Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 4, 2026

Administrator
NORTH SHORE HEALTH
515 - 5TH AVENUE WEST
GRAND MARAIS, MN 55604

RE: CCN:245384
Cycle Start Date: May 27, 2026

Dear Administrator:

On May 27, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 27, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 27, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will

not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245384	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH SHORE HEALTH	515 - 5TH AVENUE WEST , GRAND MARAIS, Minnesota, 55604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 5/26/26-5/27/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		06/08/2026
F0000	INITIAL COMMENTS On 5/26/26-5/27/26, a federal recertification survey was conducted using the Risk-Based Survey (RBS) process at your facility. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		06/08/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes	F0656	F656 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's	06/19/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245384	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/27/2026

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F0656 SS = D	Continued from page 1 measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to develop and implement care planning for chronic health conditions for 2 of 2 residents (R3, R6) reviewed for care planning. Findings include: R3's significant change in status (SCSA) minimum	F0656	Continued from page 1 allegation of compliance. The Interdisciplinary Team (IDT) reviewed and updated R3's comprehensive care plan to reflect a personalized constipation management plan on June 5, 2026. Interventions were added specifying bowel tracking protocols, dietary/fluid preferences, and triggers for when to notify the practitioner. The direct care staff profiles were updated to prompt daily bowel monitoring. The IDT reviewed and updated the R6's comprehensive care plan to include edema monitoring on June 5, 2026. On May 25, 2026, the Registered Nurse caring for R6 notified the primary physician regarding the R6's lower extremity edema and weight gain. Orders were received for Lasix and daily monitoring for edema was initiated. Interventions were added specifying the frequency of edema checks, specialized skin care, and tracking instructions. The R3's electronic Kardex was aligned to ensure the floor staff are prompted for these specific daily checks as well. All residents care plans will be reviewed for medications/diagnosis codes to verify medications include the diagnosis and that treatment is then reflected in the individual care plan. This review will be completed by June 19, 2026. The Director of Nursing will conduct re-education for all Nursing Staff during June 17, 2026, Nurses meeting. The education will focus on the following: Federal requirements under F0656 regarding comprehensive person-centered care planning, review the Comprehensive Care Plan policy, and discuss how clinical changes (such as new edema development or chronic constipation) are properly translated from the EMR into care plan interventions. Monitoring: The Director of Nursing and/or designee will review 15 resident charts each month for new or discontinued medications and/or diagnosis and verify those have been reflected on the comprehensive care plan. The monitor will begin July 2026 and will continue for three months. If 100% compliance is achieved, the monitor will be discontinued. Reports of this monitor will be reported to Quality Improvement/Peer Review quarterly for the length of the monitor.	06/19/2026

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F0656 SS = D	Continued from page 2 data set (MDS) dated 3/9/26, identified impaired cognition and diagnoses of Alzheimer's dementia, and constipation. R3 was dependent on staff for assist with transferring and toileting. A care area assessment (CAA) dated 3/9/26, identified dehydration and fluid maintenance were triggered related in part to newly present constipation. R3's care plan dated 7/1/25, identified R3 was dependent on staff for toileting needs. The care plan didn't identify a focus statement for constipation. R3's provider orders included: -Bisacodyl suppository 10 milligrams (mg) as needed (PRN) for constipation, if no bowel movement (BM) in four days, give suppository and notify provider if no results. -Miralax 17 grams every 24 hours PRN constipation. -Senna-docusate 8.6/50 mg, give one tab every 24 hours for constipation once daily PRN. R3's electronic medical record (EMR) identified R3 hadn't had a recorded bowel movement from 4/6 to 4/9, 4/13 to 4/16, 5/15 to 5/18, and 5/23 to 5/27/26. During an interview on 5/27/26 at 2:46 p.m., the director of nurses (DON) stated she would expect constipation to be on the care plan. R6's admission minimum data set (MDS) dated 4/23/26, identified moderately impaired cognition and diagnosis of chronic kidney disease, stage four (severe kidney damage and a significant loss of kidney function). R6's care plan dated 4/19/26 lacked a focus statement for edema management. R6's provider orders 5/7/26, identified to take R6's weight in the morning every Thursday, but didn't include monitoring for edema. A progress note dated 5/25/26, identified R6's provider was contacted, and nurse manager updated, due to an 18.1-pound weight gain since admission on 4/14/26. During an observation and interview on 5/26/26 at 6:14 p.m., both of R6's lower extremities were very edematous and R6 stated that is how they have been and has had those tight socks in the past but	F0656		06/19/2026

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F0656 SS = D	Continued from page 3 not here. During an interview on 5/27/26 at 1:41 p.m., RN-A stated she had just noticed R6's weight gain this past weekend and notified the provider and the nurse manager. RN-A also stated R6 was admitted with the edema and they used to have edema monitoring on the treatment administration record (TAR) but the provider discontinued it and started a nebulizer. Today, RN-A stated R6 had diminished lung sounds and both lower legs were three-plus pitting edema, and she had been waiting to hear if they got any new orders and they did get one for Lasix (a diuretic medication), and RN-A felt his legs had been getting bigger and the risk for R6 could be skin breakdown and his legs to start weeping. During an interview on 5/27/26 at 2:39 p.m., the director of nursing (DON) stated would expect the nurses to assess the edema and listen to the lungs. Also, the DON stated she would expect the ongoing monitoring, documentation, and for it to be on the care plan. The DON added that even if the provider discontinued the edema monitoring, it was still within a nurse's scope to monitor edema. A policy, Care Plans – Comprehensive dated 1/3/26, identified its purpose was for a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. Assessments of residents were ongoing and care plans were revised as information about the resident and the resident's conditions changed.	F0656		06/19/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to monitor and document the results of monitoring, for a resident with chronic	F0684	F684 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. The Interdisciplinary Team (IDT) reviewed and updated the R6's comprehensive care plan to include edema monitoring on June 5, 2026. On May 25, 2026, the Registered Nurse caring for R6 notified the primary physician regarding the R6's lower extremity edema and weight gain after the physician discontinued the monitoring for edema. Orders were received for Lasix and daily monitoring for edema	06/19/2026

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F0684 SS = D	Continued from page 4 lower extremity edema for 1 of 1 resident (R6) reviewed for quality of care. Findings include: R6's admission minimum data set (MDS) dated 4/23/26, identified moderately impaired cognition and diagnosis of chronic kidney disease, stage four (severe kidney damage and a significant loss of kidney function). R6's care plan dated 4/19/26 lacked a focus statement for edema management. R6's provider orders 5/7/26, identified to take R6's weight in the morning every Thursday, but didn't include monitoring for edema. A history and physical dated 4/14/26, identified R6 had a past medical history of chronic lower extremity edema, and had one-plus bilateral edema on exam. A Clinical Admission assessment dated 4/14/26, identified R6's left and right lower extremities were extremely "puffy" with mild non-pitting edema in the calves, ankles and dorsum of feet. A monthly rounding provider note dated 5/19/26, identified two-plus pitting edema to the knees as stable A progress note dated 5/25/26, identified R6's provider was contacted, and nurse manager updated, due to an 18.1-pound weight gain since admission on 4/14/26. A comprehensive skin assessment dated 4/16/26, identified R6 had mild bilateral, non-pitting edema in calves, ankles and dorsum of feet. During an observation and interview on 5/26/26 at 6:14 p.m., both of R6's lower extremities were very edematous and R6 stated that is how they have been and has had those tight socks in the past but not here. During an interview on 5/27/26 at 1:41 p.m., RN-A stated she had just noticed R6's weight gain this past weekend and notified the provider and the nurse manager. RN-A also stated R6 was admitted with the edema and they used to have edema monitoring on the treatment administration record (TAR) but the provider discontinued it and started a nebulizer. Today, RN-A stated R6 had diminished lung sounds and both lower legs were three-plus	F0684	Continued from page 4 was initiated. Interventions were added specifying the frequency of edema checks, specialized skin care, and tracking instructions. All residents care plans will be reviewed for medications/diagnosis codes to verify medications include the diagnosis and that treatment is then reflected in the individual care plan. This review will be completed by June 19, 2026. The Director of Nursing will conduct re-education for all Nursing Staff during June 17, 2026, Nurses meeting. The education will include a review of the Comprehensive Care Plan policy, Skin Check policy, and discuss how clinical changes (such as new edema development and weight gain) are properly addressed with the clinical team and are then translated from the EMR into care plan interventions. Monitoring: The Director of Nursing and/or designee will review 15 resident charts each month for new or discontinued medications and/or diagnosis and verify those have been reflected on the comprehensive care plan. The monitor will begin July 2026 and will continue for three months. If 100% compliance is achieved, the monitor will be discontinued. Reports of this monitor will be reported to Quality Improvement/Peer Review quarterly for the length of the monitor.	06/19/2026

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F0684 SS = D	Continued from page 5 pitting edema, and she had been waiting to hear if they got any new orders and they did get one for Lasix (a diuretic medication), and RN-A felt his legs had been getting bigger and the risk for R6 could be skin breakdown and his legs to start weeping. During an interview on 5/27/26 at 2:39 p.m., the director of nursing (DON) stated would expect the nurses to assess the edema and listen to the lungs. Also, the DON stated she would expect the ongoing monitoring, documentation, and for it to be on the care plan. The DON added that even if the provider discontinued the edema monitoring, it was still within a nurse's scope to monitor edema. A policy, Assessment – Comprehensive Skin dated 3/7/24, identified its purpose was to develop a systematic assessment for all residents at risk for alterations in skin integrity. The policy further identified a comprehensive skin assessment included, but was not limited to, the skin color, temperature, edema, turgor, moisture and integrity. A policy, Care Plans – Comprehensive dated 1/3/26, identified its purpose was for a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. Assessments of residents were ongoing and care plans were revised as information about the resident and the resident's conditions changed.	F0684		06/19/2026

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K0000 Bldg. 04	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/27/2026. At the time of this survey, North Shore Health was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us	K0000		06/08/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NORTH SHORE HEALTH	**515 - 5TH AVENUE WEST , GRAND MARAIS, Minnesota, 55604**

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K0000 Bldg. 04	Continued from page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1.A detailed description of the corrective action taken or planned to correct the deficiency. 2.Address the measures that will be put in place to ensure the deficiency does not reoccur. 3.Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4.Identify who is responsible for the corrective actions and monitoring of compliance. 5.The actual or proposed date for completion of the remedy. The facility was inspected as one building: North Shore Health, is a 1-story building with no basement. The 100 and 400 wings of the facility were constructed in 2016 and was determined to be of Type II(111) construction. In 2017 the 200 and 300 wings were constructed to the building that were determined to be of Type II(111) construction. The 100,200,300, & 400 wings were constructed to replace the original facility and the plans for these wings were approved on 04/30/2015, prior to the 2012 code adoption and are considered to be of existing construction. The building is attached to a hospital and is properly separated by a 2 hour fire rated separation. The building is separated into 2 smoke compartments by a 1 hour fire rated smoke barrier. The building is fully sprinkled throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. It also has smoke detection in all resident rooms. The facility has a capacity of 37 beds and had a census of 34 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		06/08/2026
K0232 SS = F Bldg. 04	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width	K0232	K0232 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of	06/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245384	(X2) MULTIPLE CONSTRUCTION A. BUILDING **04 - NORTH SHOR...** B. WING	(X3) DATE SURVEY COMPLETED **05/27/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH SHORE HEALTH	**515 - 5TH AVENUE WEST , GRAND MARAIS, Minnesota, 55604**

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K0232 SS = F Bldg. 04	Continued from page 2 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the minimum width and clear, unobstructed egress corridor per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, 19.2.3.5, 7.5.1.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/27/2026 at 2:39pm it was revealed by observation that the waves wing corridor is not maintained with a clear width of 48 inches required for this type of facility. Staff had stored equipment on both sides of the corridor. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0232	Continued from page 2 Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. On 05/27/2026, the Director of Facilities moved working equipment on wheels that had been left unattended in the Care Center Waves corridor to maintain the required 48" clearance. Also on 05/27/2026, other hallways were inspected to verify that the required 48" clearance was maintained. On 06/05/2026, the Director of Facilities emailed and spoke with the Care Center DON and Activities Director to increase awareness of and develop strategies for maintaining required corridor clearances. An email was then sent to all team members working in the Care Center (Nursing, Activities, Housekeeping, Dietary, Maintenance and Rehab) showing the example where equipment was left in such a manner to not maintain the required 48" clearance. Appropriate parking of equipment showing deficient and acceptable practices was also shared. The Director of Facilities or designee will perform twelve random inspections (three per quarter) of Care Center corridors for clearance issues. This report will be forwarded to the Quality Improvement/Peer Review Committee quarterly for one year.	06/08/2026
K0712 SS = F Bldg. 04	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101	K0712	K0712 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. The inspection found that the NOC fire for the second quarter 2025 was not completed. All required fire drills for the remainder of 2025, first quarter of 2026 and two of three for second 2026 were completed. The Director of Facilities conducted the second quarter NOC drill for the third shift on June 5, 2026. The completed Fire Drill Report for this event has been logged in the Fire Drill Report Book. Moving forward, the Director of Facilities or designee will continue to perform one drill per shift per quarter.	06/05/2026

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K0712 SS = F Bldg. 04	Continued from page 3 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/27/2026, at 2:15pm, it was revealed by a review of available documentation that fire drills were not completed: June NOC drill was not completed. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0712	Continued from page 3 The fire drills will continue to be incorporated into a spreadsheet that tracks annual compliance requirements by month. The summary of fire drills will be forwarded to the Quality Improvement/Peer Review Committee quarterly for one year.	06/05/2026
K0353 SS = E Bldg. 04	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings	K0353	K0353 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. On 05/28/2026, the Director of Facilities labeled the wire rack in the Care Center 300 Hall storage room with orange marking tape to delineate the required 18" clearance from sprinkler heads. No later than 06/15/2026, the Director of Facilities and other Maintenance Staff will label storage racks throughout the Care Center that are located near sprinkler heads. On 06/05/2026, the Director of Facilities emailed and spoke with the Care Center DON and Activities Director to increase awareness and develop strategies for proper storage and clearance requirements from sprinkler heads. An email was then sent to Nursing and Activities Team Members noting that items should not be stored above the marked area on the storage racks; increasing awareness of proper storage and clearance requirements from sprinkler heads. Moving forward, the Director of Facilities or designee will perform twelve random inspections (three per quarter) of the Care Center storage areas for sprinkler head clearance issues. This report will be forwarded to the Quality Improvement/Peer Review Committee quarterly for one year.	06/15/2026

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K0353 SS = E Bldg. 04	Continued from page 4 could a patterned impact on the residents within the facility. Findings include: On 05/27/2026 at 2:30pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in the storage room located on 300 wing. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0353		06/15/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 20, 2026

Administrator
NORTH SHORE HEALTH
515 - 5TH AVENUE WEST
GRAND MARAIS, MN 55604

RE: CCN: 245384
Cycle Start Date: June 30, 2026

Dear Administrator:

On June 30, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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E0000	Initial Comments On 5/26/26-5/27/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		06/08/2026
F0000	INITIAL COMMENTS On 5/26/26-5/27/26, a federal recertification survey was conducted using the Risk-Based Survey (RBS) process at your facility. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		06/08/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes	F0656	F656 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's	06/19/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245384	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/27/2026

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F0656 SS = D	Continued from page 1 measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to develop and implement care planning for chronic health conditions for 2 of 2 residents (R3, R6) reviewed for care planning. Findings include: R3's significant change in status (SCSA) minimum	F0656	Continued from page 1 allegation of compliance. The Interdisciplinary Team (IDT) reviewed and updated R3's comprehensive care plan to reflect a personalized constipation management plan on June 5, 2026. Interventions were added specifying bowel tracking protocols, dietary/fluid preferences, and triggers for when to notify the practitioner. The direct care staff profiles were updated to prompt daily bowel monitoring. The IDT reviewed and updated the R6's comprehensive care plan to include edema monitoring on June 5, 2026. On May 25, 2026, the Registered Nurse caring for R6 notified the primary physician regarding the R6's lower extremity edema and weight gain. Orders were received for Lasix and daily monitoring for edema was initiated. Interventions were added specifying the frequency of edema checks, specialized skin care, and tracking instructions. The R3's electronic Kardex was aligned to ensure the floor staff are prompted for these specific daily checks as well. All residents care plans will be reviewed for medications/diagnosis codes to verify medications include the diagnosis and that treatment is then reflected in the individual care plan. This review will be completed by June 19, 2026. The Director of Nursing will conduct re-education for all Nursing Staff during June 17, 2026, Nurses meeting. The education will focus on the following: Federal requirements under F0656 regarding comprehensive person-centered care planning, review the Comprehensive Care Plan policy, and discuss how clinical changes (such as new edema development or chronic constipation) are properly translated from the EMR into care plan interventions. Monitoring: The Director of Nursing and/or designee will review 15 resident charts each month for new or discontinued medications and/or diagnosis and verify those have been reflected on the comprehensive care plan. The monitor will begin July 2026 and will continue for three months. If 100% compliance is achieved, the monitor will be discontinued. Reports of this monitor will be reported to Quality Improvement/Peer Review quarterly for the length of the monitor.	06/19/2026

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F0656 SS = D	Continued from page 2 data set (MDS) dated 3/9/26, identified impaired cognition and diagnoses of Alzheimer's dementia, and constipation. R3 was dependent on staff for assist with transferring and toileting. A care area assessment (CAA) dated 3/9/26, identified dehydration and fluid maintenance were triggered related in part to newly present constipation. R3's care plan dated 7/1/25, identified R3 was dependent on staff for toileting needs. The care plan didn't identify a focus statement for constipation. R3's provider orders included: -Bisacodyl suppository 10 milligrams (mg) as needed (PRN) for constipation, if no bowel movement (BM) in four days, give suppository and notify provider if no results. -Miralax 17 grams every 24 hours PRN constipation. -Senna-docusate 8.6/50 mg, give one tab every 24 hours for constipation once daily PRN. R3's electronic medical record (EMR) identified R3 hadn't had a recorded bowel movement from 4/6 to 4/9, 4/13 to 4/16, 5/15 to 5/18, and 5/23 to 5/27/26. During an interview on 5/27/26 at 2:46 p.m., the director of nurses (DON) stated she would expect constipation to be on the care plan. R6's admission minimum data set (MDS) dated 4/23/26, identified moderately impaired cognition and diagnosis of chronic kidney disease, stage four (severe kidney damage and a significant loss of kidney function). R6's care plan dated 4/19/26 lacked a focus statement for edema management. R6's provider orders 5/7/26, identified to take R6's weight in the morning every Thursday, but didn't include monitoring for edema. A progress note dated 5/25/26, identified R6's provider was contacted, and nurse manager updated, due to an 18.1-pound weight gain since admission on 4/14/26. During an observation and interview on 5/26/26 at 6:14 p.m., both of R6's lower extremities were very edematous and R6 stated that is how they have been and has had those tight socks in the past but	F0656		06/19/2026

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F0656 SS = D	Continued from page 3 not here. During an interview on 5/27/26 at 1:41 p.m., RN-A stated she had just noticed R6's weight gain this past weekend and notified the provider and the nurse manager. RN-A also stated R6 was admitted with the edema and they used to have edema monitoring on the treatment administration record (TAR) but the provider discontinued it and started a nebulizer. Today, RN-A stated R6 had diminished lung sounds and both lower legs were three-plus pitting edema, and she had been waiting to hear if they got any new orders and they did get one for Lasix (a diuretic medication), and RN-A felt his legs had been getting bigger and the risk for R6 could be skin breakdown and his legs to start weeping. During an interview on 5/27/26 at 2:39 p.m., the director of nursing (DON) stated would expect the nurses to assess the edema and listen to the lungs. Also, the DON stated she would expect the ongoing monitoring, documentation, and for it to be on the care plan. The DON added that even if the provider discontinued the edema monitoring, it was still within a nurse's scope to monitor edema. A policy, Care Plans – Comprehensive dated 1/3/26, identified its purpose was for a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. Assessments of residents were ongoing and care plans were revised as information about the resident and the resident's conditions changed.	F0656		06/19/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to monitor and document the results of monitoring, for a resident with chronic	F0684	F684 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. The Interdisciplinary Team (IDT) reviewed and updated the R6's comprehensive care plan to include edema monitoring on June 5, 2026. On May 25, 2026, the Registered Nurse caring for R6 notified the primary physician regarding the R6's lower extremity edema and weight gain after the physician discontinued the monitoring for edema. Orders were received for Lasix and daily monitoring for edema	06/19/2026

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F0684 SS = D	Continued from page 4 lower extremity edema for 1 of 1 resident (R6) reviewed for quality of care. Findings include: R6's admission minimum data set (MDS) dated 4/23/26, identified moderately impaired cognition and diagnosis of chronic kidney disease, stage four (severe kidney damage and a significant loss of kidney function). R6's care plan dated 4/19/26 lacked a focus statement for edema management. R6's provider orders 5/7/26, identified to take R6's weight in the morning every Thursday, but didn't include monitoring for edema. A history and physical dated 4/14/26, identified R6 had a past medical history of chronic lower extremity edema, and had one-plus bilateral edema on exam. A Clinical Admission assessment dated 4/14/26, identified R6's left and right lower extremities were extremely "puffy" with mild non-pitting edema in the calves, ankles and dorsum of feet. A monthly rounding provider note dated 5/19/26, identified two-plus pitting edema to the knees as stable A progress note dated 5/25/26, identified R6's provider was contacted, and nurse manager updated, due to an 18.1-pound weight gain since admission on 4/14/26. A comprehensive skin assessment dated 4/16/26, identified R6 had mild bilateral, non-pitting edema in calves, ankles and dorsum of feet. During an observation and interview on 5/26/26 at 6:14 p.m., both of R6's lower extremities were very edematous and R6 stated that is how they have been and has had those tight socks in the past but not here. During an interview on 5/27/26 at 1:41 p.m., RN-A stated she had just noticed R6's weight gain this past weekend and notified the provider and the nurse manager. RN-A also stated R6 was admitted with the edema and they used to have edema monitoring on the treatment administration record (TAR) but the provider discontinued it and started a nebulizer. Today, RN-A stated R6 had diminished lung sounds and both lower legs were three-plus	F0684	Continued from page 4 was initiated. Interventions were added specifying the frequency of edema checks, specialized skin care, and tracking instructions. All residents care plans will be reviewed for medications/diagnosis codes to verify medications include the diagnosis and that treatment is then reflected in the individual care plan. This review will be completed by June 19, 2026. The Director of Nursing will conduct re-education for all Nursing Staff during June 17, 2026, Nurses meeting. The education will include a review of the Comprehensive Care Plan policy, Skin Check policy, and discuss how clinical changes (such as new edema development and weight gain) are properly addressed with the clinical team and are then translated from the EMR into care plan interventions. Monitoring: The Director of Nursing and/or designee will review 15 resident charts each month for new or discontinued medications and/or diagnosis and verify those have been reflected on the comprehensive care plan. The monitor will begin July 2026 and will continue for three months. If 100% compliance is achieved, the monitor will be discontinued. Reports of this monitor will be reported to Quality Improvement/Peer Review quarterly for the length of the monitor.	06/19/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH SHORE HEALTH	515 - 5TH AVENUE WEST , GRAND MARAIS, Minnesota, 55604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0684 SS = D	Continued from page 5 pitting edema, and she had been waiting to hear if they got any new orders and they did get one for Lasix (a diuretic medication), and RN-A felt his legs had been getting bigger and the risk for R6 could be skin breakdown and his legs to start weeping. During an interview on 5/27/26 at 2:39 p.m., the director of nursing (DON) stated would expect the nurses to assess the edema and listen to the lungs. Also, the DON stated she would expect the ongoing monitoring, documentation, and for it to be on the care plan. The DON added that even if the provider discontinued the edema monitoring, it was still within a nurse's scope to monitor edema. A policy, Assessment – Comprehensive Skin dated 3/7/24, identified its purpose was to develop a systematic assessment for all residents at risk for alterations in skin integrity. The policy further identified a comprehensive skin assessment included, but was not limited to, the skin color, temperature, edema, turgor, moisture and integrity. A policy, Care Plans – Comprehensive dated 1/3/26, identified its purpose was for a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. Assessments of residents were ongoing and care plans were revised as information about the resident and the resident's conditions changed.	F0684		06/19/2026