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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: G9GS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00593

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245483**

2.STATE VENDOR OR MEDICAID NO.
(L2) **940220900**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE NORTH SHORE ESTATES LLC**
(L4) **7700 GRAND AVENUE**
(L5) **DULUTH, MN** (L6) **55807**

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) **07/14/2016**

6. DATE OF SURVEY **06/04/2018** (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 **70** (L18)
13.Total Certified Beds **70** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(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):

17. SURVEYOR SIGNATURE Date:
Terri Ament, Unit Supervisor 06/12/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 06/12/2018 (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
05/01/1987
(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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/31/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245483 June 12, 2018

Mr. Justin Teal, Administrator
The North Shore Estates Llc
7700 Grand Avenue
Duluth, MN 55807

Dear Mr. Teal:

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 May 31, 2018 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 12, 2018

Mr. Justin Teal, Administrator
The North Shore Estates Llc
7700 Grand Avenue
Duluth, MN 55807

RE: Project Number S5483027

Dear Mr. Teal:

On May 2, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 19, 2018. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On June 4, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 7, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 19, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 31, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 19, 2018, effective May 31, 2018 and therefore remedies outlined in our letter to you dated May 2, 2018, 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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: G9GS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00593

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245483**
2.STATE VENDOR OR MEDICAID NO.
(L2) **940220900**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE NORTH SHORE ESTATES LLC**
(L4) **7700 GRAND AVENUE**
(L5) **DULUTH, MN** (L6) **55807**

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) **07/14/2016**

6. DATE OF SURVEY **04/19/2018** (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 **70** (L18)
13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(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):

17. SURVEYOR SIGNATURE Date :
Kathie Siemsen, HFE NE II 05/22/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 05/30/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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
05/01/1987
(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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 2, 2018

Mr. Justin Teal, Administrator
The North Shore Estates LLC
7700 Grand Avenue
Duluth, MN 55807

RE: Project Number S5483027

Dear Mr. Teal:

On April 19, 2018, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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;

Electronic 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

Informal Dispute Resolution - 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
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 May 29, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- 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 ePoC 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 ePoC 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 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, 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 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.

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 July 19, 2018 (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 October 19, 2018 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 4/16/18, through 4/19/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 4/16/18, through 4/19/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a	F 623		5/9/18

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

Electronically Signed | 05/09/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 623	Continued From page 1	F 623		

language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 623	Continued From page 2	F 623		

(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 623	Continued From page 3 In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to send notice of a hospital transfer to a representative of the Office of the State Long-Term Care Ombudsman for 1 of 1 residents (R60) reviewed for hospitalizations. Findings Include: R60's Face Sheet undated, indicated diagnoses that included acute and chronic respiratory failure with hypoxia. On 1/17/18, a progress note identified R60 transferred to the hospital at 2:24 p.m. for respiratory concerns. R60 chose to decline the bed hold at the time of the hospital transfer. On 4/19/18, at 3:24 p.m. the administrator was interviewed and stated he was not aware the facility was required to send notice of a hospital transfer to the Ombudsman. The facility policy Bed-Hold Notice For Hospital Transfer and Therapeutic Leave revised 12/16, lacked direction to send notice of a hospital transfer to the Ombudsman.	F 623	Ombudsman was notified of affected resident□s transfer on 5/9/2018 . Trained new social services director on process for sending Ombudsman notifications. Revised facility process for tracking and notifying Ombudsman of resident hospital transfers. Administrator or designee will audit all hospital transfers for notification of Ombudsman weekly for four weeks, bi weekly for 2 months, monthly for 2 months, then report to QA for further review and recommendations.	
F 677	ADL Care Provided for Dependent Residents	F 677		5/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 677 SS=D	Continued From page 4 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of 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 failed to ensure facial hair was removed for 1 of 1 residents (R38), and oral care was provided for 1 of 1 residents (R12) reviewed for activities of daily living (ADLs). Findings include: R38's Diagnosis Report printed 4/18/18, indicated diagnoses that included dementia without behavioral disturbance. R38's quarterly Minimum Data Set (MDS) dated 3/21/18, indicated R38 had moderately impaired cognition, and required extensive assistance of one staff with personal hygiene. R38's Initial/Comprehensive care plan dated 3/2/18, indicated R38 required extensive assistance of one staff with grooming. The AM and PM Care Guides (nursing assistant care guides) dated 4/17/18, directed to ensure all male and female residents' facial hair was shaved. On 4/16/18, at 6:53 p.m. R38 was observed to have a line of black and gray hair approximately one half inch long along the bottom edge of her chin, and at the corners of her mouth.	F 677	Affected resident□s facial hair was removed and oral care provided the day the concern was brought to our attention. All residents with facial hair and who need assistance with oral care have the potential to be affected. These residents will be reviewed to ensure that facial hair is removed and oral provided as per their individualized care plan. Will update care plans as needed. All nursing staff will be reeducated on policy and procedure for proper oral care and facial hair removal preference by 5/31/18. DON or designee will complete oral care and facial hair removal audits weekly for four weeks, bi weekly for 2 months, monthly for 2 months, then report to QA for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 677	Continued From page 5	F 677		

On 4/17/18, at 9:53 a.m. R38's facial hair remained. R38 stated she shaved it at home, "I always took care of myself. I wore make up, it was important to look nice."

On 4/18/18, at 7:26 a.m. R38 was up and dressed for the day. The facial hair had been removed.

On 4/18/18, at 8:16 a.m. R38's family member (FM)-A stated sometimes she waxed R38's chin hair and sometimes she shaved it. FM-A further stated previously R38 had always kept her facial hair removed, as it was important to R38.

On 4/18/18, at 8:23 a.m. nursing assistant (NA)-B stated she had shaved R38 that morning with her shower. NA-B stated she usually did R38's personal cares, and kept R38 shaved, but she had been off for a few days.

On 4/18/18, at 9:26 a.m. the director of nursing (DON) stated she would expect staff to remove R38's facial hair.

The facility's Quality of Life-Dignity policy dated 10/09, directed each resident would be cared for in a manner that promoted and enhanced quality of life, dignity, respect and individuality. The policy further indicated residents would be groomed as they wished to be groomed. This included facial hair.

R12's Admission Record printed 4/18/18,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 677	Continued From page 6	F 677		

indicated R12's diagnoses included dementia.

R12's quarterly MDS dated 2/12/18, indicated R12 had severely impaired cognitive skills for daily decision making, and required extensive assistance of one staff for personal hygiene.

R12's significant change MDS dated 11/22/17, indicated R12 had no oral cavity concerns.

R12's care plan initiated 1/2/18, indicated R12 had some broken teeth in fair condition, denied pain or difficulty chewing related to broken teeth, and declined a dental visit. R12's care plan directed staff to provide oral care in the morning and at bedtime and per resident request.

The AM and PM Care Guides indicated R12 had her own teeth, and required the assist of one staff for grooming.

On 4/16/18, at 3:42 p.m. R12 was observed lying in bed, and had a large amount of very thick white to light yellow phlegm in her mouth that was sticking to the roof of her mouth. R12 stated it bothered her, and she made mouth movements, swallowed hard, and had a difficult time talking with the phlegm in her mouth. R12 also had a white sticky coating on her bottom teeth, near the gums. After some time, R12 was able to clear the phlegm and was able to talk more clearly.

On 4/18/18, during continuous observations from 7:24 a.m. through 9:21 a.m. R12 was lying in bed. At 9:21 a.m. R12's incontinent brief was changed, and she was repositioned. R12 was not provided oral cares.

On 4/18/18, nursing assistant (NA)-A entered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 677	Continued From page 7 R12's room to do cares. NA-A washed R12's face, washed her body, changed her incontinent brief, and transferred R12 to the wheelchair. NA-A combed R12's hair, cleaned her glasses and put them on R12, and gave R12 a drink of water. NA-A did not provide oral cares for R12. NA-A then brought R12 to the dining room and served her toast, juice and milk. NA-A ate and drank independently. On 4/18/18, at 12:28 p.m. following lunch, R12 was brought to the tub room to use the toilet. R12 was not provided oral cares. On 4/18/18, at 12:42 p.m. NA-A stated she usually does oral cares when she gets R12 up in the morning, and verified she did not do oral cares on this date. NA-A then brought R12 to her sink, and set her up for oral cares. R12 brushed her teeth, and was cued to swish and spit. R12 stated, "Thank you" to NA-A following oral cares. NA-A stated R12 sometimes has thick phlegm in the mornings, and said it might be her medications that cause that. On 4/18/18, at 2:21 p.m. the director of nursing (DON) stated staff should provide oral cares in the morning. The facility's Mouth Care policy dated 2/16, indicated staff were to provide thorough mouth care assistance, but lacked direction for when mouth care should be provided.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		5/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 686	Continued From page 8 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure interventions were implemented to prevent the development and worsening of pressure ulcers for 2 of 2 residents (R12, R2) reviewed for pressure ulcers. Findings include: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed	F 686	Tissue tolerance for R12 and R2 will be completed by 5/10/18. All residents at risk for skin breakdown have the potential to be affected. Tissue tolerance evaluations and care plans will be reviewed for all residents at risk. All nursing staff will be reeducated on interventions and documentation of interventions regarding preventing development and worsening of pressure ulcers. HIM Director will audit with clinical managers to ensure care plans match worksheets, audits will be done weekly for four weeks, bi weekly for 2 months, monthly for 2 months, then report to QA for further review and recommendations. DON or designee will conduct audits for repositioning of residents who are on repositioning plans to ensure residents are being repositioned according to their care plan, audits will be done weekly for four weeks, bi weekly for 2 months, monthly for 2 months, then report to QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 686	Continued From page 9 dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an unstageable Pressure Injury.	F 686	for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 686	Continued From page 10	F 686		

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

R12's Admission Record printed 4/18/18, indicated R12's diagnoses included dementia, chronic kidney disease, and diabetes mellitus.

R12's quarterly Minimum Data Set (MDS) dated 2/12/18, indicated R12 had severely impaired cognitive skills for daily decision making. The MDS also indicated R12 required extensive assistance with bed mobility, transfers, toilet use, personal hygiene, and dressing. R12's MDS further indicated R12 was always incontinent of bowel and bladder, was at risk for pressure ulcers, and had no unhealed pressure ulcers.

R12's Care Area Assessments (CAAs) dated 11/22/17, indicated staff must anticipate R12's needs, and encourage participation. The CAAs also indicated R12 was at risk for skin breakdown related to bowel and bladder incontinence and required assistance with bed mobility. The CAA further indicated R12 had a previous unstageable pressure ulcer of the left heel, and continued with a discoloration of the left heel, and had an Allevyn heel (foam cup shaped dressing) in place, though she did have pressure ulcers at that time. R12's CAA indicated R12 required assistance of one staff for turning and repositioning every 1 hour, though R12 was noncompliant at times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 686	Continued From page 11	F 686		

R12's care plan 1/27/17, indicated R12 was at high risk for skin breakdown, and on 2/20/18, R12 had a Stage 2 pressure ulcer on the coccyx (tailbone), and required extensive assistance for bed mobility. R12's care plan directed staff R12 was to have heels elevated when in bed, an air mattress in bed, and a ROHO pressure relieving cushion (a cushion with individual air cells that distribute weight evenly to relieve pressure) in the wheelchair, and reposition every one hour. Nursing was to reapproach R12 and educate on the importance of repositioning when she refused. Treatments to the pressure ulcers were to be completed per physician orders.

R12's nursing assistant care guide sheet dated 4/17/18, directed staff to reposition R12 every one hour, always elevate heels off the bed, and R12 required assistance of one for bed mobility.

R12's physician Order Summary Report included orders for a protective foam dressing to the coccyx, skin prep and Allevyn heel to the left heel, a ROHO cushion, an air mattress, and document pressure injury to coccyx every dressing change.

R12's Tissue Tolerance Observation (a tool used to help determine the ability of the skin and tissues to endure the effects of pressure with out adverse effects) for lying dated 3/6/17, was not completed. R12's Tissue Tolerance Observation for sitting dated 4/14/17, indicated R12 tolerated sitting in one position for 2 hours without redness over bony prominences.

R12's Braden Scale (a tool used to assist in determining an individual's risk for skin breakdown) dated 2/9/18, indicated R12 was at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 686	Continued From page 12	F 686		

high risk for skin breakdown.

R12's Weekly Wound Evaluation dated 2/6/18, indicated R12 had an unstageable left heel pressure ulcer that was initially identified on 7/6/17, and measured 1.5 centimeters (cm) x 1 cm. R12's pressure ulcer was described as a slightly discolored light purple area on the back of the heel that was intact.

R12's Weekly Wound Evaluation dated 2/23/18, indicated R12 had a Stage 2 pressure ulcer on the coccyx that was identified on 2/19/18, and measured 0.5 cm x 0.7 cm, was superficial, and was 100% granulation tissue (new tissue on the surface of the wound).

R12's Weekly Wound Evaluation dated 3/6/18, indicated R12's coccyx pressure ulcer was intact with pink fragile tissue. Protective foam dressing treatment continued.

R12's Weekly Wound Evaluation dated 4/12/18, indicated R12's coccyx was intact with no signs of skin impairment and R12's heels were pink, firm and intact with dry skin.

On 4/18/18, at 7:24 a.m. R12 was lying quietly on her back in her bed. During continuous observations from 7:24 a.m. until 9:21 a.m. (one hour and 57 minutes) R12 remained in the same position, and staff had not repositioned or offered to reposition R12.

On 4/18/18, at 9:21 a.m. nursing assistant (NA)-A entered R12's room. NA-A stated she had last changed R12's incontinent brief at about 6:30 a.m. NA-A stated if R12 was at all resistive, they would leave her alone. NA-A stated she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 686	Continued From page 13	F 686		

going to reposition R12 at this time, and get her up after her break. NA-A checked R12's brief and stated it needed to be changed. NA-A left the room to get the registered nurse (RN) to check R12's coccyx. R12's heels were elevated and she had thin foam heel protectors on, and was lying on the air mattress. NA-A verified R12 should be repositioned every hour. When the director of nursing (DON) entered the room, R12 was turned to the right, and had intact skin without reddened areas. R12's foam heel protectors were reapplied with gripper socks on over them, her feet elevated on pillows, and she was positioned for comfort.

On 4/18/18, at 10:12 a.m. the DON stated R12 was to be repositioned every hour and her expectation was staff was to follow the care plan.

On 4/18/18, at 10:13 a.m. NA-A and licensed practical nurse (LPN)-A entered R12's room to complete daily cares, dressing, and grooming, and transferred R12 to the wheelchair with the ROHO cushion in place. NA-A stated the rest of the day, R12 would be repositioned by standing her in the bathroom at the rail. R12 was brought to the dining room and given toast, milk and juice. During continuous observations, R12 remained in her wheelchair in the dining room through lunch. At 12:28 p.m. (two hours and 15 minutes) R12 was brought to the tub room to stand and reposition.

On 4/18/18, at 12:30 p.m. R12 was stood with the assist of two staff at the hand rail in the bathroom, but she was unable to stand long, so was assisted to stand with the stand lift and transferred to the toilet. R12 had no increased redness to the coccyx. NA-A stated they have a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 686	Continued From page 14	F 686		

two hour time frame between meals to reposition residents, and said she could not get R12 to the toilet since she was eating. NA-A stated they communicate positioning times to other staff by writing on a log in the tubroom. NA-A verified she had not written the repositioning times down for R12.

On 4/18/18, at 2:21 p.m. the DON stated staff should tell their partner when they go to lunch, so residents could be repositioned on time.

On 4/18/18, at 2:52 p.m. the DON stated it is their protocol to reposition residents with open areas every one hour. The DON stated they decided to keep R12 on an every one hour repositioning plan though her pressure ulcer had healed. The DON stated they do a Braden assessment quarterly (to assess risk for skin breakdown) and a Tissue Tolerance Test annually, unless there is a change in mobility, or the resident develops a pressure ulcer. The DON verified they did not do a new Tissue Tolerance for R12 with she had a new pressure ulcer.

The facility policy and procedure for the Prevention of Pressure Ulcers revised 9/13, indicated pressure ulcers usually develop when a resident remains in the same position for an extended period of time, and directed staff to change the position of a resident in bed at least every two hours, and at least every hour when in a chair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 686	Continued From page 15	F 686		

R2's Admission Record printed 4/19/18, indicated diagnoses that included diabetes, chronic diastolic congestive heart failure, and adult failure to thrive.

R2's quarterly MDS dated 1/25/18, indicated R2 had moderate cognitive impairment, was at risk of pressure ulcer development, and had unhealed pressure ulcers. The MDS further indicated R2 had a pressure reducing device in her wheelchair and bed, was on a turning and repositioning schedule, had nutrition or hydration to manage pressure ulcers, and had received pressure ulcer cares.

R2's CAA dated 8/17/17, indicated R2 returned from a hospital stay with unstageable pressure ulcers to bilateral heels. The CAA indicated R2's right heel had a 2.0 centimeter (cm) x 1.3 cm black ulcer, and the left heel had a 3.0 cm x 2 cm purple blister. The CAA indicated further skin concerns that included an unstageable pressure ulcer to R2's coccyx area prior to the hospitalization. The CAA indicated R2's tissue tolerance revealed R2 was to be repositioned every 1 hour, have heels elevated off the bed, a ROHO cushion in her wheelchair, and Juven (a nutritional supplement) twice daily to promote wound healing. The CAA indicated R2 needed an assist of one for bed mobility and turning, repositioning, and boosting in bed.

R2's care plan initiated 8/16/17, indicated R2 had an alteration in mobility, with interventions that included no pressure to heels due to wounds. R2's care plan initiated 8/16/17, indicated R2 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 686	Continued From page 16	F 686		

alterations in skin integrity, and was being seen at a wound clinic for bilateral unstageable heel ulcers, and an unstageable pressure ulcer on her buttocks. Interventions included no pressure over the heels, float heels off bed with pillows, pressure reduction mattress, repositioning every one hour, wound care per physician order, monitor skin integrity daily during cares, weekly skin audit/evaluation by nurse on bath days, and weekly measurements and assessment of wounds. R2's care plan dated 3/19/18, indicated the implementation of a concave mattress with cut-outs due to R2's recent falls out of bed on 3/16/18, and 3/19/18.

R2's Clinical Physician Orders printed 4/19/18, indicated active orders for documentation of compliance with hourly repositioning, check settings on R2's alternating air pressure mattress to ensure that it matched weigh every shift, and no pressure over heels; float heels off bed with pillows.

R2's nursing assistant care guide sheet directed ROHO cushion in wheelchair, air mattress on bed, no sitting in chair or lying on back for more than one hour, and to reposition side to side every hour. The care guide sheet also directed to elevate heels off of bed at water pass.

On 4/16/18, at 1:54 p.m. R2 was observed lying on her back in bed, with a pillow under her knees, and both heels lying directly on the bed. R2 was wearing grippy socks, and had no boots or other device to protect her heels from the pressure of being on the mattress. R2's mattress was a concave mattress with cut outs.

On 4/19/18, during continuous observations from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 686	Continued From page 17	F 686		

8:07 a.m. until 8:27 a.m. R2 was observed lying on her back in bed with her heels lying directly on the mattress, and a pillow under her knees.

On 4/19/18, at 8:27 a.m. NA-C confirmed R2's heels were directly on the mattress.

On 4/19/18, at 11:15 a.m. RN-C was observed to provide daily wound care to R2's heels. RN-C described R2's left heel wound as nearly healed, with a small scabbed area with a dry, larger area surrounding it that measured 1.2 centimeters (cm) x 0.7 cm. RN-C measured R2's right heel at 1.5 cm in length and 2.0 cm in width. RN-C stated depth could not be measured on R2's right heel because there was eschar (dead tissue) covering the area. RN-C stated it was an unstageable pressure ulcer.

On 4/19/18, at 11:48 a.m. RN-C stated R2 refused to wear heel protecting boots when they offered them as an intervention to reduce pressure on her heels. RN-C stated R2 had been seen by the wound clinic since 9/6/17, and they had been treating pressure ulcers on her buttocks and her heels. RN-C stated the pressure ulcer on R2's coccyx had healed, and her heels were much improved. RN-C also stated R2 liked to move her feet and didn't like to float her heels. RN-C stated she would expect staff to document when R2 refused to float her heels. RN-C also verified the following: R2's electronic record lacked documentation of R2's refusals to float her heels, or when they found that R2 had moved her pillow so that her heels were no longer floated; R2's group sheet, which indicated R2 was to be repositioned hourly and had an alternating air pressure mattress, was not current and she did not know when those interventions had ended;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 686	Continued From page 18 R2's Treatment Administration Record (TAR) printed 4/19/18, directed staff to check the setting on R2's mattress to ensure that it matched weight every day shift. Staff had indicated on their TAR documentation that this treatment was completed, even though R2 no longer had an alternating air pressure mattress. RN-C confirmed the documentation could not be accurate as there was not an alternating air pressure mattress on R2's bed; R2's TAR also indicated staff were to document compliance with hourly repositioning. Staff were indicating attempts at administration, but this was not R2's current intervention; R2 was at risk of pressure ulcer development, even more at risk without an air mattress. On 4/19/18, at 1:43 p.m. the director of nursing (DON) stated she expected the group sheet to be updated, R2's refusals to float heels to be documented, and a risk-versus-benefit of intervention refusals to be explained to R2. The facility policy Prevention of Pressure Ulcers revised 9/13, directed when in bed every attempt should be made to "float heels" by placing a pillow from knee to ankle or with other devices as recommended by clinical staff or by the physician.	F 686		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		5/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 880	Continued From page 19 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 880	Continued From page 20 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure gloves were worn and hand hygiene was maintained for 1 of 2 residents (R34) observed during insulin administration. In addition, the facility failed to ensure hygiene was maintained during personal cares for 2 of 5 residents (R12, R2) observed during cares. Findings include: R34's Diagnoses Report dated 4/19/18, indicated diagnoses that included type two diabetes. R34's Order Summary Report dated 4/19/18, included Basaglar (glargine insulin) 32 units subcutaneously at bedtime for diabetes. On 4/16/18, at 6:12 p.m. R34's insulin	F 880	Staff that were involved were educated at the time of the concern. All residents have the potential to be affected by the deficient practice of inadequate hand hygiene and not wearing gloves during tasks that involve body fluids. All nurses will be reeducated on use of gloves with injections and all staff will be re- educated and take a course on hand hygiene by 5/31/18. DON or designee will complete handwashing audits and injection audits for proper procedure weekly for four weeks, bi weekly for 2 months, monthly for 2 months, then report to QA for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 880	Continued From page 21	F 880		

administration was observed with licensed practical nurse (LPN)-B. LPN-B approached R34, and with ungloved hands. LPN-B injected the insulin pen into the right side of R34's abdomen. LPN-B exited R34's room, removed the needle from the insulin pen, and placed it into the Sharps container. LPN-B took keys from her pocket, opened the medication cart, and put the insulin pen into the medication cart. LPN-B did not perform hand hygiene after insulin administration.

On 4/16/18, at 6:20 p.m. LPN-B stated she did not know if she was suppose to wear gloves during insulin administration. LPN-B verified she had not performed hand hygiene after administering the insulin.

On 4/19/18, at 10:02 a.m. the assistant director of nursing (ADON) verified staff should be wearing gloves when injecting insulin, and they should perform hand hygiene prior to exiting a resident's room after injecting insulin. The ADON stated, "They have all been trained."

The facility's Hand Washing policy dated 1/08, directed hand washing was generally considered the most important single procedure in preventing healthcare associated infections. The policy directed hand hygiene be completed before and after direct contact with the resident.

The facility's Subcutaneous Injections policy dated 12/16, directed staff to wash hands and put on gloves.

R12's Admission Record dated 4/18/18, indicated R12's diagnoses included dementia, chronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 880	Continued From page 22	F 880		

kidney disease, history of a urinary tract infection, and diabetes mellitus.

R12's quarterly Minimum Data Set (MDS) assessment dated 2/12/18, indicated R12's cognitive skills for daily decision making were severely impaired, and R12 required extensive assistance of one staff for toilet use, personal hygiene and dressing. R12's MDS further indicated R12 was always incontinent of bowel and bladder.

R12's care plan dated 1/27/18, indicated R12 was frequently incontinent, and required the assist of two staff to toilet.

On 4/18/18, at 12:30 p.m. nursing assistant (NA)-A and NA-D brought R12 into the tubroom to stand at the handrail. R12 began to void when she was stood with the stand assist lift, and she was transferred to the toilet. NA-A put on gloves, sanitized the stand assist lift, removed the soiled gloves and put on clean gloves without performing hand hygiene. NA-A cleansed R12's perineal area, removed her soiled gloves, and did not perform hand hygiene. NA-A and NA-D changed R12's incontinent brief. NA-A and NA-D transferred R12 to her wheelchair with the stand assist lift. NA-A moved the stand assist lift, opened the tubroom door, and pushed R12's wheelchair out of the room with her unwashed hands on the handle bars, and began down the hall. NA-A verified she should have washed her hands right away after removing her gloves. NA-A then opened the dirty utility room, washed her hands in the dirty utility room sink, and went back to R12's wheelchair. NA-A put her hands on the same handle bars, and pushed the wheelchair down the hall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 880	Continued From page 23 On 4/18/18, at 2:21 p.m. the director of nursing (DON) stated staff should wash hands before gloving and doing cares, and wash or sanitize after removing gloves. On 4/19/18, at 1:21 p.m. RN-C stated she does training on hand hygiene at orientation, and it is done annually with the online training. The facility policy and procedure for Using Gloves dated 1/08, directed staff to wash hands after removing gloves. R2's Admission Record printed 4/19/18, indicated diagnoses that included diabetes, chronic diastolic congestive heart failure, and adult failure to thrive. R2's quarterly MDS dated 1/25/18, indicated R2 had moderate cognitive impairment, and required extensive assistant with dressing, personal	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 880	Continued From page 24 hygiene, and toileting. R2's care plan initiated 8/16/17, directed staff to provide assistance with pericares in the morning, at bedtime and as needed. The care plan also directed staff to provide incontinent products, assist to change as needed, and to monitor bowel movements as they occur. On 4/19/18, at 8:27 a.m. nursing assistant (NA)-C was observed to enter R2's room to assist her into the bathroom to use the toilet and perform morning cares. NA-C washed her hands and donned gloves before assisting R2 to the bathroom and onto the toilet. NA-C assisted R2 with washing her face, her under arms and under her breast. At 8:41 a.m. R2 asked if she should stand up from the toilet so that NA-C could, "Clean her bottom" as R2 had had a bowel movement. After wiping R2's bottom, NA-C removed her soiled gloves and donned clean gloves without performing hand hygiene. NA-C pulled up R2's pants, and assisted R2 into her wheelchair. NA-C then performed hand hygiene. On 4/19/18, at 8:56 a.m. NA-C stated she did not think she washed or sanitized her hands in between glove changes after cleaning R2's bottom. On 4/19/18, at 12:06 p.m. RN-C confirmed hand hygiene should occur when gloves were removed. On 4/1/18, at 1:43 p.m. the DON confirmed hand hygiene should occur when gloves were removed.	F 880		
F 883	Influenza and Pneumococcal Immunizations	F 883		5/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 883 SS=D	Continued From page 25 CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 883	Continued From page 26 immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide education and document consent or refusal of the pneumococcal polysaccharide vaccine (PPSV23), the pneumococcal conjugate vaccine (PCV13), and influenza vaccine for 1 of 5 residents (R52) reviewed for immunizations. Findings include: R52's Admission Record printed 4/20/18, indicated R52's diagnoses included pneumonia, and acute respiratory failure with hypoxia (low oxygen levels). R52's Admission Record further indicated R52 was over the age of 65. On 4/19/18, at 1:55 p.m. registered nurse (RN)-C verified all new admissions were assessed within five days of admission for their vaccination status, and would be offered the vaccines (if needed). RN-C stated a physician's order would be	F 883	Vaccine form completed for resident 5/7/18. All residents have the potential to be affected. All current and new resident□s medical records will be reviewed to ensure vaccine education and consent was documented. All nurses will be re-educated on offering resident vaccines, documenting consent or refusal, and providing/documenting education of vaccines by 5/31/18. DON or designee will audit new admissions for proper documentation weekly for four weeks, bi weekly for 2 months, monthly for 2 months, then report to QA for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 883	Continued From page 27 obtained, and the resident or representative would receive education regarding the vaccines, according to the facility policy. R52's medical record lacked documentation of education, if offered the vaccines, and consent or refusal of the vaccines. The facility Pneumococcal policy revised 11/17, directed all new admissions were to be assessed within five days of admission for their vaccination status, the would be offered the vaccine, a physician's order would be obtained, and the resident or representative would receive the education regarding the vaccines. The pneumococcal vaccination would be administered per the MD order and CDC recommendations. The CDC Pneumococcal Vaccine Timing for Adults guideline dated 11/15, was used by the facility to determine appropriate vaccines to be offered to residents. The guideline recommended for residents over the age of 65 who have not had either pneumococcal vaccine should receive the PCV13 and a dose of PPSV23 at least one year later. The facility policy for Influenza and Influenza-Like Illness dated 11/17, directed between October 1 and March 31, each year, the influenza vaccine would be offered to the residents and staff, and upon admission during that time. The policy further directed residents would be provided the education upon admission and annually, consent would be obtained, and the education and the resident's refusal would be documented in the medical record.	F 883		
F 921	Safe/Functional/Sanitary/Comfortable Environ	F 921		5/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 921 SS=D	Continued From page 28 CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions 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 wheelchair arms were in good repair for 2 of 3 residents (R18, R41) whose wheelchairs were reviewed. Findings include: R18's Admission Record printed 4/19/18, indicated diagnoses that included hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following a stroke. R18's annual Minimum Data Set (MDS) dated 3/1/18, indicated R18 did not walk during the assessment period, had impairment on one side of his body, and used a walker and a wheelchair for ambulation. R18's care plan dated 7/10/17, indicated R18 had an alteration in mobility, and independently used a wheelchair for locomotion in the facility. On 4/16/18, at 2:44 p.m. the vinyl arms on R18's wheelchair arms were observed to be cracked which created an unsanitary surface. R41's Admission Record printed 4/19/18, indicated diagnoses that included multiple sclerosis. R41's quarterly MDS dated 3/21/18, indicated	F 921	Both wheelchairs have been repaired. All residents who require wheelchair for mobility have the potential to be affected. All wheelchairs in facility will be inspected for damage and repaired if needed. This will be completed by 5/31/18 A new preventative maintenance procedure will be in place by 6/1/18 to ensure all resident□s wheelchairs are inspected routinely. Maintenance director or designee will audit all wheelchairs in facility by 5/17/18. Maintenance director or designee will conduct random audits of wheelchairs for damage weekly for four weeks, bi weekly for 2 months, monthly for 2 months, then report to QA for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 921	Continued From page 29 R41 was not stable with transfers unless assisted by another person, had not walked in the assessment period, and used a walker and a wheelchair for assistive devices. R41's care plan dated 1/30/18, indicated R41 had an alteration in mobility, and was independent with locomtion in his wheelchair for short distances. On 4/16/18, at 3:08 p.m. vinyl arms on R41's wheelchair arms were observed to be cracked which created an unsanitary surface. On 4/19/18, at 10:48 a.m. the environmental services director (ESD) confirmed R18's and R41's wheelchair arms were cracked and open, which created an unsanitary surface, and stated they needed to be replaced. On 4/19/18, at 10:48 a.m. the ESD stated he had a schedule for monthly wheelchair cleaning, which was the responsibility of the afternoon housekeepers. The ESD confirmed the monthly wheelchair cleaning form did not direct staff to look at condition of the wheelchair. A policy on wheelchair maintenance was requested but not received from the facility.	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/18/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	**7700 GRAND AVENUE** **DULUTH, MN 55807**

(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 FIRE SAFETY 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The North Shore Estates 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/11/2018

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
	245483	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/18/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	**7700 GRAND AVENUE** **DULUTH, MN 55807**

(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	K 000		

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
445 MINNESOTA STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

By e-mail to both:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

The North Shore Estates is a 2-story building with a full basement. The building was constructed at 2 different times. The original building was constructed in 1971 with an addition in 2005. Both buildings are type II (111) construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one building, the 2005 building is support services only.

The building is fully sprinkler protected, by a complete automatic fire sprinkler system. The facility has a complete fire alarm system with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/18/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	**7700 GRAND AVENUE** **DULUTH, MN 55807**

(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 2 smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 70 beds and had a census of 56 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		5/14/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/18/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	**7700 GRAND AVENUE** **DULUTH, MN 55807**

(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 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility has failed to ensure that the semi-annual inspections of the kitchen hood ventilation and fire suppression system protecting the cooking appliances have been completed. NFPA 96 (11), states that for moderate-volume cooking operations, the hood system and components shall be inspected and maintained semiannually by a properly trained, qualified, and certified company or person. This deficient practice could affect the residents as well as an undetermined number of staff, and visitors to the facility. Findings Include: On facility tour between 10:30 a.m. to 2:30 p.m. on 04/18/2018, during the review of all available documentation for the kitchen hood ventilation and fire suppression system inspection reports, and interview with the Maintenance Supervisor, the facility could not provide 1 of 2 service reports showing that the kitchen hood ventilation and fire suppression system has been professionally inspected within the last 12 month time period. This deficient condition was verified by the Maintenance Supervisor.	K 324	The North Shore Estates has the kitchen hood ventilation and fire suppression system inspection scheduled for 4/14/2018. All Inspections will be scheduled 6 months later than the previous inspection in order to stay in compliance by inspecting and maintaining kitchen hood ventilation and fire suppresion systems semiannually. The director of Maintenance will be responsible for ensuring this is met.	

Electronically delivered
May 2, 2018

Mr. Justin Teal, Administrator
The North Shore Estates Llc
7700 Grand Avenue
Duluth, MN 55807

Re: State Nursing Home Licensing Orders - Project Number S5483027

Dear Mr. Teal:

The above facility was surveyed on April 16, 2018 through April 19, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Teresa Ament, Unit Supervisor at (218) 302-6151 or teresa.ament@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please 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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 4/16/18 through 4/19/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure facial hair was removed for 1 of 2 residents (R38) reviewed for activities of daily living (ADL). Findings include: R38's Diagnosis Report printed 4/18/18, indicated diagnoses that included dementia without behavioral disturbance. R38's quarterly Minimum Data Set (MDS) dated 3/21/18, indicated R38 had moderately impaired cognition, and required extensive assistance of one staff with personal hygiene. R38's Initial/Comprehensive care plan dated 3/2/18, indicated R38 required extensive assistance of one staff with grooming. The AM and PM Care Guides (nursing assistant	2 850	Corrected	5/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 850	Continued From page 3 care guides) dated 4/17/18, directed to ensure all male and female residents' facial hair was shaved. On 4/16/18, at 6:53 p.m. R38 was observed to have a line of black and gray hair approximately one half inch long along the bottom edge of her chin, and at the corners of her mouth. On 4/17/18, at 9:53 a.m. R38's facial hair remained. R38 stated she shaved it at home, "I always took care of myself. I wore make up, it was important to look nice." On 4/18/18, at 7:26 a.m. R38 was up and dressed for the day. The facial hair had been removed. On 4/18/18, at 8:16 a.m. R38's family member (FM)-A stated sometimes she waxed R38's chin hair and sometimes she shaved it. FM-A further stated previously R38 had always kept her facial hair removed, as it was important to R38. On 4/18/18, at 8:23 a.m. nursing assistant (NA)-B stated she had shaved R38 that morning with her shower. NA-B stated she usually did R38's personal cares, and kept R38 shaved, but she had been off for a few days. On 4/18/18, at 9:26 a.m. the director of nursing (DON) stated she would expect staff to remove R38's facial hair. The facility's Quality of Life-Dignity policy dated 10/09, directed each resident would be cared for in a manner that promoted and enhanced quality of life, dignity, respect and individuality. The policy further indicated residents would be groomed as they wished to be groomed. This included facial	2 850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 850	Continued From page 4 hair. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure all residents are shaved per their preference. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 850		
2 855	MN Rule 4658.0520 Subp. 2 E. Adequate and Proper Nursing Care;Oral Hygiene Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. Assistance as needed with oral hygiene to keep the mouth, teeth, or dentures clean. Measures must be used to prevent dry, cracked lips This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oral care was provided for 1 of 2 residents (R12) reviewed for activities of daily living (ADL). Findings include: R12's Admission Record printed 4/18/18, indicated R12's diagnoses included dementia. R12's quarterly MDS dated 2/12/18, indicated	2 855	Corrected	5/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 855	Continued From page 5	2 855		

R12 had severely impaired cognitive skills for daily decision making, and required extensive assistance of one staff for personal hygiene.

R12's significant change MDS dated 11/22/17, indicated R12 had no oral cavity concerns.

R12's care plan initiated 1/2/18, indicated R12 had some broken teeth in fair condition, denied pain or difficulty chewing related to broken teeth, and declined a dental visit. R12's care plan directed staff to provide oral care in the morning and at bedtime and per resident request.

The AM and PM Care Guides indicated R12 had her own teeth, and required the assist of one staff for grooming.

On 4/16/18, at 3:42 p.m. R12 was observed lying in bed, and had a large amount of very thick white to light yellow phlegm in her mouth that was sticking to the roof of her mouth. R12 stated it bothered her, and she made mouth movements, swallowed hard, and had a difficult time talking with the phlegm in her mouth. R12 also had a white sticky coating on her bottom teeth, near the gums. After some time, R12 was able to clear the phlegm and was able to talk more clearly.

On 4/18/18, during continuous observations from 7:24 a.m. through 9:21 a.m. R12 was lying in bed. At 9:21 a.m. R12's incontinent brief was changed, and she was repositioned. R12 was not provided oral cares.

On 4/18/18, nursing assistant (NA)-A entered R12's room to do cares. NA-A washed R12's face, washed her body, changed her incontinent brief, and transferred R12 to the wheelchair. NA-A combed R12's hair, cleaned her glasses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 855	Continued From page 6	2 855		

and put them on R12, and gave R12 a drink of water. NA-A did not provide oral cares for R12. NA-A then brought R12 to the dining room and served her toast, juice and milk. NA-A ate and drank independently.

On 4/18/18, at 12:28 p.m. following lunch, R12 was brought to the tub room to use the toilet. R12 was not provided oral cares.

On 4/18/18, at 12:42 p.m. NA-A stated she usually does oral cares when she gets R12 up in the morning, and verified she did not do oral cares on this date. NA-A then brought R12 to her sink, and set her up for oral cares. R12 brushed her teeth, and was cued to swish and spit. R12 stated, "Thank you" to NA-A following oral cares. NA-A stated R12 sometimes has thick phlegm in the mornings, and said it might be her medications that cause that.

On 4/18/18, at 2:21 p.m. the director of nursing (DON) stated staff should provide oral cares in the morning.

The facility's Mouth Care policy dated 2/16, indicated staff were to provide thorough mouth care assistance, but lacked direction for when mouth care should be provided.

SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure all residents are provided oral care. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures.

TIME PERIOD FOR CORRECTION: Twenty one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 855	Continued From page 7 (21) days.	2 855		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure interventions were implemented to prevent the development and worsening of pressure ulcers for 2 of 2 residents (R12, R2) reviewed for pressure ulcers. Findings include: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable	2 900	Corrected	5/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 900	Continued From page 8	2 900		

erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury: Full-thickness skin and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 900	Continued From page 9 tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. R12's Admission Record printed 4/18/18, indicated R12's diagnoses included dementia, chronic kidney disease, and diabetes mellitus. R12's quarterly Minimum Data Set (MDS) dated 2/12/18, indicated R12 had severely impaired cognitive skills for daily decision making. The MDS also indicated R12 required extensive assistance with bed mobility, transfers, toilet use, personal hygiene, and dressing. R12's MDS further indicated R12 was always incontinent of bowel and bladder, was at risk for pressure ulcers, and had no unhealed pressure ulcers. R12's Care Area Assessments (CAAs) dated 11/22/17, indicated staff must anticipate R12's needs, and encourage participation. The CAAs also indicated R12 was at risk for skin breakdown related to bowel and bladder incontinence and	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 900	Continued From page 10	2 900		

required assistance with bed mobility. The CAA further indicated R12 had a previous unstageable pressure ulcer of the left heel, and continued with a discoloration of the left heel, and had an Allevyn heel (foam cup shaped dressing) in place, though she did have pressure ulcers at that time. R12's CAA indicated R12 required assistance of one staff for turning and repositioning every 1 hour, though R12 was noncompliant at times.

R12's care plan 1/27/17, indicated R12 was at high risk for skin breakdown, and on 2/20/18, R12 had a Stage 2 pressure ulcer on the coccyx (tailbone), and required extensive assistance for bed mobility. R12's care plan directed staff R12 was to have heels elevated when in bed, an air mattress in bed, and a ROHO pressure relieving cushion (a cushion with individual air cells that distribute weight evenly to relieve pressure) in the wheelchair, and reposition every one hour. Nursing was to reapproach R12 and educate on the importance of repositioning when she refused. Treatments to the pressure ulcers were to be completed per physician orders.

R12's nursing assistant care guide sheet dated 4/17/18, directed staff to reposition R12 every one hour, always elevate heels off the bed, and R12 required assistance of one for bed mobility.

R12's physician Order Summary Report included orders for a protective foam dressing to the coccyx, skin prep and Allevyn heel to the left heel, a ROHO cushion, an air mattress, and document pressure injury to coccyx every dressing change.

R12's Tissue Tolerance Observation (a tool used to help determine the ability of the skin and tissues to endure the effects of pressure with out adverse effects) for lying dated 3/6/17, was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 900	Continued From page 11	2 900		

completed. R12's Tissue Tolerance Observation for sitting dated 4/14/17, indicated R12 tolerated sitting in one position for 2 hours without redness over bony prominences.

R12's Braden Scale (a tool used to assist in determining an individual's risk for skin breakdown) dated 2/9/18, indicated R12 was at high risk for skin breakdown.

R12's Weekly Wound Evaluation dated 2/6/18, indicated R12 had an unstageable left heel pressure ulcer that was initially identified on 7/6/17, and measured 1.5 centimeters (cm) x 1 cm. R12's pressure ulcer was described as a slightly discolored light purple area on the back of the heel that was intact.

R12's Weekly Wound Evaluation dated 2/23/18, indicated R12 had a Stage 2 pressure ulcer on the coccyx that was identified on 2/19/18, and measured 0.5 cm x 0.7 cm, was superficial, and was 100% granulation tissue (new tissue on the surface of the wound).

R12's Weekly Wound Evaluation dated 3/6/18, indicated R12's coccyx pressure ulcer was intact with pink fragile tissue. Protective foam dressing treatment continued.

R12's Weekly Wound Evaluation dated 4/12/18, indicated R12's coccyx was intact with no signs of skin impairment and R12's heels were pink, firm and intact with dry skin.

On 4/18/18, at 7:24 a.m. R12 was lying quietly on her back in her bed. During continuous observations from 7:24 a.m. until 9:21 a.m. (one hour and 57 minutes) R12 remained in the same position, and staff had not repositioned or offered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 900	Continued From page 12 to reposition R12. On 4/18/18, at 9:21 a.m. nursing assistant (NA)-A entered R12's room. NA-A stated she had last changed R12's incontinent brief at about 6:30 a.m. NA-A stated if R12 was at all resistive, they would leave her alone. NA-A stated she was going to reposition R12 at this time, and get her up after her break. NA-A checked R12's brief and stated it needed to be changed. NA-A left the room to get the registered nurse (RN) to check R12's coccyx. R12's heels were elevated and she had thin foam heel protectors on, and was lying on the air mattress. NA-A verified R12 should be repositioned every hour. When the director of nursing (DON) entered the room, R12 was turned to the right, and had intact skin without reddened areas. R12's foam heel protectors were reapplied with gripper socks on over them, her feet elevated on pillows, and she was positioned for comfort. On 4/18/18, at 10:12 a.m. the DON stated R12 was to be repositioned every hour and her expectation was staff was to follow the care plan. On 4/18/18, at 10:13 a.m. NA-A and licensed practical nurse (LPN)-A entered R12's room to complete daily cares, dressing, and grooming, and transferred R12 to the wheelchair with the ROHO cushion in place. NA-A stated the rest of the day, R12 would be repositioned by standing her in the bathroom at the rail. R12 was brought to the dining room and given toast, milk and juice. During continuous observations, R12 remained in her wheelchair in the dining room through lunch. At 12:28 p.m. (two hours and 15 minutes) R12 was brought to the tub room to stand and reposition.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 900	Continued From page 13 On 4/18/18, at 12:30 p.m. R12 was stood with the assist of two staff at the hand rail in the bathroom, but she was unable to stand long, so was assisted to stand with the stand lift and transferred to the toilet. R12 had no increased redness to the coccyx. NA-A stated they have a two hour time frame between meals to reposition residents, and said she could not get R12 to the toilet since she was eating. NA-A stated they communicate positioning times to other staff by writing on a log in the tubroom. NA-A verified she had not written the repositioning times down for R12. On 4/18/18, at 2:21 p.m. the DON stated staff should tell their partner when they go to lunch, so residents could be repositioned on time. On 4/18/18, at 2:52 p.m. the DON stated it is their protocol to reposition residents with open areas every one hour. The DON stated they decided to keep R12 on an every one hour repositioning plan though her pressure ulcer had healed. The DON stated they do a Braden assessment quarterly (to assess risk for skin breakdown) and a Tissue Tolerance Test annually, unless there is a change in mobility, or the resident develops a pressure ulcer. The DON verified they did not do a new Tissue Tolerance for R12 with she had a new pressure ulcer. The facility policy and procedure for the Prevention of Pressure Ulcers revised 9/13, indicated pressure ulcers usually develop when a resident remains in the same position for an extended period of time, and directed staff to change the position of a resident in bed at least every two hours, and at least every hour when in a chair.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 900	Continued From page 14 R2's Admission Record printed 4/19/18, indicated diagnoses that included diabetes, chronic diastolic congestive heart failure, and adult failure to thrive. R2's quarterly MDS dated 1/25/18, indicated R2 had moderate cognitive impairment, was at risk of pressure ulcer development, and had unhealed pressure ulcers. The MDS further indicated R2 had a pressure reducing device in her wheelchair and bed, was on a turning and repositioning schedule, had nutrition or hydration to manage pressure ulcers, and had received pressure ulcer cares. R2's CAA dated 8/17/17, indicated R2 returned from a hospital stay with unstageable pressure ulcers to bilateral heels. The CAA indicated R2's right heel had a 2.0 centimeter (cm) x 1.3 cm black ulcer, and the left heel had a 3.0 cm x 2 cm purple blister. The CAA indicated further skin concerns that included an unstageable pressure ulcer to R2's coccyx area prior to the hospitalization. The CAA indicated R2's tissue tolerance revealed R2 was to be repositioned every 1 hour, have heels elevated off the bed, a ROHO cushion in her wheelchair, and Juven (a nutritional supplement) twice daily to promote wound healing. The CAA indicated R2 needed an assist of one for bed mobility and turning, repositioning, and boosting in bed. R2's care plan initiated 8/16/17, indicated R2 had an alteration in mobility, with interventions that included no pressure to heels due to wounds. R2's care plan initiated 8/16/17, indicated R2 had alterations in skin integrity, and was being seen at a wound clinic for bilateral unstageable heel ulcers, and an unstageable pressure ulcer on her buttocks. Interventions included no pressure over	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 900	Continued From page 15	2 900		

the heels, float heels off bed with pillows, pressure reduction mattress, repositioning every one hour, wound care per physician order, monitor skin integrity daily during cares, weekly skin audit/evaluation by nurse on bath days, and weekly measurements and assessment of wounds. R2's care plan dated 3/19/18, indicated the implementation of a concave mattress with cut-outs due to R2's recent falls out of bed on 3/16/18, and 3/19/18.

R2's Clinical Physician Orders printed 4/19/18, indicated active orders for documentation of compliance with hourly repositioning, check settings on R2's alternating air pressure mattress to ensure that it matched weigh every shift, and no pressure over heels; float heels off bed with pillows.

R2's nursing assistant care guide sheet directed ROHO cushion in wheelchair, air mattress on bed, no sitting in chair or lying on back for more than one hour, and to reposition side to side every hour. The care guide sheet also directed to elevate heels off of bed at water pass.

On 4/16/18, at 1:54 p.m. R2 was observed lying on her back in bed, with a pillow under her knees, and both heels lying directly on the bed. R2 was wearing grippy socks, and had no boots or other device to protect her heels from the pressure of being on the mattress. R2's mattress was a concave mattress with cut outs.

On 4/19/18, during continuous observations from 8:07 a.m. until 8:27 a.m. R2 was observed lying on her back in bed with her heels lying directly on the mattress, and a pillow under her knees.

On 4/19/18, at 8:27 a.m. NA-C confirmed R2's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 900	Continued From page 16 heels were directly on the mattress. On 4/19/18, at 11:15 a.m. RN-C was observed to provide daily wound care to R2's heels. RN-C described R2's left heel wound as nearly healed, with a small scabbed area with a dry, larger area surrounding it that measured 1.2 centimeters (cm) x 0.7 cm. RN-C measured R2's right heel at 1.5 cm in length and 2.0 cm in width. RN-C stated depth could not be measured on R2's right heel because there was eschar (dead tissue) covering the area. RN-C stated it was an unstageable pressure ulcer. On 4/19/18, at 11:48 a.m. RN-C stated R2 refused to wear heel protecting boots when they offered them as an intervention to reduce pressure on her heels. RN-C stated R2 had been seen by the wound clinic since 9/6/17, and they had been treating pressure ulcers on her buttocks and her heels. RN-C stated the pressure ulcer on R2's coccyx had healed, and her heels were much improved. RN-C also stated R2 liked to move her feet and didn't like to float her heels. RN-C stated she would expect staff to document when R2 refused to float her heels. RN-C also verified the following: R2's electronic record lacked documentation of R2's refusals to float her heels, or when they found that R2 had moved her pillow so that her heels were no longer floated; R2's group sheet, which indicated R2 was to be repositioned hourly and had an alternating air pressure mattress, was not current and she did not know when those interventions had ended; R2's Treatment Administration Record (TAR) printed 4/19/18, directed staff to check the setting on R2's mattress to ensure that it matched weight every day shift. Staff had indicated on their TAR documentation that this treatment was completed, even though R2 no longer had an	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 900	Continued From page 17 alternating air pressure mattress. RN-C confirmed the documentation could not be accurate as there was not an alternating air pressure mattress on R2's bed; R2's TAR also indicated staff were to document compliance with hourly repositioning. Staff were indicating attempts at administration, but this was not R2's current intervention; R2 was at risk of pressure ulcer development, even more at risk without an air mattress. On 4/19/18, at 1:43 p.m. the director of nursing (DON) stated she expected the group sheet to be updated, R2's refusals to float heels to be documented, and a risk-versus-benefit of intervention refusals to be explained to R2. The facility policy Prevention of Pressure Ulcers revised 9/13, directed when in bed every attempt should be made to "float heels" by placing a pillow from knee to ankle or with other devices as recommended by clinical staff or by the physician. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current pressure ulcer policies and procedures to ensure all residents receive care and assistance as need to prevent the development of or further worsening of pressure ulcers. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
21385	Continued From page 18	21385		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure gloves were worn and hand hygiene was maintained for 1 of 2 residents (R34) observed during insulin administration. In addition, the facility failed to ensure hygiene was maintained during personal cares for 2 of 5 residents (R12, R2) observed during cares. Findings include: R34's Diagnoses Report dated 4/19/18, indicated diagnoses that included type two diabetes. R34's Order Summary Report dated 4/19/18, included Basaglar (glargine insulin) 32 units subcutaneously at bedtime for diabetes. On 4/16/18, at 6:12 p.m. R34's insulin administration was observed with licensed practical nurse (LPN)-B. LPN-B approached R34, and with ungloved hands. LPN-B injected the insulin pen into the right side of R34's abdomen. LPN-B exited R34's room, removed the needle from the insulin pen, and placed it into the Sharps container. LPN-B took keys from her pocket, opened the medication cart, and put the insulin	21385	Corrected	5/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
21385	Continued From page 19	21385		

pen into the medication cart. LPN-B did not perform hand hygiene after insulin administration.

On 4/16/18, at 6:20 p.m. LPN-B stated she did not know if she was suppose to wear gloves during insulin administration. LPN-B verified she had not performed hand hygiene after administering the insulin.

On 4/19/18, at 10:02 a.m. the assistant director of nursing (ADON) verified staff should be wearing gloves when injecting insulin, and they should perform hand hygiene prior to exiting a resident's room after injecting insulin. The ADON stated, "They have all been trained."

The facility's Hand Washing policy dated 1/08, directed hand washing was generally considered the most important single procedure in preventing healthcare associated infections. The policy directed hand hygiene be completed before and after direct contact with the resident.

The facility's Subcutaneous Injections policy dated 12/16, directed staff to wash hands and put on gloves.

R12's Admission Record dated 4/18/18, indicated R12's diagnoses included dementia, chronic kidney disease, history of a urinary tract infection, and diabetes mellitus.

R12's quarterly Minimum Data Set (MDS) assessment dated 2/12/18, indicated R12's cognitive skills for daily decision making were severely impaired, and R12 required extensive assistance of one staff for toilet use, personal hygiene and dressing. R12's MDS further indicated R12 was always incontinent of bowel and bladder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
21385	Continued From page 20	21385		

R12's care plan dated 1/27/18, indicated R12 was frequently incontinent, and required the assist of two staff to toilet.

On 4/18/18, at 12:30 p.m. nursing assistant (NA)-A and NA-D brought R12 into the tubroom to stand at the handrail. R12 began to void when she was stood with the stand assist lift, and she was transferred to the toilet. NA-A put on gloves, sanitized the stand assist lift, removed the soiled gloves and put on clean gloves without performing hand hygiene. NA-A cleansed R12's perineal area, removed her soiled gloves, and did not perform hand hygiene. NA-A and NA-D changed R12's incontinent brief. NA-A and NA-D transferred R12 to her wheelchair with the stand assist lift. NA-A moved the stand assist lift, opened the tubroom door, and pushed R12's wheelchair out of the room with her unwashed hands on the handle bars, and began down the hall. NA-A verified she should have washed her hands right away after removing her gloves. NA-A then opened the dirty utility room, washed her hands in the dirty utility room sink, and went back to R12's wheelchair. NA-A put her hands on the same handle bars, and pushed the wheelchair down the hall.

On 4/18/18, at 2:21 p.m. the director of nursing (DON) stated staff should wash hands before gloving and doing cares, and wash or sanitize after removing gloves.

On 4/19/18, at 1:21 p.m. RN-C stated she does training on hand hygiene at orientation, and it is done annually with the online training.

The facility policy and procedure for Using Gloves dated 1/08, directed staff to wash hands after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
21385	Continued From page 21 removing gloves. R2's Admission Record printed 4/19/18, indicated diagnoses that included diabetes, chronic diastolic congestive heart failure, and adult failure to thrive. R2's quarterly MDS dated 1/25/18, indicated R2 had moderate cognitive impairment, and required extensive assistant with dressing, personal hygiene, and toileting. R2's care plan initiated 8/16/17, directed staff to provide assistance with pericares in the morning, at bedtime and as needed. The care plan also directed staff to provide incontinent products, assist to change as needed, and to monitor bowel movements as they occur. On 4/19/18, at 8:27 a.m. nursing assistant (NA)-C was observed to enter R2's room to assist her into the bathroom to use the toilet and perform morning cares. NA-C washed her hands and donned gloves before assisting R2 to the bathroom and onto the toilet. NA-C assisted R2 with washing her face, her under arms and under her breast. At 8:41 a.m. R2 asked if she should stand up from the toilet so that NA-C could, "Clean her bottom" as R2 had had a bowel movement. After wiping R2's bottom, NA-C removed her soiled gloves and donned clean gloves without performing hand hygiene. NA-C pulled up R2's pants, and assisted R2 into her wheelchair. NA-C then performed hand hygiene. On 4/19/18, at 8:56 a.m. NA-C stated she did not think she washed or sanitized her hands in between glove changes after cleaning R2's bottom.	21385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
21385	Continued From page 22 On 4/19/18, at 12:06 p.m. RN-C confirmed hand hygiene should occur when gloves were removed. On 4/1/18, at 1:43 p.m. the DON confirmed hand hygiene should occur when gloves were removed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure staff follow infection control guidelines. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.	21426		5/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
21426	Continued From page 23 (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) baseline risk assessments and two-step tuberculin skin tests (TST) were completed or read timely 3 of 5 residents (R14, R50, R52) upon admission, and 3 of 5 staff (NA-F, SSD-A, NA-E) upon hire. This had the potential to affect all residents residing in the facility. Findings include: R14's Admission Record printed 4/20/18, indicated R14 was admitted on 2/6/18. R14's medical record lacked a TB baseline symptom screening, and indicated a first step TST was administered on 2/10/18, and read on 2/12/18. R14's first step TST indicated results were negative, with 0 millimeters (mm) of induration (firm bump). The time the TST was given and the time it was read were not recorded. R14's medical record lacked a second step TST. R50's Admission Record printed 4/20/18, indicated R50 was admitted on 3/19/18. R50's medical record lacked a TB baselines symptom screening, and indicated a first step TST was administered on 3/19/18, and read on	21426	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
21426	Continued From page 24 3/21/18. R50's first step TST indicated results were negative with 0 mm of induration, but lacked documentation of time given and time read. R50's second step TST was read on 4/4/18, had negative results and no induration, but lacked documentation of the date and time given and the time read. R52's Admission Record printed on 4/20/18, was admitted on 1/9/18. R52's medical record lacked a TB baseline symptom screening and a first step TST was given on 1/12/18, and was not read. R52's medical record indicated a second step TST was given, but the date given and the date read were not recorded. A review of staff records revealed the following: Nursing assistant (NA)-F was hired on 2/19/18. NA-F had a first step TST on 2/19/18, at 11 a.m. and it was read on 2/21/18, at 1:30 p.m. with negative results and 0 mm. A second step TST was given on 2/28/18, at 10:00 a.m. and was not read. NA-F was administered another second step TST on 3/6/18, at 11:50 p.m. and it was read on 3/8/18, at 9:00 a.m., with negative results and 0 mm induration. NA-F's second TST was read in less than 48 hours. Social Services director (SSD)-A was hired on 1/29/18. SSD-A had a first step TST on 1/29/18, which was administered and read timely, with negative results and 0 mm. SSD-A had a second step TST administered on 2/7/18 at 1:40 p.m. and read on 2/9/18, at 11:20 a.m. with negative results and 0 mm. SSD-A's second TST was read in less than 48 hours.	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
21426	Continued From page 25	21426		

NA-E was hired on 1/15/18. NA-E had a first step TST on 2/26/18, at 9:00 p.m. and it was read on 2/28/18, at 1:30 p.m. with negative results and 0 mm induration. NA-E had a second step TST on 3/7/18, at 7:00 p.m. and read on 3/9/18, at 4:30 p.m. with negative results and 0 mm of induration. NA-E's first and second TST's were read in less than 48 hours.

On 4/19/18, at 2:15 p.m. registered nurse (RN)-C verified the findings for residents and staff. RN-C verified a two step TST was required, and had not been done consistently.

On 4/19/18, at 2:25 p.m. RN-C verified TST's should be read between 48 and 72 hours.

The facility policy and procedure for Tuberculosis Infection Control Program revised 12/17, directed all residents would have a baseline tuberculin screening.

The facility policy and procedure for Infection Prevention and Control Program dated 8/17, directed all staff to have pre-employment TB screening.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and/or revise the current TB policies and procedures to ensure all employees and residents are screened for physical signs and symptoms of active TB disease and provided the TB testing as recommended by the CDC.
The DON or designee could educate the appropriate staff on the policies/procedures.
The DON or designee could develop a monitoring system to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
21426	Continued From page 26 (21) days.	21426		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure wheelchair arms were in good repair for 2 of 3 residents (R18, R41) whose wheelchairs were reviewed. Findings include: R18's Admission Record printed 4/19/18, indicated diagnoses that included hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following a stroke. R18's annual Minimum Data Set (MDS) dated 3/1/18, indicated R18 did not walk during the assessment period, had impairment on one side of his body, and used a walker and a wheelchair for ambulation. R18's care plan dated 7/10/17, indicated R18 had an alteration in mobility, and independently used a wheelchair for locomotion in the facility. On 4/16/18, at 2:44 p.m. the vinyl arms on R18's wheelchair arms were observed to be cracked	21695	Corrected	5/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
21695	Continued From page 27 which created an unsanitary surface. R41's Admission Record printed 4/19/18, indicated diagnoses that included multiple sclerosis. R41's quarterly MDS dated 3/21/18, indicated R41 was not stable with transfers unless assisted by another person, had not walked in the assessment period, and used a walker and a wheelchair for assistive devices. R41's care plan dated 1/30/18, indicated R41 had an alteration in mobility, and was independent with locomtion in his wheelchair for short distances. On 4/16/18, at 3:08 p.m. vinyl arms on R41's wheelchair arms were observed to be cracked which created an unsanitary surface. On 4/19/18, at 10:48 a.m. the environmental services director (ESD) confirmed R18's and R41's wheelchair arms were cracked and open, which created an unsanitary surface, and stated they needed to be replaced. On 4/19/18, at 10:48 a.m. the ESD stated he had a schedule for monthly wheelchair cleaning, which was the responsibility of the afternoon housekeepers. The ESD confirmed the monthly wheelchair cleaning form did not direct staff to look at condition of the wheelchair. A policy on wheelchair maintenance was requested but not received from the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing or environmental services designee or designee could develope and	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
21695	Continued From page 28 implement policies and procedures to ensure all residents have wheelchairs/equipment in good repair. The director of nursing, environmental services director, or designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21695		