by a dietician. RN-A stated they were going to contract a dietician.</p> <p>During observation and interview on 1/31/25 at 12:51 p.m., C-B stated there were no residents with a cardiac diet, R10 had a vegetarian diet, and everyone else had a regular diet. C-B presented menus which indicated regular House Diet and another menu with renal diet, but C-B stated the resident with the renal diet was not currently at the facility.</p> <p>When interviewed on 1/31/25 at 12:53 p.m., licensed practical nurse (LPN)-A stated they checked with the cook, and all residents had a regular diet.</p> <p>Per email correspondence on 1/31/25 at 5:47 a.m., RN-A indicated the previous registered dietician's last day with the facility was 5/31/24.</p> <p>When interviewed on 2/3/25 at 9:05 a.m., certified physician assistant (CPA)-B stated they were not involved with the facility's nutritional assessments or diet orders.</p> <p>When interviewed on 2/3/25 at 10:09 a.m., RN-A stated the facility did not have a lot of special diets and nursing completed nutritional assessments in the absence of a registered dietician. RN-A stated C-B made changes to the menu as needed and cycled the menus by season. RN-A stated R3 ate what was prepared in the kitchen and staff added extra sodium at mealtimes for R3, R2 followed their house diet which was cardiac friendly, R1 was noncompliant with their diet when they ate food outside the facility, and R5 only ate what the kitchen prepared. RN-A stated staff followed items on the menu but served items on days which differed from the menu. RN-A stated they will get organized once they have a new dietician.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>When interviewed on 2/3/25 at 10:33 a.m., C-B stated they only knew about R3's sodium diet and R10's vegetarian preference. C-B stated the residents knew their diets and some tried to cheat. C-B stated they would not need to serve differently for R2's cardiac diet, and R2 told staff what they do or do not eat. C-B stated they ordered items which were sugar free and would not serve R1 and R5 concentrated sweets.</p> <p>Facility policy Resident's Care Supervised by a Physician dated 12/31/24, indicated the following:</p> <p>A resident's attending physician may delegate the task of writing dietary orders, consistent with 483.60, to a qualified dietitian or other clinically qualified nutrition professional who is acting within the scope of practice as defined by State law; and is under the supervision of the physician.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper sanitization of dishware used for meal preparation and resident service, and ensure food was properly stored and dated and disposed of. Furthermore, the facility failed to ensure staff followed appropriate infection control techniques while rinsing dirty dishes, placing clean dishes to dry, and placing items into the refrigerator. This deficient practice affected all 11 residents residing in the facility.</p> <p>Findings include:</p> <p>During the initial tour of the kitchen on 1/27/25 at 12:04 p.m., cook (C)-B, who was the head cook, had gloves on and rinsed dishes in the sink, placed silverware and serving trays into the dish machine, and removed gloves and did not perform hand hygiene. The dish machine ran, and the wash temperature fluctuated between 141 to 144 degrees Fahrenheit (F) and the rinse temperature raised to 178 F . C-B stated the temperature of the dish machine fluctuated, and the dish machine was fixed multiple times. C-B stated the front door did not completely close, one of the side panels stuck out, and the dish machine leaked. The right-side panel of the dish machine was not secured, and the top edge of the panel was visible. C-B stated they did not remove the dishes until the temperature reached 155 F and started the dish machine again. The wash temperature raised to 156 F , and the rinse temperature was 176 F . C-B opened the dishwasher, removed the trays which were already dry, and stacked the trays.</p> <p>During the continued initial tour, the main kitchen refrigerator had orange juice and 1% milk which was undated, and C-B stated those were opened today and/or Friday. There was a cup of juice which was uncovered and unlabeled. C-B stated they had poured too many glasses this morning so they saved it. The kitchen freezer had an area for ice, and a small coffee-type mug with a handle was on top of the ice. C-B stated they used the mug this morning to get ice out of the freezer and their practice was to take the mug out of the freezer when they cleaned up after lunch. There were tater tots in clear plastic which had been opened. C-B verified the tater tots had an expiration date but did not have a label to indicate they were opened on Friday. Approximately two to three pieces of fish were wrapped in plastic and did not have a label. C-B stated they had fish on Friday, three days prior. C-B stated the items should be labeled when opened.</p> <p>During the continued initial tour, the dry storage in the main kitchen had two opened cereal bags which were opened and not secured shut. C-B stated they went through cereal fast and used a twist tie to close the two bags of cereal. C-B washed their hands before leaving the main kitchen. C-B stated they wore gloves to wash dishes and washed their hands when gloves were removed, however, C-B verified they did not wash hand their hands after glove removal and before stacking the clean trays.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During the continued initial tour, the downstairs storage area had a meat freezer, and chicken, with white flaky crusts in the bag, was not labeled. C-B stated the bag with the chicken was probably opened on Thursday, four days earlier. C-B stated they had stickers they used to label opened items with the date the items were opened. In the non-meat freezer downstairs a bag of undated, partially used cauliflower was covered in white flaky crusts. C-B looked at the white flaky crusts in the bag and stated the cauliflower was no good. A partially used bag of green beans was not labeled with an opened date, and C-B verified opened items should be labeled with the date they were opened. A downstairs refrigerator had lettuce, eggs, carrots, cheese, and tortillas. The head of lettuce in the refrigerator had a large spot of purplish discoloration, and C-B verified the head of lettuce should not be used. C-B stated lettuce was supposed to be on the menu and used already, but the cook made something else instead. The freezer above the refrigerator with the lettuce and eggs had frozen bread and two freezer packs. C-B stated they were not sure who placed the freezer packs in the refrigerator, and the freezer packs did not belong in the bread freezer.</p> <p>During observation and interview on 1/27/25 at 3:21 p.m., C-A placed a resident's personal water bottle into the dish machine. The dish machine wash temperature was between 112 F and 115 F , and the rinse temperature reached 168 F . C-A removed the resident's water bottle and handed it back to the resident. C-A stated they observe the dish machine temperature get to 130 F for the wash and 170 F for the rinse. C-A stated they were told the dish machine door did not close all the way. Registered nurse (RN)-A entered the kitchen, washed their hands, and stated to try the yellow thermometer above the dish machine. The yellow thermometer was placed in the empty dish machine and ran. The wash temperature varied between 128 F and 132 F , and the rinse temperature reached 181 F on the digital dish machine gauge. C-B stated the yellow thermometer read 150.6 as the max (maximum) temperature, and RN-A instructed to run the dish machine again since it was just turned on. The dish machine wash temperature reached 143 F and the rinse reached 183 F . C-B stated the yellow thermometer indicated 160.1 F as the max temperature. RN-A instructed the dish machine needed to run a few times to get up to appropriate temperatures.</p> <p>During observation and interview on 1/28/25 at 8:15 a.m., C-A had gloves on and loaded dirty dishes into the dish machine. C-A removed their gloves, did not wash their hands, and started to place food items away into the refrigerator. C-A rinsed dirty dishes, did not have gloves on, did not perform hand hygiene, and took clean trays, a plate, and plasticware out of the dish machine. C-A placed some rinsed dishes into the dish machine with no gloves on. C-A washed their hands, tapped their hands on the inside side of the sink, and dried their hands with a paper towel. C-A stated they wash their hands after dealing with food and any raw food. C-A stated they had washed their hands prior to placing on gloves. C-A removed more clean dishes from the dish machine.</p> <p>When interviewed on 1/28/25 at 8:58 a.m., C-A verified the mug in the ice bin of the freezer and stated they changed the cup out every week.</p> <p>When interviewed on 1/28/25 at 2:59 p.m., C-A stated they kept cereal closed in their original boxes, so they knew the expiration date. Otherwise, they closed the cereal bags with a twist tie. C-A stated items needed to be labeled and dated when opened. C-A stated they checked inventory of food throughout the day, so they knew what they needed to throw away.</p> <p>The dish machine was an Ecolab and model U-HT-1-70. A manufacturer sticker on the dish machine indicated a wash temperature of 150 F and rinse temperature of 180 F .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A U-HT Dishmachine Lease Program brochure dated 2013, indicated minimum operating temperature for the wash was 150 degrees F and sanitizing rinse was 180 degrees F.</p> <p>The yellow thermometer was a 2023 [NAME] Precision product dishwasher thermometer and was labeled ip67 waterproof with number 8791.</p> <p>The [NAME] website with copyright date of 2025, indicated the product had a temperature range of 32 F to 194 F with accuracy of +/- 1.8 F, was FDA Food Code compliant for sanitization, accurately measured the surface temperature of water, and designed for use in commercial dishwashers.</p> <p>When interviewed on 2/3/25 at 10:09 a.m., RN-A, who was the administrator and director of nursing, stated when the maximum temperature on the [NAME] Precision thermometer reached 160 F , the dish machine was reaching its 180 F rinse temperature and sanitization requirements. RN-A stated they educated C-A the dish machine needed multiple cycles to reach the appropriate sanitization temperatures and re-educated C-A about the [NAME] Precision thermometer. RN-A stated they knew the mug in the ice was sometimes used more than once and was not sure if the mug should be replaced each day or each use. RN-A stated food needed to have a label with a date when opened and helped staff know when items needed to be discarded. RN-A stated they had white stickers and sharpies for labeling dates on food. RN-A expected staff to throw away damaged food and rotated food as first in, first out. RN-A expected staff to wash their hands between dirty and clean tasks.</p> <p>The facility Food Storage and Procurement Policy and Procedure dated 12/31/24, indicated opened bags of food must be labeled with the date the food was opened and staff would discard spoiled or contaminated food. The policy directed staff to label food prepared at the facility with the name of the food, date the food was made, and use by date.</p> <p>The facility Infection Prevention and Control Manual Dietary Department dated 11/28/24, directed staff to wash hand as frequently as needed between tasks. The policy further directed staff to ensure high-temperature dish machine water temperature reached at least 150 degrees F or according to manufacturer instructions, and rinse temperature reached at least 180 degrees F or according to manufacturer instructions.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>49617</p> <p>Based on observation, interview and document review, the administration failed to provide adequate oversight, training, and guidance for appropriate resident care related to accurate Minimum Data Set (MDS) Assessments, qualified staff and related services, the pre-admission screen and resident review (PASARR) process, and Quality Assurance and Performance Improvement (QAPI) plan and Quality Assurance and Assessment (QAA) committee requirements. This deficient practice had the potential to affect all 11 residents residing in the facility, potential new admissions, visitors, and employees of the facility.</p> <p>Findings include:</p> <p>QUALIFIED STAFF AND RELATED SERVICES</p> <p>ADMINISTRATOR</p> <p>Per Southside Care Center Nursing and Administrator Coverage policy and procedure updated 12/5/24, the administration would have addressed all the proposed plans of correction (POC) to ensure consistent compliance with both state and federal regulations for nursing facilities and would audit these corrective actions throughout the QAPI process. Furthermore, the policy indicated the facility's administration would ensure ongoing monitoring and ensure staff would be educated in the POC to make the needed improvements. Additionally, the policy directed the administrator to oversee the QAPI program and plan and provide written documentation about the good faith attempts by the committee to correct potential deficiencies identified.</p> <p>Per interview on 2/3/25 at 1:37 p.m., registered nurse (RN)-A, who also identified as the facility's director of nursing (DON) and administrator, reported the facility's previous assistant director of nursing (ADON) retired in 9/2024 and the facility had not replaced the position. RN-A stated, it was easier when there was two of us, and I have been trying to train someone to backfill for [that position], and that hasn't been easy. RN-A believed day-to-day nursing should take priority and stated, I think I've managed my charge nurse role alright, but I'll have to stay late to get the other things done because that's stuff other people can't do, like getting the new admissions applied for medical assistance. RN-A confirmed, in short, I need help.</p> <p>During interview on 2/3/25 at 3:16 p.m., the facility's owner stated RN-A's primary responsibilities are nursing, to ensure the staff are trained, responsible for admissions and taking care of those things. When asked how RN-A was expected to allocate the hours between the facility's main charge nurse and DON versus the administrative, the facility's owner reported an expectation for RN-A to put the nursing and DON role full-time and the administrative role mostly on the weekends, this additional part time gig. It's obviously not part-time, but that side of the job.</p> <p>QUALIFIED DIETARY STAFF - SEE F801</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Per interview on 2/3/25 at 3:16 p.m., the facility's owner was aware of the facility failing to employ a registered dietitian or other active qualified clinical nutrition professional to carry out the functions of a facility registered dietician. The facility's owner stated the dietitian they hired believed the role could be entirely virtual. The facility's owner stated, we were going back and forth, we were telling her some elements could be, and RN-A and the previous ADON both stated it couldn't be done 100% virtually. The facility's owner confirmed due to technology issues, the dietitian was not able to perform the role virtually and we ended up parting ways, but it wasn't official I guess, indicating they were unaware of the dietitian's official employment status.</p> <p>INFECTION PREVENTIONIST - SEE F882</p> <p>Per interview on 1/28/25 at 9:04 a.m., RN-A confirmed acting as the facility's infection preventionist and verified not having specialized training in infection prevention and control.</p> <p>Per interview on 2/3/25 at 3:16 p.m., the facility's owner was not aware the facility failed to ensure the acting infection preventionist (IP) had completed specialized training.</p> <p>Per facility policy titled Infection Preventionist revised 7/24, relevant staff would be trained in infection control upon hire and periodically thereafter. The content of the employee training was dependent on the degree of direct resident contact and job responsibilities.</p> <p>ACCURATE MDS ASSESSMENTS - SEE F641</p> <p>Per interview on 1/29/25 at 9:14 a.m., RN-B confirmed responsibility for the MDS assessments and stated RN-A provided training. RN-B stated, I am fairly new to MDS, and I took this role over in September. I get the information [for the MDS] from staff and residents, from chart review and by performing medication reconciliation. When asked how RN-B interviewed residents for section F, activity preferences during the MDS, RN-B stated, Depending on the situation, I will engage the resident and ask about what they liked to do prior [to admission] . I don't care for the questions themselves; I think they are silly questions. The question set is geared towards different [population] set than ours.</p> <p>Per interview on 2/3/25 at 1:37 p.m., RN-A, also identified as the facility's director of nursing (DON) and administrator, confirmed training RN-B on the MDS process and stated, it could have been better. RN-A stated if there was a second nurse available to help during the facility's new admissions, I could have helped RN-B more, I could have made it [the training] more robust. RN-A stated if there was more time, I could have been more available.</p> <p>During interview on 2/3/25 at 3:16 p.m., the facility's owner stated RN-A's primary responsibilities are nursing, to ensure the staff are trained, responsible for admissions and taking care of those things.</p> <p>PASARR - SEE F645</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During interview on 1/28/25 at 2:46 p.m., the Hennepin County supervisor (HCS)-L for Health and Human Services for adult access explained they were the contact person for the mental illness level II PASARR for the county. HCS-L stated a person should not be admitted to a facility without having the level II PASARR completed to ensure whatever services the individual was assessed to need are in place once the individual admits the facility. HCS-L confirmed receiving level II PASARR referrals for R7, R9, R10, and R11 and stated, I don't see a note that it was completed, but I see the referral came to use in October.</p> <p>Per follow-up interview on 1/28/25 at 4:44 p.m., HCS-L stated after many attempted contacts with the facility, the assessor assigned to R7's level II PASARR was not able to obtain the needed documentation to complete the assessment. HCS-L stated, Clearly we have a disjunct here, which sometimes happens when a nursing facility admission is done without an assessment and the facility isn't clear about what is required in this situation.</p> <p>When interviewed on 1/30/25 at 8:39 a.m., health unit coordinator (HUC)-A, who also facilitated activities and was the social services director, stated RN-A handled the PASARR as part of the admission process, and HUC-A reviewed referrals and completed the Therapeutic Recreation Assessment form with new admissions.</p> <p>Per interview on 2/3/25 at 1:37 p.m., RN-A stated, The PASARR thing, I don't necessarily know how to read them if I'm being honest. RN-A stated the intended use of PASARRs was to ensure individuals with intellectual disabilities and developmental disabilities don't end up in the nursing home.</p> <p>QAPI AND QAA - SEE F865, F867, F868</p> <p>A request for interview from the medical director was made on 2/3/25 at 8:42 a.m. but was not received.</p> <p>During interview on 2/3/25 at 1:37 p.m., RN-A stated most of the QAA information goes through the medical director's designee. RN-A stated the certified physician assistant (CPA)-B was present during the QAA meetings and was their continuity person. RN-A stated, we used to rely on medical doctor (MD)-I quite a bit, but not as much now that we have another physician working with CPA-B, although, RN-A confirmed, the other physician was not as involved in the QAPI stuff. RN-A stated correcting quality deficiencies was not a formal process and it was not always included in the meeting minutes. When asked how the facility was made aware of high-risk, high-volume or problem-prone areas, as well as health outcomes, resident safety, choice autonomy and quality of care, RN-A stated, we could probably do a better job at comparing ourselves to benchmarks, we don't do enough of that.</p> <p>During interview on 2/3/25 at 3:16 p.m., the facility's owner agreed there was definitely room for improvement regarding RN-A's time allocation between acting as the facility's DON and administrator. The facility's owner verbalized relying on RN-A to provide updates about survey results and the facility's plan of correction and stated they would review the deficiencies and talk them through, however, stated, there's definitely room for improvement when it comes to QAPI. The facility's owner also agreed when it came to QAPI, there was room for improvement when it comes to communication.</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>49617</p> <p>Based on document review and interview, the facility failed to submit complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data, during 1 of 1 quarter reviewed (Q4), to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS.</p> <p>Findings include:</p> <p>Review of the facility's payroll based journal (PBJ) staffing data report dated 7/1/24 - 9/30/24 (Q4), identified the facility failed to have licensed nursing coverage 24 hours/day for the following dates: 7/3/24, 7/6/24, 7/7/24, 7/12/24, 7/13/24, 7/14/24, 7/19/24, 7/20/24, 7/28/24, 7/29/24, 7/30/24, 8/1/24, 8/2/24, 8/3/24, 8/4/24, 8/5/24, 8/6/24, 8/10/24, 8/11/24, 8/12/24, 8/13/24, 8/16/24, 8/17/24, 8/18/24, 8/20/24, 8/23/24, 8/24/24, 8/25/24, 8/27/24, 8/28/24, 8/30/24, 8/31/24, 9/1/24, 9/2/24, 9/3/24, 9/6/24, 9/7/24, 9/8/24, 9/9/24, 9/10/24, 9/10/24, 9/11/24, 9/14/24, 9/15/24, 9/20/24, 9/21/24, 9/22/24, 9/25/24, 9/26/24, 9/27/24, 9/28/24, and 9/30/24.</p> <p>The facility's schedule dated 7/1/24 - 7/15/24 indicated they did have licensed nursing coverage 24 hours/day for the dates of 7/3/24, 7/6/24, 7/7/24, 7/12/24, 7/13/24, and 7/14/24.</p> <p>The facility's schedule dated 7/16/24 - 7/31/24 indicated they did have licensed nursing coverage 24 hours/day for the dates of 7/19/24, 7/20/24, 7/28/24, 7/29/24, and 7/30/24.</p> <p>The facility's schedule dated 8/1/24 - 8/15/24 indicated they did have licensed nursing coverage 24 hours/day for the dates of 8/2/24, 8/3/24, 8/4/24, 8/5/24, 8/6/24, 8/10/24, 8/11/24, 8/12/24, and 8/13/24. The schedule lacked licensed nursing coverage for the evening shift (2:30 p.m. - 11:00 p.m.) on 8/1/24.</p> <p>An employee time card dated 8/1/24, indicated registered nurse (RN)-A punched in at 6:51 a.m. on 8/1/24 and punched out at 6:52 p.m.</p> <p>An employee time card dated 8/1/24, indicated RN-C punched in at 4:03 p.m. on 8/1/24 and punched out at 10:53 p.m. on 8/1/24.</p> <p>The facility's schedule dated 8/16/24 - 8/31/24, indicated they did have licensed nursing coverage 24 hours/day for the dates of 8/16/24, 8/17/24, 8/18/24, 8/20/24, 8/23/24, 8/24/24, 8/25/24, 8/27/24, 8/28/24, 8/30/24, and 8/31/24.</p> <p>The facility's schedule dated 9/1/24 - 9/15/24, indicated they did have licensed nursing coverage 24 hours/day for the dates of 9/1/24, 9/2/24, 9/3/24, 9/6/24, 9/7/24, 9/8/24, 9/9/24, 9/10/24, 9/10/24, 9/11/24, 9/14/24, and 9/15/24.</p> <p>The facility's schedule dated 9/15/24 - 9/30/24, indicated they did have licensed nursing coverage 24 hours/day for the dates of 9/20/24, 9/21/24, 9/22/24, 9/25/24, 9/26/24, 9/27/24, 9/28/24, and 9/30/24.</p> <p>(continued on next page)</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Per interview on 2/3/25 at 1:37 p.m., RN-A, who was also identified as the facility's director of nursing (DON) and administrator, verified responsibility for submitting the facility's PBJ data. RN-A stated the data reported on the facility's PBJ report were artificially low because sometimes I enter lower numbers than what we actually have due to losing the ability to report staff that have been discharged from their payroll system. RN-A reviewed the PBJ triggered dates with the schedule and verified there was licensed nursing coverage for the triggered dates. RN-A stated if there was inaccurate data reported, it was by accident.</p> <p>A policy pertaining to reporting PBJ data was requested but not received.</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>49617</p> <p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>Based on observation, interview and document review, the facility failed to implement a Quality Assurance and Performance Improvement (QAPI) plan assuring care and services were identified to maintain acceptable levels of performance and continual improvement. Additionally, facility failed to identify and prioritize problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicators, and resident and staff input. Furthermore, the facility failed to ensure governing body oversight of the facility's QAPI program and activities. This deficient practice had the potential to affect all 11 residents residing in the facility.</p> <p>Findings include:</p> <p>An undated facility policy titled Quality Assessment and Assurance program (QAA) indicated the facility would maintain a QAA committee which would meet quarterly, and its purpose was to develop an on-going quality assurance program through an interdisciplinary approach and assess the effectiveness of the health care provided to the residents. The policy indicated the structure of the committee should consist of the administrator, the medical director, director of nursing (DON), program director, and consulting pharmacist. The policy directed the committee to develop and implement appropriate plans of action to correct identified quality deficiencies.</p> <p>The facility's Quality Assurance Meeting sign-in sheets dated 1/8/24, 4/8/24, 7/8/24, 10/7/24, and 1/13/25 were reviewed on 1/31/25 at 1:47 p.m. and revealed the medical director had not signed in for any QAA meetings. The sign-in sheets further identified registered nurse (RN)-A identified as both director of nursing (DON) and administrator.</p> <p>An undated quality of life and quality of care projects meeting minutes was reviewed and identified a quality deficiency and a potential improvement project. The minutes indicated the improvement project was aimed at developing meaningful activities for residents and improving resident participation and their overall quality of life. The meeting minutes reviewed the nursing and quality of life systems, included data collection and analysis, and interventions and plan evaluation. There were no further meeting minutes for review, however. The meeting minutes did not identify falls or falls with injury as a current issue.</p> <p>A request for interview from the facility's medical director was made on 2/3/25 at 8:42 a.m., but not received.</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During interview on 2/3/25 at 1:37 p.m., RN-A stated most of the QAA information goes through the medical director's designee. RN-A stated the certified physician assistant (CPA)-B was present during the QAA meetings and was their continuity person. RN-A stated, we used to rely on medical doctor (MD)-I quite a bit, but not as much now that we have another physician working with CPA-B, although, RN-A confirmed, the other physician was not as involved in the QAPI stuff. RN-A stated information from the QAA meetings was provided to the designee and I know she takes it to MD-I. RN-A stated correcting quality deficiencies was not a formal process and it was not always included in the meeting minutes. When asked how the facility was made aware of high-risk, high-volume or problem-prone areas, as well as health outcomes, resident safety, choice autonomy and quality of care, RN-A stated, we could probably do a better job at comparing ourselves to benchmarks, we don't do enough of that. RN-A stated the QAA committee included subjective and objective feedback and identified resident data like medication reports from the consultant pharmacist and related information, like their weights and vital signs as the objective data. RN-A stated, I get real-time feedback, and I can observe it firsthand while I'm doing med admin and confirmed it was not a formal process brought back to QAA or like where people are doing surveys. RN-A stated, the important thing is the feedback is accurate and it gives us the ability to gauge, 'is it effective or not? Do we need to make a course change?' RN-A provided an example of correcting a quality concern identified by resident input; the palatability of the cooking and stated the real-time feedback received was all positive except sometimes cook (C)-A will move the menu things around and sometimes that can play into the dietary aspect. RN-A stated old business and new business items discussed during QAA meetings were kept in a binder and sometimes there's a formal report I do, however for more informal things, RN-A stated I'll give a quick verbal update. I do send emails. RN-A stated when the facility owner came, they would ask, what do I need to know? and stated it was not a formal process, but believed the owner felt informed.</p> <p>During interview on 2/3/25 at 3:16 p.m., the facility's owner agreed there was definitely room for improvement regarding RN-A's time allocation between acting as the facility's DON and administrator. The facility's owner verbalized relying on RN-A to provide updates about survey results and the facility's plan of correction and stated they would review the deficiencies and talk them through, however, stated, there's definitely room for improvement when it comes to QAPI.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>49617</p> <p>Based on interview and document review the facility failed to ensure the Quality Assessment and Assurance (QAA)/Quality Assurance Process improvement (QAPI) committee was effective in implementing appropriate action plans to correct quality deficiencies identified in previous surveys related to Minimum Data Set (MDS) assessment inaccuracies, activities, trauma-informed care, food sanitation, and failure to implement a QAPI plan and maintain a QAPI committee with improvement projects which resulted in deficiencies identified during this survey. This deficient practice had the potential to affect all residents residing in the facility.</p> <p>Findings include:</p> <p>A review of the Certification and Survey Provider Enhanced Reporting (CASPER) system report (a quality measure report for nursing facilities) last updated 1/22/25, indicated the facility had the following deficiencies with a survey exit date of 11/30/23:</p> <ul style="list-style-type: none"> - F641 Accuracy of Assessments - F679 Activities Meet Interest/Needs of Each Resident - F699 Trauma-Informed Care - F812 Food Procurement, Store/Prepare/Serve Sanitary - F865 QAPI Program/Plan, Disclosure/Good Faith Attempt - F867 QAA Committee <p>The CASPER report further indicated the facility had the following repeat deficiencies with a survey exit date of 10/22:</p> <ul style="list-style-type: none"> - F679 Activities Meet Interest/Needs of Each Resident - F865 QAPI Program/Plan, Disclosure/Good Faith Attempt <p>The facility's QAPI meeting minutes dated 1/8/24, were reviewed and lacked documentation on how the facility developed, monitored, and evaluated performance indicators for improvement activities. Furthermore, the meeting minutes lacked documentation on how the facility identified, reported and tracked or intended to track adverse events, high risk, high volume, and/or problem-prone concerns.</p> <p>The facility's QAPI meeting minutes dated 4/8/24, were reviewed and revealed an undated quality of life and quality of care project that identified an improvement project related to activities. The meeting minutes included a comprehensive system analysis and data collection review, as well as potential corrective actions.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Southside Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2644 Aldrich Avenue South Minneapolis, MN 55408	
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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility's QAPI meeting minutes dated 7/8/24, were reviewed and lacked documentation on how the facility developed, monitored, and evaluated performance indicators for improvement activities. Furthermore, the meeting minutes lacked documentation on how the facility identified, reported and tracked or intended to track adverse events, high risk, high volume, and/or problem-prone concerns. The meeting minutes included a duplicate undated quality of life and quality of care projects with no new data identified or evaluated regarding the improvement project.</p> <p>The facility's QAPI meeting minutes dated 10/7/24, and 1/13/25, were reviewed and lacked documentation on how the facility developed, monitored, and evaluated performance indicators for improvement activities. Furthermore, the meeting minutes lacked documentation on how the facility identified, reported and tracked or intended to track adverse events, high risk, high volume, and/or problem-prone concerns. The meeting minutes lacked documentation on an improvement project.</p> <p>A request for interview from the facility's medical director was made on 2/3/25 at 8:42 a.m., but not received.</p> <p>During interview on 2/3/25 at 1:37 p.m., RN-A stated correcting quality deficiencies was not a formal process and was not always included in the meeting minutes. When asked how the facility was made aware of high-risk, high-volume or problem-prone areas, as well as health outcomes, resident safety, choice autonomy, and quality of care, RN-A stated, we could probably do a better job at comparing ourselves to benchmarks, we don't do enough of that. RN-A stated the QAA committee included subjective and objective feedback and stated, I get real-time feedback, and I can observe it firsthand while I'm doing med admin [administration] and confirmed it was not brought back to QAA or like where people are doing surveys. RN-A stated, the important thing is the feedback is accurate and it gives us the ability to gauge, 'is it effective or not? Do we need to make a course change?' RN-A provided an example of correcting a quality concern identified by resident input; the palatability of the cooking and stated the real-time feedback received was all positive except sometimes cook (C)-A will move the menu things around and sometimes that can play into the dietary aspect. When asked about the facility's improvement projects and how the facility identified and made good faith efforts to correct quality deficiencies from previous survey results, RN-A stated, we got feedback about improvements on the house [facility], so we promoted housekeeper (HSKP)-A. Residents wanted more access to the community, so health unit coordinator (HUC)-A changed his position to accommodate that so he can help take people to stores. We target falls heavily because we had some people that had fallen and they were high risks for scary falls. RN-A described assessing high-risk residents and collaborating with the interdisciplinary team (IDT) to discharge those residents to a higher level of care because those residents needed more care than the facility could offer. RN-A explained tracking falls with those residents in the facility and performing ongoing monitoring when they discharged and stated the falls dropped dramatically once those residents discharged . RN-A was not able to identify other improvement projects, including the project identified in the undated quality of life and quality of care project meeting minutes.</p> <p>During interview on 2/3/25 at 3:16 p.m., the facility's owner confirmed, there's definitely room for improvement when it comes to QAPI. The facility's owner verbalized relying on RN-A to provide updates about survey results and the facility's plan of correction.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An undated facility policy titled Quality Assessment and Assurance program (QAA) indicated the facility would maintain a QAA committee which would meet quarterly, and its purpose was to develop an on-going quality assurance program through an interdisciplinary approach and assess the effectiveness of the health care provided to the residents. The policy directed the committee to develop and implement appropriate plans of action to correct identified quality deficiencies.</p>

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>49617</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on interview, and document review, the Quality Assurance (QA) committee failed to ensure required members of the committee attended the quarterly meetings. This had the potential to affect all 11 residents who resided at the facility.</p> <p>Findings include:</p> <p>An undated facility policy titled Quality Assessment and Assurance program (QAA) indicated the facility would maintain a QAA committee which would meet quarterly, and the structure of the committee would consist of the administrator, the medical director, director of nursing (DON), program director, and consulting pharmacist. The policy further indicated the objective of the QAA program was the ensure compliance with standards and regulations and other staff and/or individuals may be asked to attend the meetings by request of the committee.</p> <p>The facility's Quality Assurance Meeting sign-in sheets dated 1/8/24, 4/8/24, 7/8/24, 10/7/24, and 1/13/25 were reviewed on 1/31/25 at 1:47 p.m. and revealed the medical director had not signed in for any QAA meetings. The sign-in sheets further identified registered nurse (RN)-A identified as both director of nursing (DON) and administrator.</p> <p>Per interview on 1/27/25 at 12:40 p.m., registered nurse (RN)-A reported the facility's infection preventionist retired in 9/24.</p> <p>Per subsequent interview on 1/28/25 at 9:04 a.m., RN-A confirmed there was no individual in the facility who had completed the specialized training for infection prevention and control and no staff were currently enrolled in any specialized training or education.</p> <p>A request for interview from the facility's medical director was made on 2/3/25 at 8:42 a.m., but not received.</p> <p>During follow-up interview on 2/3/25 at 1:37 p.m., RN-A stated most of the QAA information goes through the medical director's designee. RN-A stated the certified physician assistant (CPA)-B was present during the QAA meetings and was their continuity person. RN-A stated, we used to rely on medical doctor (MD)-I quite a bit, but not as much now that we have another physician working with CPA-B, although, RN-A confirmed, the other physician was not as involved in the QAPI stuff. RN-A stated information from the QAA meetings was provided to the designee and I know she takes it to MD-I.</p> <p>During interview on 2/3/25 at 3:16 p.m., the facility's owner stated, there's definitely room for improvement when it comes to QAPI.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48299</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were maintained during laundry services. This had potential to affect all 11 residents who resided in the facility.</p> <p>Findings include:</p> <p>During observation and interview on 1/28/25 at 8:05 a.m., housekeeping (HK)-D, who was also the head of housekeeping and laundry services, wore gloves and no gown to put laundry detergent and Clorox Bleach into the washer machine, took linens and bed sheets from a bag on the floor and placed them into the washer machine in multiple loads, and closed the washer machine. HK-D folded clean washcloths with the same gloves. HK-D stated they do not need to wear a gown to load dirty linen and clothes into the washer machine. HK-D verified they used the same gloves to load the dirty laundry and fold the clean washcloths.</p> <p>When interviewed on 2/3/25 at 10:09 a.m., registered nurse (RN)-A, who was the administrator and director of nursing, expected staff to wear gloves to handle soiled laundry and change gloves and perform hand hygiene prior to touching clean laundry. RN-A stated the facility was more residential, and staff should not touch dirty laundry to their body or arms. RN-A stated staff could be more careful and wear gowns when dirty laundry handled.</p> <p>The facility Housekeeping and Laundry - Policy and Procedure Southside Care Center dated 1/5/25, directed the facility to ensure gowns were available to wear while sorting linens. The policy directed staff to handle all potentially contaminated linen with appropriate measures to prevent cross-transmission and follow standard precautions for all used linen which is potentially contaminated.</p>

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>51577</p> <p>Based on interview and document review, the facility failed to ensure the acting infection preventionist (IP) had completed specialized training in infection prevention and control. This deficient practice had the potential to affect all 11 residents residing in the facility.</p> <p>Findings include:</p> <p>After reviewing the facility documents, no certification for Infection Preventionist was revealed.</p> <p>On 1/28/25 at 9:04 a.m., director of nursing (DON) stated he was currently the acting facility infection preventionist and was responsible for overseeing the infection control program. DON verified he had not completed specialized training for infection prevention and control. and no staff were currently enrolled in any specialized training at this time nor had any specialized infection control education scheduled.</p> <p>A facility policy titled Infection Preventionist, revised 7/2024, indicated the following:</p> <p>Policy Interpretation and Implementation</p> <ol style="list-style-type: none"> 1. The facility's infection control policies and procedures apply to all personnel, consultants, contractors, residents, visitors, volunteer workers and the general public. 2. The Infection Control Nurse and Housing Director shall oversee the implementation of infection control policies and procedures and help department directors and managers ensure that they are implemented and followed. 3. Relevant staff will be trained in infection control upon hire and periodically thereafter, including when and how to find pertinent procedures and equipment related to infection control. The content of the employee training is dependent on the degree of direct resident contact and job responsibilities. 4. The facility's infection control policies and procedures will be reviewed and revised or updated as needed. The Facility Nurse and Housing Director will be responsible for keeping the infection control program (policies and procedures) current and staff members will be notified of changes or updates. 5. Questions about the infection control policies and procedures should be referred to the Facility Nurse. <p>Required Skills and Experience (Minimum requirements in terms of educational background, work experience, licenses/certifications or other knowledge skills and abilities)</p> <p>* Must be unrestricted licensed with the State of Minnesota as a Registered Nurse, and maintain current unencumbered licensure</p> <p>(continued on next page)</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>*Thorough knowledge of state and federal regulations regarding long term care</p> <p>*Knows and practices of infection control and prevention in a nursing facility healthcare setting</p>