DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 7Q0G

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00080

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245384**

2.STATE VENDOR OR MEDICAID NO.
(L2) **365745100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COOK CO NORTHSHORE HOSP & C&NC**
(L4) **515 - 5TH AVENUE WEST**
(L5) **GRAND MARAIS, MN** (L6) **55604**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 11/18/2013 (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

Post Certification Revisit by review of the facility's plan of correction to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective November 8, 2013, the facility is certified for 37 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Pat Halvorson, Unit Supervisor 11/18/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/31/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/05/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5384 December 31, 2013

Ms. Kimber Wraalstad, Administrator
Cook County Northshore Hosp & C&NC
515 - 5th Avenue West
Grand Marais, Minnesota 55604

Dear Ms. Wraalstad:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 8, 2013, the above facility is certified for:

37 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 37 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

November 19, 2013

Ms. Kimber Wraalstad, Administrator
Cook County Northshore Hospital C&NC
Grand Marais, Minnesota 55604

RE: Project Number S5384023

Dear Ms. Wraalstad:

On October 30, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 26, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On November 18, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 26, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 8, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 26, 2013, effective November 8, 2013 and therefore remedies outlined in our letter to you dated October 30, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245384	A. Building B. Wing	11/18/2013

Name of Facility	Street Address, City, State, Zip Code
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **11/06/2013**	ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **11/07/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **11/08/2013**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **11/08/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **09/27/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **09/27/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** PH/KJ	**Date:** 11/19/2013	**Signature of Surveyor:** 12835	**Date:** 11/18/2013
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/26/2013	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 7Q0G

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00080

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245384**

2.STATE VENDOR OR MEDICAID NO.
(L2) **365745100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COOK CO NORTHSHORE HOSP & C&NC**
(L4) **515 - 5TH AVENUE WEST**
(L5) **GRAND MARAIS, MN** (L6) **55604**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/26/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Chris Elmgren, HFE NE II — 11/12/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 12/05/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/05/2013
(L33)

DETERMINATION APPROVAL

CCN 24-5384

At the time of the standard survey completed September 26, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to bea pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

An investigation of complaint #H5384010 was completed. The complaint was unsubstantiated, no deficiencies cited.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 6855

October 30, 2013

Ms. Kimber Wraalstad, Administrator
Cook Co. Northshore Hosp & C&NC
515 - 5th Avenue West
Grand Marais, Minnesota 55604

RE: Project Number S5384023

Dear Ms. Wraalstad:

On September 26, 2013, a standard survey was completed at your facility by the Minnesota Departments 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Pat Halverson
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007

Telephone: (218) 723-4637
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 5, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

If an acceptable PoC 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved

in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 December 26, 2013 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 26, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

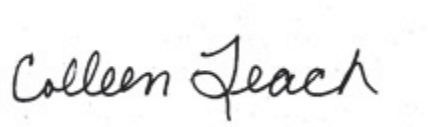
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Colleen B. Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (612) 201-4117
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 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

F 000	INITIAL COMMENTS
	
	THE FACILITY PLAN OF CORRECTION (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.
	An investigation of complaint #H5384010 was completed. The complaint was unsubstantiated, no deficiencies cited.
	Census = 33
		F 000	OK 11-12-13 PLH	

F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure direct care staff completed cares in a respectful manner, and communicated with the resident during cares to maintain dignity for 1 of 1 residents (R21) who was reviewed for activities of daily living (ADL's). Findings include:	F 241	**F241** NA-A was counseled by the facility administrator about the importance of communicating with residents as personal cares are provided. It was explained that we expect that residents will be treated with dignity and respect. Direct interaction with the resident is one way of showing dignity and respect. In addition, the Director of Nursing met with NA-A and reviewed Resident 21's care card and Cook County North Shore Care Center's policies and procedures for the Maintenance of Resident Dignity and Oral Care.	09/27/2013

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

Kimberly L Woodstock | Administrator | 11/7/2013

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 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
F 241	Continued From page 1 R21's diagnoses included dementia, and senile delusion. The quarterly Minimum Data Set (MDS) dated 8/26/13, indicated R21 had short and long term memory problems with severe cognitive impairment; had physical behavioral symptoms directed towards others from one to three days during the assessment period; and required extensive assistance of staff with all ADL's. The self-care deficit care plan dated 2/15/13, indicated R21 had late stage dementia with the inability to process information, sequence, and had cognitive slowing, grasping of objects and caregivers with difficulty releasing. Interventions included to explain procedures, allow a processing time of 10 seconds, and be slow and gentle. R21 was still able to feed himself and drink from a special cup with a non-removable straw for fluids. The communication care plan dated 3/20/13, indicated R21 had communication deficits related to dementia, did not speak, seemed to hear and was able to follow some commands. The care plan further indicated R21 was understood through expressions, smiles, and other non-verbal cues. Interventions included to explain procedures. The nursing assistant (NA) care guide dated 9/9/13, directed staff to tell R21 what they were going to do, allow a processing time of 10 seconds, and be slow and gentle. The guide identified R21 was cognitively impaired, could not express with words, and it was difficult to know what he understands. On 9/25/13, at 7:40 a.m. nursing assistant (NA)-A entered the room and shut the door. NA-A washed her hands in the bathroom, and raised R21's bed. While raising the bed, R21 made eye contact with NA-A and placed his hand to his mouth. NA-A stated "are you hungry?, that's why	F 241	The next regularly scheduled Nursing Assistant staff meeting is November 26, 2013. At this meeting, the Director of Nursing will review facility's expectation that employees are to communicate with residents during cares and they are to explain procedures with the resident as they are providing care. The importance of always treating our resident's with dignity and respect will be emphasized. The Maintenance of dignity policies and procedures will be reviewed at the same meeting. The "Maintenance of Resident Dignity" policy and procedure was revised to reflect the facility's expectations while providing cares. Clinical Performance evaluations will be conducted on the nursing assistant staff before the end of 2013. The Nursing Assistant Clinical Evaluation checklist will be completed at least every six months for 2014. The results of Nursing Assistants performance regarding interaction with residents during cares will be reported to the Quality Assurance Committee in January 2014, July 2014, and January 2015.	11/6/2013 10/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 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
F 241	Continued From page 2 we're getting ready so you can go eat breakfast." When spoken to R21 would make eye contact, but was non-verbal and occasionally would smile when NA-A spoke to him. NA-A removed R21's gown and totally applied a shirt. The surveyor questioned NA-A regarding a bed bath, and NA-A stated "well he gets showers once a week", and "I did a bed bath yesterday." At that time, NA-B entered the room with the EZ stand and turned on R21's fan blowing it directly towards R21. NA-A picked up two washcloths from the bedside stand and told NA-B "we need to wash him." NA-A wet the washcloths in the shared bathroom in the room and returned to the bedside holding the cloths in her hand. Without explaining the procedure, NA-A washed R21's face, hands, and when NA-A attempted to wash under the arms R21 would push NA-A away when the washcloth touched the skin. The surveyor questioned NA-A if the washcloths had gotten cold. NA-B stated the wash cloths were hot. NA-A stated "well not now they're not, they're cold because of the fan blowing on them." NA-A then abruptly picked up a pink basin from the bedside stand, poured out the contents (care supplies) onto the shelf, and obtained hot water in the basin from the bathroom. NA-A returned to the bedside and washed under R21's arms and the perineal area. During the cares NA-A and NA-B were having an inappropriate conversation regarding the surveyors. The NA's did not converse with R21 nor explain any of the care procedures. Throughout the cares NA-A and NA-B talked over R21 with no eye contact and R21 just stared at the ceiling. On 9/25/13, at 2:30 p.m. the registered nurse (RN)-A stated the survey process had previously been discussed with staff and included	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 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
F 241	Continued From page 3 information that surveyors may observe cares. RN-A confirmed the NA's were expected to communicate with the residents during cares and explain procedures.	F 241		
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: The facility failed to act upon a grievance complaint from the resident council for 2 of 2 residents (R28, R12) who voiced a preference to have female caregivers. Findings include: On 9/24/13, at 11:02 a.m. R28 was interviewed regarding the resident council. The quarterly Minimum Data Set (MDS) dated 7/15/13, indicated R28 had no cognitive impairment and required the extensive assistance of staff with transferring, dressing, toilet use, and personal hygiene. R28 stated "about 4 or 5 months ago" some women in the council meeting voiced concerns regarding a preference to have female care givers. R28 stated "we still have a male all the time due to staffing. I had one last night [9/23]. I prefer a woman care giver. About four of us would. They [facility staff] said we just have to accept it. They told us that." R28 added, the male	F 244	**F244** The plan of care/care card for Resident 28 was updated on 10/10/13 stating "Bath: resident prefers a female NAR for bathing only. Otherwise male giver ok. Check with charge nurse for assistance in arranging for female. Resident is willing to wait for another time or DAY bathing in order to have female." The plan of care/care card for Resident 12 was updated on 10/7/13 stating "Bath: resident prefers a female NAR for bathing only. Otherwise male giver ok. Check with charge nurse for assistance in arranging for female. Resident is willing to wait for another time or DAY bathing in order to have female." Any concern or grievance expressed to Care Center staff either in a 1:1 conversation or at the resident or family council meetings will be followed up using the Care Center Concern form and the grievance procedure.	10/10/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 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
F 244	Continued From page 4 aides are nice and provide good care, "but I would like a woman." Review of the Resident Council Meeting Minutes dated 1/30/13, indicated there was resident concerns in regard to personal cares and nursing staff. The director of nursing (DON) told the residents that the nursing staff in the facility were a mixed work force of men and women. The social worker (LSW) referred to the Resident Bill of Rights booklet from the MN Department of Health with reference to the right to refuse treatment or personal cares. The minutes noted "Some members asked questions & seemed satisfied with the answers." There was no further documentation regarding the concerns. Review of the staffing schedules from 8/12/13, to 9/24/13, indicated there was a male caregiver working on R28's the unit along with a female caregiver on the afternoon shift on 8/19, 8/20, 9/6, 9/9, 9/10, 9/11, 9/18, 9/19, 9/23, and 9/24. On 9/25/13, at 12:30 p.m. the LSW verified she was involved in the concern voiced at the resident council meeting regarding some female residents preferring to have female caregivers. The LSW stated she was asked by the DON to come to the council meeting and was told to read the residents their rights regarding the right to refuse treatment. The LSW stated the residents were told they could refuse care, but the facility could not guarantee when they would be accommodated for cares due to the other staff having their own residents. The LSW was unsure if there were any attempts to adjust/change the staffing schedules in an effort to accommodate the residents. The LSW stated the DON mainly dealt with the issue (the DON was not available	F 244	A revision to the Grievance Policy and Procedure has been completed on November 7, 2013. This revision states: "a. Concerns/grievances brought up at resident and/or family council should be referred to follow the facility's formal grievance policy and procedure. Presentation of the amended concern form and grievance policy and procedure will be shared at a future resident council meeting. A report concerning the number of grievances files and their outcome will be submitted Quality Assurance Committee by the facility Social Worker. The first report will be submitted January 2014 and quarterly thereafter for one year.	11/07/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 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
F 244	Continued From page 5 during the survey). The LSW stated there was no formal document/complaint form filled out. The LSW added, "I'm pretty sure the only documentation would be the resident council minutes." No further documentation was provided. On 9/25/13, at 1:43 p.m. R12 stated she attends the resident council meetings regularly. The quarterly MDS dated 9/12/13, indicated R12 had no cognitive impairment and required the extensive assistance of staff with transferring, dressing, toilet use, and personal hygiene. R12 stated she doesn't remember the exact conversation at the meeting regarding the concern over male caregivers, but stated she and R28 would prefer a female caregiver. R12 stated "I have had to accept it. It makes me feel uncomfortable." R12 stated she does get a female caregiver for all of her showers, but not for daily a.m. and p.m. cares. "They still wash your bottom. I would rather have a female, but it's tolerable." R12 stated she had reported the issue to R28 and she brought it up at the council meeting. R12 stated "I was married for 54 years, and only my husband saw my naked body." R28 and R12 both reside on the same unit in the facility. R28 and R12's care plans did not address a preference to have a female caregiver. On 9/25/13, at 2:30 p.m. registered nurse (RN)-A stated he was not familiar with the problem. RN-A stated it was difficult because "we do not have the staff. You can try to switch, but they have breaks." Residents were coached to talk with the charge nurse regarding issues/concerns. RN-A confirmed preferences for female caregivers	F 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 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
F 244	Continued From page 6 would not be on the resident care plans. RN-A stated it would be reasonable to look at the issue and possibly look at scheduling changes. The Grievance Procedure policy (not dated), indicated complaints or grievances would be brought immediately to the attention of the charge nurse or social worker and the charge nurse or social worker would attempt to resolve the issue. Documentation would be completed according to facility policy and forwarded to the administrator. If the issue was not satisfactorily resolved the complainant would be advised of further options - submit the grievance to the administrator, DON, or social worker, or request a meeting via phone or in person. If the response from the facility was not satisfactory, the complainant would be advised to contact outside agencies. The policy did not address if follow up would be completed to ensure the grievance had been resolved.	F 244		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure oral care services were provided as directed by the care plan for 1 of 1 residents (R21) who was reviewed for dental status. Findings included:	F 282	**F282** NA-A was monitored for the completion of oral cares by the Resident Care Coordinator using the Nursing Assistant Clinical Evaluation checklist. In addition, the Director of Nursing met with NA-A and reviewed Resident 21's care card and Cook County North Shore Care Center's policies and procedures for Oral Care. The Oral Care Policy and Procedure was placed in the Nursing Assistants mailboxes. They are to read the policy, sign, date and return to the Director of Nursing. An email was also sent to all	10/03/2013 11/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 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
F 282	Continued From page 7 On 9/24/13, at 11:39 a.m. R21 was observed sitting in a geri chair in the dining room. R21 had a few natural bottom teeth with some broken, jagged bottom teeth, and a bad breath odor was noted. R21's diagnoses included dementia and senile delusion. The self-care deficit care plan dated 2/15/13, indicated R21 required extensive assistance of staff with dressing, grooming, hygiene, and bathing due to late stage dementia and the inability to process information. Interventions included extensive assistance of one to two staff for all hygiene care "AM and HS" (hour of sleep). The nutrition care plan revised 8/26/13, indicated R21 received a pureed diet, and instructed staff to check R21's mouth after meals. The nursing assistant (NA) care guide dated 9/9/13, indicated R21 required extensive assist for all tasks in the "AM and HS." The care guide did not direct staff to check R21's mouth after meals. On 9/25/13, R21 was continuously observed from 7:20 a.m. to 9:56 a.m. and no oral cares were provided. At 7:20 a.m. R21 was observed in bed sleeping. At 7:40 a.m. a nursing assistant (NA)-A entered the room and shut the door. NA-A completed morning cares; however, no oral care was observed. At 7:55 a.m. NA-A and NA-C assisted R21 to sit up on the side of the bed and stood R21 after applying a transfer belt. While standing, NA-B finished personal cares with R21. NA-A and NA-C ambulated R21 out of the room towards the dining room and NA-C followed with the geri chair. After ambulating R21 was placed at a table in the dining room in the geri chair. No oral cares were observed to be completed	F 282	the Nursing Assistants informing them that the policy and procedure was in their mailboxes and reminding them of their responsibility to provide oral care for the Residents. The next regularly scheduled Nursing Assistant staff meeting is November 26, 2013. At this meeting, the Director of Nursing will review facility's expectations regarding the provision of oral care and following the residents' plan of care. Clinical Performance evaluations will be conducted on the nursing assistant staff before the end of 2013. The Nursing Assistant Clinical Evaluation checklist will be completed at least every six months for 2014. The results of Nursing Assistants performance regarding the completion of oral cares will be reported to the Quality Assurance Committee in January 2014, July 2014, and January 2015. The Director of Nursing or designee will also monitor the provision of oral care by randomly evaluating each Resident for the status of oral hygiene. Beginning the week of November 18, 2013, Resident observations will be made once a week for four weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 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
F 282	Continued From page 8 throughout the observation. At 8:35 a.m. R21 received the breakfast meal and NA-C assisted R21 with eating until 9:17 a.m. At 9:17 a.m. NA-A assisted R21 in the geri chair out of the dining room placing him in the hall by the nurses station where LPN-A provided medications crushed and mixed with pudding. At 9:25 a.m. NA-B assisted R21 in the geri chair to his room and NA-D followed with the EZ stand. R21 was stood in the EZ stand and incontinence care was provided. NA-A entered the room and R21 was transferred to the recliner. NA-A washed R21's face and then all NA's stated they were done and left the room. No oral care was observed to be completed throughout the observation. R21's remaining bottom teeth were observed to be coated with a thick white substance. At 9:56 a.m. on 9/25/13, the NA-A was questioned regarding R21's oral cares. NA-A confirmed she had not completed oral care on R21 with cares and stated "we forgot". NA-A stated "I'll do it now, for you" and entered the room. On 9/25/13, at 2:30 p.m. the registered nurse (RN)-A stated the expectation would be for staff to complete oral care with morning cares, or sometimes right after eating, and as directed by the care plan. The Oral Care Policy dated 2/05, directed staff to complete oral care twice a day and as needed by the condition of the resident's mouth.	F 282	Then the monitor will be done monthly for 6 months. The information will be reported to Quality Improvement/Peer Review Committee.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 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
F 312	Continued From page 9 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure oral care services were provided for 1 of 1 residents (R21) who was reviewed for dental status. Findings included: On 9/24/13, at 11:39 a.m. R21 was observed sitting in a geri chair in the dining room. R21 had a few natural bottom teeth with some broken, jagged bottom teeth, and a bad breath odor was noted. R21's diagnoses included dementia and senile delusion. The admission Minimum Data Set (MDS) dated 2/26/13, did not identify any oral/dental problems such as broken/missing teeth. The Oral/Nutritional status form dated 8/25/13, identified R21 had loss of liquids and solids from the mouth when eating; had trouble chewing with only a couple of teeth; and staff completed mouth care. The quarterly MDS dated 8/26/13, indicated R21 had short and long term memory problems with severe cognitive impairment; exhibited physical behavioral symptoms directed towards others from one to three days during the assessment period; and required extensive assistance of staff with all activities of daily living (ADL's). The MDS further identified R21 had loss of liquids/solids from the mouth when eating or drinking; holding food in	F 312	**F312** NA-A was monitored for the completion of oral cares by the Resident Care Coordinator using the Nursing Assistant Clinical Evaluation checklist. In addition, the Director of Nursing met with NA-A and reviewed Resident 21's care card and Cook County North Shore Care Center's policies and procedures for Oral Care. The Oral Care Policy and Procedure was placed in the Nursing Assistants mailboxes. They are to read the policy, sign, date and return to the Director of Nursing. An email was also sent to all the Nursing Assistants informing them that the policy and procedure was in their mailboxes and reminding them of their responsibility to provide oral care for the Residents. The next regularly scheduled Nursing Assistant staff meeting is November 26, 2013. At this meeting, the Director of Nursing will review facility's expectations regarding the provision of oral care and following the residents' plan of care. Clinical Performance evaluations will be conducted on the nursing assistant	10/13/2013 11/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 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
F 312	Continued From page 10 the mouth/cheeks or residual food in mouth after meals; and was on a mechanically altered diet. The self-care deficit care plan dated 2/15/13, indicated R21 required extensive assistance of staff with dressing, grooming, hygiene, and bathing due to late stage dementia and the inability to process information. Interventions included extensive assistance of one to two staff for all hygiene care "AM and HS" (hour of sleep). The nutrition care plan revised 8/26/13, indicated R21 received a pureed diet, and instructed staff to check R21's mouth after meals. The nursing assistant (NA) care guide dated 9/9/13, indicated R21 required extensive assist for all tasks in the "AM and HS." The care guide did not direct staff to check R21's mouth after meals. On 9/25/13, at 7:20 a.m. R21 was observed in bed sleeping. At 7:40 a.m. a nursing assistant (NA)-A entered the room and shut the door. NA-A washed her hands in the bathroom, and raised the bed. NA-B then entered the room with the EZ stand and assisted with morning cares. NA-A washed R21's face, hands, and completed personal cares. At 7:42 a.m. NA-B left the room. At 7:53 a.m. NA-C entered the room and stated R21 would be ambulated to breakfast. At 7:55 a.m. NA-B returned. NA-A and NA-C assisted R21 to sit up on the side of the bed and stood R21 after applying a transfer belt. While standing, NA-B finished personal cares with R21. NA-A and NA-C ambulated R21 out of the room towards the dining room and NA-C followed with the geri chair. After ambulating R21 was placed at a table in the dining room in the geri chair. No oral cares were observed to be completed throughout the observation. At 8:35 a.m. R21 received the breakfast meal and NA-C assisted R21 with	F 312	staff before the end of 2013. The Nursing Assistant Clinical Evaluation checklist will be completed at least every six months for 2014. The results of Nursing Assistants performance regarding the completion of oral cares will be reported to the Quality Assurance Committee in January 2014, July 2014, and January 2015. The Director of Nursing or designee will also monitor the provision of oral care by randomly evaluating each Resident for the status of oral hygiene. Beginning the week of November 18, 2013, Resident observations will be made once a week for four weeks. Then the monitor will be done monthly for 6 months. The information will be reported to Quality Improvement/Peer Review Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 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
F 312	Continued From page 11 eating. At 9:17 a.m. R21 had finished eating and NA-A assisted R21 in the geri chair out of the dining room placing him in the hall by the nurses station where LPN-A provided medications crushed and mixed with pudding. At 9:25 a.m. NA-B assisted R21 in the geri chair to his room and NA-D followed with the EZ stand. R21 was stood in the EZ stand and incontinence care was provided. NA-A entered the room and R21 was transferred to the recliner. NA-A washed R21's face and then all NA's stated they were done and left the room. No oral care was observed to be completed throughout the observation. R21's remaining bottom teeth were observed to be coated with a thick white substance. At 9:56 a.m. on 9/25/13, the NA-A was questioned regarding R21's oral cares. NA-A confirmed she had not completed oral care on R21 with cares and stated "we forgot". NA-A stated "I'll do it now, for you" and entered the room. NA-A stated "now I have to wake him up. Normally I wouldn't. Normally it [oral care] would be done with morning cares and at bed time on afternoons." NA-A obtained three toothettes and two cups of water. When NA-A told R21 she was going to clean his mouth, R21 opened his mouth wide and let NA-A move the toothette around in the mouth. R21 smiled. NA-A stated "he likes it when we clean his mouth, he likes to suck" (on the toothette). NA-A cleansed R21's mouth with the three toothettes and water. On 9/25/13, at 2:30 p.m. the registered nurse (RN)-A stated the expectation would be for staff to complete oral care with morning cares, or sometimes right after eating, and as directed by the care plan.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 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
F 312	Continued From page 12 The Oral Care Policy dated 2/05, directed staff to complete oral care twice a day and as needed by the condition of the resident's mouth.	F 312		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 356	**F 356** The form for the posting of Nurse Staffing Information was modified immediately after discussion with Surveyor to include unlicensed direct care staff/nursing assistant hours. The Director of Nursing will review all the posting reports from the previous month to verify that the posted Nurse Staffing Information includes both licenses and unlicensed nursing staff. The results of this review will be reported to Quality Improvement/Peer Review Committee quarterly for one year. POC date can not be befor the exit date changed to 9/27/13. ML	09/26/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 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
F 356	Continued From page 13 by: Based on observation and interview, the facility failed to ensure the posted nurse staffing information included the unlicensed direct care staff/nursing assistants (NA's). This had the potential to affect all 33 residents who resided in the facility. Findings include: Observations of the facility nurse staffing postings on 9/23/13, 9/24/13, 9/25/13, and 9/26/13, noted the records did not include the total number and actual number of hours worked for the NA's. Review of the nurse staffing information which was previously posted for September 2013, indicated the NA's were not included on the records. On 9/26/13, at 10:11 a.m. the administrator verified the nurse staffing postings did not include the NA's, and stated there was no actual policy to provide related to the nurse staffing information.	F 356		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a clean environment for five of eight residents whose rooms were inspected.	F 465	**F465** The exhaust vents in the bathrooms Shared by rooms 101 and 102, 103 and 104, 105 and 106, 201 and 202, and 306 and 307 were cleaned by Housekeeping on September 27, 2013. All other exhaust fans were also evaluated and cleaned as necessary The Housekeeping Infection Control policy was revised to include a statement that Housekeeping staff will check the exhaust fans weekly and clean as necessary.	09/27/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 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
F 465	Continued From page 14 Findings include: During resident observations on 9/23/13 and 9/24/13, ceiling vents in resident bathrooms were found to have heavy accumulation of dust. The environmental tour with the Housekeeping Supervisor, on 9/26/13 at 1:00 p.m., established the bathrooms which had heavy build up of dust on the exhaust vents were shared by (but not limited to) rooms 101 and 102, 103 and 104, 105 and 106, 201 and 202, and, 306 and 307. Review of the duty list, provided by the housekeeping supervisor, revealed cleaning of the bathroom vents was not addressed, except for the the men's and women's bathrooms by the staff locker rooms. The housekeeping supervisor stated the vents were to be cleaned by her staff on a daily basis and acknowledged, with the heavy buildup of dust, they were not getting cleaned on a regular basis. She stated the cleaning of the vents in resident bathrooms was "certainly an area that needs to be addressed."	F 465	The Director of Housekeeping or her designee will monitor the evaluation of exhaust fans for cleanliness weekly for the next six months. The information will be reported to Quality Improvement/Peer Review Committee on a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/25/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	**515 - 5TH AVENUE WEST GRAND MARAIS, MN 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
K 000	INITIAL COMMENTS Surveyor: 03005 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Cook County Northshore Hospital C & NC was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Cook County Northshore Hospital C & NC, is a 1-story building with no basement. The original building was constructed in 1953 and was determined to be of Type II(111) construction. In 1999 additions were constructed to the building that was determined to be of Type V(111) construction. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building also has a hospital attached that is properly separated. The building is fully sprinklered 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. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 37 beds and had a census of 35 at the time of the survey.	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/25/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	**515 - 5TH AVENUE WEST GRAND MARAIS, MN 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
K 000	Continued From page 1 It is the determination of this Life Safety Code Surveyor that the fire sprinkler coverage in the resident rooms is adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (99) and CMS S&C-05-38, A1. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		