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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GUM0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00080

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

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

3. NAME AND ADDRESS OF FACILITY
(L3) **NORTH SHORE HEALTH**
(L4) **515 - 5TH AVENUE WEST**
(L5) **GRAND MARAIS, MN** (L6) **55604**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/28/2018** (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 **37** (L18)
13.Total Certified Beds **37** (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
	37			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date:
Teresa Ament, Unit Supervisor 06/28/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 06/28/2018 (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
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/25/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245384 June 28, 2018

Ms. Kimber Wraalstad, Administrator
North Shore Health
515 - 5th Avenue West
Grand Marais, MN 55604

Dear Ms. Wraalstad:

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

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

Effective June 19, 2018 the above facility is certified for:

37 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 28, 2018

Ms. Kimber Wraalstad, Administrator
North Shore Health
515 - 5th Avenue West
Grand Marais, MN 55604

RE: Project Number S5384029

Dear Ms. Wraalstad:

On May 25, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 10, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On June 28, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 10, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 19, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 10, 2018, effective June 19, 2018 and therefore remedies outlined in our letter to you dated May 25, 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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@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: GUM0

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

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(L1) **245384**
2.STATE VENDOR OR MEDICAID NO.
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(L3) **NORTH SHORE HEALTH**
(L4) **515 - 5TH AVENUE WEST**
(L5) **GRAND MARAIS, MN** (L6) **55604**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/10/2018** (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 **37** (L18)
13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
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
	37			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date:
Susan Frericks, HPR Social Work Specialist 06/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 06/21/2018 (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
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

On February 5, 2018, a Life Safety Code Survey was conducted by the Public Safety Department - State Fire Marshal Division on Phase 3. Floors 2 and 3 have been remodeled, 14 beds on each floor, and the center core areas on these floors, including the nurse station and related service areas, commons/dining areas, an Oxygen Room, and a neighborhood kitchen with a Denlar hood on each floor. At the time of the survey, this facility was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid certification. Please refer to the attached CMS-2567 and CMS-2786.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 25, 2018

Ms. Kimber Wraalstad, Administrator
North Shore Health
515 - 5th Avenue West
Grand Marais, MN 55604

RE: Project Number S5384029

Dear Ms. Wraalstad:

On May 10, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the 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 June 19, 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 August 10, 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 November 10, 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

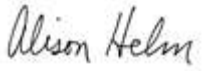
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	05/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted May 3, 2018, through May 7, 2018, during a recertification survey. The facility is not in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least	E 004		6/19/18

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

Electronically Signed | 06/04/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	05/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 004	Continued From page 1 annually. This REQUIREMENT is not met as evidenced by: Based on interview and document review of the facility's emergency preparedness plan (EP) binder, the facility failed to ensure compliance with all applicable Federal, State and local emergency preparedness requirements. The facility failed to develop, establish and maintain, a comprehensive emergency preparedness program that meets the requirements of this section. This had the potential to affect all 37 residing in the facility. Findings include: On 5/10/18, at 10:00 a.m. the administrator stated the EP binder was for the entire medical campus, of which the nursing home was a part. The administrator stated the EP was a work in progress. The EP binder lacked a plan specifically to address all the requirements for the nursing home, and a mechanism to review the nursing home requirements on an annual basis.	E 004	E004 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility□s allegation of compliance. The Emergency Preparedness Plan for North Shore Health will be reviewed and revised by June 19, 2019 by the Administrator, Paramedic/Emergency Preparedness Coordinator and Interim Directors of Nursing. Opportunities for revision and enhancement identified during the drill will be incorporated into the Plan as will the opportunities identified during drills and exercises with the Cook County Emergency Preparedness Committee.	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing.	E 039		6/19/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	05/10/2018

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

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E 039	Continued From page 2 The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group	E 039		

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E 039	Continued From page 3 discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure exercises were conducted to test their emergency plan at least annually, including unannounced staff drills using the emergency procedures. Findings include: The facility emergency preparedness plan (EP) binder lacked information on testing the emergency preparedness program. On 5/10/18, at 10:00 a.m. the administrator stated two facility registered nurses had attended a county-wide table top exercise, but the facility had not yet done a tabletop or full-scale testing of the facility EP.	E 039	E039 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility□s allegation of compliance. A table top exercise testing the Care Center specific Emergency Preparedness Plan will be conducted on Friday, June 15, 2018. The scenario will be based upon one of the top issues identified on the Hazard Vulnerability Assessment for North Shore Health □ Inclement Weather, Temperature Extremes or Fire. Participate in the drill will include the Administrator, Interim Directors of Nursing and other Department Leaders. The Director of the Cook County Office of Emergency Management & Public Information will participate or critique the	

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E 039	Continued From page 4	E 039	exercise.	
F 000	INITIAL COMMENTS On 5/7/18 - 5/10/18, 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 plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC 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 578 SS=E	Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		6/19/18

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F 578	Continued From page 5 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure CPR(Cardio-Pulmonary Resuscitation)/DNR (Do Not Resuscitate) decisions were discussed and documented for 4 of 4 residents (R17, R20, R31, and R8) reviewed for advance directives. Findings include: R17's Face Sheet printed 5/10/18, indicated R17 was admitted on 2/3/15.	F 578	F578 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility□s allegation of compliance.	

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F 578	Continued From page 6 R17's annual Minimum Data Set (MDS) dated 2/6/18, indicated R17 had a severe cognitive impairment for daily decision making, understood others and was understood by others, had a diagnosis of dementia, and did not have a terminal condition. R17's care plan initiated on 2/4/15, lacked direction for resuscitation status. R17's Physician Orders for Care Center Admission, lacked direction for resuscitation status. R17's signed Physician Orders dated 3/20/18, lacked direction for resuscitation status. R17's medical record lacked a signed advanced directive or POLST (Provider Orders for Life-Sustaining Treatment) to clearly reflect R17's resuscitation status decision. R17's Minnesota Health Care Directive dated 5/18/04, indicated that if R17 were, "In a terminal condition with no reasonable hope of recover, she would wish to be allowed to die naturally," but did not provide direction or guidance for staff regarding code status at this time. On 5/8/18, at 10:13 a.m. health unit coordinator (HUC)-I stated she did not recall that R17 had a POLST. HUC-I verified R17's paper medical record and electronic medical record lacked a directive for code status. R20's Face Sheet printed 5/10/18, indicated R20 was admitted on 2/28/18. R20's significant change MDS dated 3/28/18, indicated R20 was cognitively intact, understood	F 578	The following action has been taken regarding the Residents identified during the survey: 1. R-17 □ The Resident has an Advanced Health Care Directive dated May 18, 2004 that was placed in her chart upon Admission that indicates wishes to be allowed to die naturally and not be kept alive by artificial means or life prolonging measures. On May 18, 2018, R-17□s Attending Physician wrote a DNR/DNI order based upon discussions with patient prior to current level of dementia. R-17 currently does not have a completed POLST form and the Attending Physician requested the family be contacted to complete a POLST. On May 18, 2018, the Social Worker had a telephone conversation with R-17□s closest family member (sister) explaining purpose of POLST with the desire to help them complete form. During this conversation, R-17□s Sister confirmed DNR/DNI status but was reluctant to complete form over phone without the document in front of her. A blank copy of form has been sent via email and the Social Worker has made attempts to contact the Sister to follow up. The Social Worker will continue to make efforts to complete the POLST form with family cooperation. Currently, R-17□s status is DNR/DNI which is consistent with Health Care Directive and family wishes. 2. R-20 □ During R-20□s Swing Bed stay prior to admission to Care Center,	

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F 578	Continued From page 7 others, was understood by others, and did not have a terminal condition. R20's care plan dated 2/28/18, lacked direction for resuscitation status. R20's signed Physician Orders dated 5/2/18, indicated R20 was a DNR code status. R20's medical record indicated R20 was a DNR status, but lacked a POLST or an advanced directive. R20's admission progress note dated 2/28/18, lacked discussion regarding code status. A review of R20's progress notes indicated there had not been discussion of R20's resuscitation status. R20's physician progress note dated 3/25/18, indicated R20 had a sudden change in condition with a possible stroke, though R20's resuscitation status was not discussed. R20's physician progress notes lacked documentation of discussion with resident regarding resuscitation status. R20's hospital discharge papers had the first page of an incomplete advanced directive dated 1/15/18, scanned, but did not provide guidance for R20's resuscitation status decision. On 5/8/18, at 10:05 a.m. HUC-I verified R20 did not have a POLST, but stated R20 had an advanced directive that was not in R20's nursing home medical record. On 5/9/18, at 10:20 a.m. social worker (SW)-I stated the POLST is included in the admission packet, and she reviews it with new admissions	F 578	the Social Worker witnessed a discussion between R-20 and his Health Care Agent (Grandson) and with provider regarding code status. Upon investigation it was discovered the Physician did not document this discussion in notes. This discussion was the basis for the DNR order upon admission to the Care Center. The Social Worker will approach family to complete a POLST form by June 19, 2018. 3. R-31 □ R-31 had two Advanced Directives in her chart, August 20, 2012 and June 25, 2014. These forms create some ambiguity regarding specific DNR/DNI wishes even though R-31□s Attending Physician wrote DNR/DNI orders upon admission. R-31□s Heath Care Agent (Sister) was contacted on May 9, 2018 to discuss by the Interim Director of Nursing to clarify resuscitation orders and verify R-31 previously stated wishes. R-31□s sister confirmed the DNR/DNI order to allow R-17 to die a natural death and to provide comfort cares only in the event of a medical issue. The POLST form was reviewed and R-31□s sister signed the POLST on May 9, 2018 following the telephone conversation. The POLST was then signed by R-31□s Attending Physician on May 10, 2018 who had confirmed her DNR/DNI order on the afternoon of May 9, 2018. 4. R-8 □ R-8 does not have an Advanced Directive and on May 2, 2018 his Attending Physician requested the	

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F 578	Continued From page 8 who don't have one when they come in. SW-I stated if they have a health care directive of POLST, it is reviewed on admission, but is not re-addressed with them. SW-I stated if the resident or resident representative does not address it right away, she does not follow up on it; it becomes a team effort and the doctor and nursing department is part of that effort. SW-I stated the physician would write an order for resuscitation status on admission, and she expected the physician would have discussed it with the resident or the family. SW-I stated they would review it if there were a change in the resident's condition as needed, but it was not reviewed routinely or at care conferences. The facility policy Advance Directives (Living Will) approved 6/17, directed all residents would be given written information regarding the right to participate in their plan of care which would include advance directives information. The policy directed the admitting nurse would place the advance directive in the chart, notify the primary physician, and document the receipt in the progress notes and on the Kardex. The living will would go into effect when the resident was unable to express their wishes, and the physician determined that the medical condition was terminal. The facility form Physicians Orders for Care Center Admission dated 1/17, included DNR orders and would indicated if advance directives were present. The Physicians Orders for Care Center Admission lacked documentation of the resident's or resident representative's wishes for code status or discussion regarding code status.	F 578	Social Worker to discuss POLST at next Care Conference. Upon admission on April 26, 2016, a DNR/DNI order was written noting R-8 did not have an Advanced Directive. On June 1, 2018, the Social Worker spoke with R-8 who confirmed his DNR/DNI status his desire to die a natural death. He also confirmed he has had previous discussions with his Attending Physician regarding his desire. The Social Worker will approach him again by June 14, 2018 to complete the POLST form. The charts of all Residents will be reviewed by June 15, 2018 verify the DNR/DNI orders are consistent with Advanced Directive information and discussion with the Resident and/or Health Care agent. Follow up by the Social Worker and/or Director of Nursing will be completed for any Residents who are identified as lacking a clear direction. Upon admission, the Social Worker and Nursing will work with Resident/Resident□s Representative to complete a POLST. It will be noted that if the Resident/Resident□s Representative is not ready to make decision, then Resident status will be full code. Resident code status will be reviewed at Care Conferences. The Code policy has been revised to note the designation of code status on the Resident Status Board used by all Nursing employees. The Interim Director of Nursing or Designee will complete a monitor of all	

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F 578	Continued From page 9 R31's Face Sheet printed 5/10/18, indicated R31 was admitted to the facility on 4/21/17. The Face Sheet indicated R31 was a DNR resuscitation status, but lacked documentation or a signature that this was R31's own decision, or her representative's understanding of R31's wishes. R31's quarterly MDS dated 2/4/18, indicated R31 had severely impaired cognition. R31's Physician Order Sheet dated 4/24/18, indicated R31's resuscitation status was DNR, and further indicated R31 had an advance directive. R31's Minnesota Health Care Directive (HCD) signed 8/20/12, did not indicate R31's desires if R31 were to have a cardiac arrest and her heart stopped. Specifically, the HCD did not specify CPR or DNR. R31's Honoring Choices Minnesota Health Care Directive signed 6/25/14, indicated R31 wanted CPR attempted unless the doctor determined: --R31 had an incurable illness or injury and was dying; or --R31 had no reasonable chance of survival if her heart or breathing stopped; or --R31 had little chance of long-term survival if her heart or breathing stopped and the process of resuscitation would cause significant suffering. On 5/9/18, at 11:00 a.m. HUC-I stated R31's Physician Order Sheet indicated DNR resuscitation status, but there was no Physician Order for Life Sustaining Treatment (POLST) form that indicated a discussion or documented a signature of R31, or R31's representative, in R31's medical record. HUC-I confirmed R31's	F 578	new admissions for documentation of expressed wishes per Health Care Directive Code Status and verifying that Physician admission orders are consistent with expressed Resident wishes. Two charts of current residents will be monitored weekly for three months. The monitor will begin on June 15, 2018. The results of this monitor will be reported to Quality Improvement/Peer Review Committee quarterly for one year.	

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F 578	Continued From page 10	F 578		

record indicated she was DNR based on the Physician Order Sheet.

R8's Face Sheet printed 5/10/18, indicated R8's resuscitation staus DNR/Do Not Resuscitate (DNI), but lacked documentation or a signature indicating that this was R8's own decision.

R8's annual MDS dated 3/3/18, indicated R8 was cognitively intact.

R8's Physician Order Sheet dated 5/9/18, indicated R8's code status was DNR/DNI, and further indicated R8 had an advance directive.

R8's Physician Orders For Care Center Admission form signed 4/26/16, indicated R8 had a DNR/DNI code status, and lacked an advance directive.

A progress note dated 5/9/17, indicated the facility social worker discussed completion of a health care directive with R8 and a family member.

A progress note dated 5/12/17, indicated the social worker again discussed completion of a health care directive with R8, with R8 deferring the completion decision.

R8's Physician Orders note dated 5/2/18, directed the social worker to discuss POLST completion at the next care conference.

On 5/8/18, at 9:50 a.m. HUC-I stated they have a form where the physician documents if the resident has a DNR order, and if there was a HCD on file, but there was no other documentation or signatures done on resident

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F 578	Continued From page 11	F 578		

resuscitation status.

On 5/9/18, at 1:25 p.m. licensed practical nurse (LPN)-A stated she would look in the upper right corner of an electronic record to determine a resident's resuscitation status in an emergency. LPN-A stated if it did not indicate DNR, she would initiate CPR.

On 5/9/18, at 1:39 p.m. trained medication aide (TMA)-A stated she didn't know where to look for resident's resuscitation status, but in an emergency she would go find a nurse.

On 5/9/18, at 3:00 p.m. the administrator stated the facility did not have a POLST policy.

On 5/9/18, at 3:19 p.m. the director of nursing (DON) stated their physicians don't do a POLST form, and indicating a resident's CPR/DNR resuscitation status was not part of the nursing admission. The DON stated the Physician Orders for Care Center Admission had an area where physicians indicate a resident's resuscitation status, and if an advance directive was present. The DON further stated they assume physicians have had the conversation of resuscitation status with residents or their representatives, as physicians have had long-standing community relationships with their residents.

On 5/9/18, at 3:22 p.m. the administrator stated they do not currently have a system to document if a resident or their representative made the resuscitation status decision or that the resuscitation decision was discussed with a resident or their representative.

A Summary of Care Center Advance Directive

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F 578	Continued From page 12 Policies undated, from the facility admission packet indicated the facility would maintain written policies and procedures for all adults receiving care that provide information (in writing) concerning and individuals's right to make medical care decision, including the right to accept or refuse surgical or medical treatment and the right to formulate advance directives. The policy also directed the facility would inquire at the time of admission whether an individual has an advance directive, and document in the individual's medical record whether an advance directive has been executed. A blank copy of the Minnesota POLST dated 2/17, was also available in the admission packet, with no defining information. The facility policy titled Advance Directives (Living Will) approved 6/6/17, lacked information on POLST or resuscitation status in the event of a cardiac arrest. The facility's Cardiac Arrest Policy reviewed 2/23/17, directed staff who identify a person with a cardiac arrest to "determine code status" and to honor resident wishes regarding resuscitation.	F 578		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.	F 655		6/19/18

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F 655	Continued From page 13 The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written summary of the baseline care plan was provided to 1 of 2	F 655	F655 Preparation, submission and implementation of this Plan of Correction	

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

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F 655	Continued From page 14 residents (R20) reviewed for admission. Findings include: R20's undated Face Sheet indicated R20 was admitted on 2/28/18. R20's Diagnoses Summary printed 5/10/18, indicated R20's diagnoses included dementia without behavioral disturbance, and cerebral infarction (stroke). R20's admission Minimum Data Set (MDS) dated 3/13/18, indicated R20 was cognitively intact, and participated in the MDS assessment, along with family and legal representative. R20's significant change MDS dated 3/28/18, indicated R20 remained cognitively intact, and participated in the MDS assessment, along with family and legal representative. R20's admission nursing note dated 2/28/18, indicated R20 had a severe cognitive impairment, was alert and confused, was able to express needs, and participated in the admission assessment accompanied by a family member. R20's admission nursing note lacked documentation of R20 being provided with a written baseline summary of his care plan. R20's nursing note dated 5/4/18, (late entry for R20's care conference held on 4/26/18), indicated R20's care conference was attended by R20's family members, but indicated R20 did not attend his care conference. R20's care conference documentation lacked documentation of R20 or family members being provided with a written baseline summary of R20's care plan.	F 655	does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility□s allegation of compliance. A copy of the current written Care Plan has been given to R-20 and sent to his Health Care Agent. By June 15, 2018, a copy of the written Care Plan will be given to all Resident with capacity to understand and will be sent to all Health Care Agents or Resident□s Representative. The admission policy has been revised to state the Admission Nurse or Designee will review and provide a copy of the baseline Care Plan to the Resident and/or Resident Representative within 48 hours of admission either providing it personally or via US mail. Nurses completing admissions have been provided education regarding the need to provide the plan of care to the Resident and Resident representative at admission. The Interim Director of Nursing or Designee will complete a monitor of all new admissions for documentation stating the baseline Care Plan has been reviewed with the Resident/Resident Representative and a copy offered and/or mailed. The monitor will begin on June	

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F 655	Continued From page 15 A review of R20's medical record lacked documentation that R20 or his resident representative was provided with a written summary of his care plan. On 5/10/18, at 9:29 a.m. social worker (SW)-I stated a baseline care plan is developed, and the assessments are done with the residents and families. SW stated the care plans are reviewed at care conference, and the resident and/or family members sign the attendance sheet. On 5/10/18, at 2:24 p.m. director of nursing (DON)-F stated they discuss and review the initial care plan on admission during the assessment with the resident and family, but do not provide a written copy of the care plan to the resident or resident representative. DON-F stated an admission care conference is not held; they do care conferences quarterly, and was not sure how they were scheduled. DON-F stated they do not review the comprehensive care plan until the quarterly care conference. DON-F verified R20's care conference was held on 4/26/18, almost 2 months after admission, though R20 had a significant change in status prior to 4/26/18. The facility policy and procedure for MDS, Resident Assessment and Nursing Care Screening dated 9/14, lacked direction for provision of a written baseline care plan summary to the resident and/or resident representative by the comprehensive care plan development.	F 655	15, 2018. The results of this monitor will be reported to Quality Improvement/Peer Review Committee quarterly for one year.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		6/19/18

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F 657	Continued From page 16 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and review the admission and significant change comprehensive care plans with the residents and/or resident representative for 1 of 1 residents (R20) reviewed for comprehensive. Findings include: R20's undated Face Sheet indicated R20 was admitted on 2/28/18.	F 657	F657 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the	

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F 657	Continued From page 17 R20's Diagnoses Summary printed 5/10/18, indicated R20's diagnoses included dementia without behavioral disturbance, and cerebral infarction (stroke). R20's admission Minimum Data Set (MDS) dated 3/13/18, indicated R20 was cognitively intact, and participated in the MDS assessment, along with family and legal representative. R20's significant change MDS dated 3/28/18, indicated R20 remained cognitively intact, and participated in the MDS assessment, along with family and legal representative. R20's care plan dated 2/28/18, indicated it was developed the date of R20's admission. R20's admission nursing note dated 2/28/18, indicated R20 had a severe cognitive impairment, was alert and confused, was able to express needs, and participated in the admission assessment accompanied by a family member. R20's admission nursing note lacked documentation of R20 or representative was provided with a written baseline summary of his care plan. R20's nursing note dated 5/4/18, (late entry for R20's care conference held on 4/26/18), indicated R20's care conference was attended by R20's family members, but indicated R20 did not attend his care conference. A review of R20's medical record lacked documentation that R20 or resident representative was provided with a written summary of his care plan, R20 or resident	F 657	facility□s allegation of compliance. A copy of the current written Care Plan has been given to R-20 and sent to his Health Care Agent. By June 15, 2018, a copy of the written Care Plan will be given to all Resident with capacity to understand and will be sent to all Health Care Agents or Resident□s Representative. The admission policy has been revised to state that an Admission Care Conference will be scheduled within 21 days of admission. Nurses completing admissions have been provided education regarding the need to provide the plan of care to the Resident and Resident representative at admission. During every Care Conference, the Care Plan will be reviewed with the Resident and/or Resident Representative. A copy the Care Plan will be offered to the Resident and/or Resident Representative in attendance at the Care Conference or will be sent via US mail (or in an agreed upon form) to those not in attendance. The Interim Director of Nursing or Designee will complete a monitor of all new admissions and significant changes to verify Care Conferences have been held within 21 days. All Care Conferences will be reviewed for documentation stating the Care Plan has been reviewed with the Resident/Resident Representative and a copy offered and/or mailed. The monitor will begin on June	

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F 657	Continued From page 18 representative and an opportunity to participate in the development of the comprehensive care plan, or the care plan was reviewed with R20 or the resident representative until 4/26/18, which was 57 days after admission, and 29 days after the significant change MDS. On 5/10/18, at 9:29 a.m. social worker (SW)-I stated a baseline care plan is developed and the assessments are done with the residents and families. SW-I stated the care plans were reviewed at care conference, and the resident and/or family members sign the attendance sheet. On 5/10/18, at 2:24 p.m. the director of nursing (DON)-F stated they discuss and review the initial care plan on admission during the admission assessment with the resident and family, but do not provide a written copy of the care plan to the resident or resident representative. DON-F stated an admission care conference is not held; they do care conferences quarterly, and was not sure how they were scheduled. DON-F stated they do not review the comprehensive care plan until the quarterly care conference. DON-F verified R20's care conference, when the care plan was reviewed, was held on 4/26/18, almost 2 months after admission, though R20 had a significant change in status prior to 4/26/18. The facility policy and procedure for MDS, Resident Assessment and Nursing Care Screening dated 9/14, directed the resident care plans are updated with information from the family and resident at care conferences. The facility policy lacked direction for inclusion of the resident and/or resident representative in the development of the comprehensive care plan and	F 657	15, 2018. The results of this monitor will be reported to Quality Improvement/Peer Review Committee quarterly for one year.	

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F 657	Continued From page 19 for timeliness of the admission, significant change and quarterly care conferences. The Resident Assessment Instrument (RAI-a regulatory interdisciplinary assessment that helps the nursing home assess and evaluate a residents strengths and needs, and develop an individualized comprehensive care plan to direct the provision of necessary and appropriate care to the resident with a focus on quality of care and quality of life) manual dated 10/17, directed the baseline care plan to be completed within 48 hours of admission, "To provide effective and person-centered care of the resident that meets professional standards of care." The RAI manual directed the MDS and Care Area Assessment must be completed no later than the 14th day after admission (date of admission plus 13 days) and within 14 days a significant change in status has been identified, and the comprehensive care plan must be completed no later than 7 calendar days after the CAA completion. The RAI manual indicated care planning includes input from the resident and/or resident representative, the physician and interdisciplinary team. The RAI manual further indicated the resident has improved outcomes when the resident is actively involved in the care planning process.	F 657		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755		6/19/18

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F 755	Continued From page 20 a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure fentanyl patches were accurately destroyed to prevent potential diversion for 2 of 2 residents (R1, R26) reviewed for medication storage. Findings include: On 5/10/18, at 11:27 a.m. the medication room was observed with registered nurse (RN)-B. A locked Sharps container attached to the wall was observed, and the container indicated "For patches only." RN-B stated that the used fentanyl	F 755	F755 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility□s allegation of compliance.	

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F 755	Continued From page 21 patches were discarded into the Sharps container. RN-B stated there were two residents currently prescribed fentanyl patches, and explained that the staff passing medications removed the patch from the resident's skin after three days. The removed patch was shown to a second staff who was passing medications. Either two nurses visualized the patch, or one nurse and a trained medication aide (TMA) observed the patch before one of them discarded the patch into the identified Sharps container. RN-B stated that the second staff person may not always witness the patch going into the container. R1's Physician Order Sheet dated 4/6/18, indicated R1 had an order for Duragesic patch (fentanyl, an opiod pain medication patch) 12 micrograms (mcg) per hour. Apply transdermally (place on the skin) every 3 days at 8:00 a.m. for degenerative joint disease. R26's Physician Order Sheet dated 11/19/17, indicated R26 had an order for Duragesic (fentanyl) 24 mcg per hour patch. Apply transdermally every 3 days at 8:00 p.m. for pain. On 5/10/18, at 11:54 a.m. the director of nursing (DON)-F verified one staff member put the used fentanyl patch into the Sharps container. DON-F stated that the electronic Medication Administration Record (eMAR) prompted staff to document the identity of the second staff member who saw the patch being removed, but only one staff member actually placed the patch into the Sharps receptacle. On 5/10/18, at 12:38 p.m. pharmacist-D stated two staff should be watching as the fentanyl patch was being placed in the locked Sharps container	F 755	The Interim Director of Nursing and Consulting Pharmacist have created a policy and process to address the appropriate disposal of Fentanyl transdermal patches. This policy was completed on May 30, 2018. Education for nursing staff on the new policy and process will be completed at the June staff meetings and will be completed no later than June 15, 2018. The Interim Director of Nursing and the Consulting Pharmacists collaborated with Clinical Information Technology Coordinator to create an improved method of electronically co-signing the destruction of Fentanyl transdermal patches. The electronic co-signing is embedded into the electronic medication administration process. The documentation of the application is linked to the disposal of the transdermal patch so that one cannot move forward with the medication administration documentation without the co-signature. The electronic co-signature went live May 30, 2018. Education for Registered Nurses, Licensed Practical Nurses and Trained Medication Assistants on the new policy and process will be part of the June staff meetings and will be completed with all no later than June 15, 2018. The Interim Director of Nursing or designee will monitor the disposal and co-signature of the patch disposal twice in the first week then once per week for four (4) weeks. The results of this monitor will be reported to Quality Improvement/Peer	

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F 755	Continued From page 22 in the locked medication room. Pharmacist-D stated staff document on the eMAR the removal of the patch, and a skin assessment if they are reapplying a patch. Both staff sign on the waste documentation assessment that the removed patch was waste. Pharmacist-D and maintenance staff pick up the Sharps container, which is affixed to the wall, and bring the container to the pharmacy where the patches are flushed down the toilet. Two pharmacists witness the flushing of the used patches. The facility's Medication Administration, Transdermal Patch policy dated 9/1/14, directed that the transdermal patch that is being removed needs to be witnessed (i.e. two charge nurses or charge nurse and TMA) disposal into the designated container.	F 755	Review Committee and the monitor will be discontinued if 100% compliance is observed.	
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. §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,	F 880		6/15/18

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F 880	Continued From page 23 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 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.	F 880		

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F 880	Continued From page 24 §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 hand hygiene was completed during eye drop administration for 1 of 2 residents (R27) reviewed for eye drop administration. In addition, the facility failed to ensure the policy and procedure for Legionella identified testing procedures, how to recognize Legionella, identify those at risk, and how to proceed if Legionella was suspected or identified and prevent outbreaks. This had the potential to affect all 37 residents residing in the facility. Findings include: R27's undated Diagnoses Summary printed 5/10,18, indicated a diagnosis of glaucoma. R27's Physician Order sheet dated 5/10/18, included orders for Alphagan-P (brimonidine tartrate ophthalmic solution) 0.15% one drop each eye twice daily for glaucoma. On 5/9/18, at 9:45 a.m. licensed practical nurse (LPN)-A was observed with medication pass. LPN-A sanitized her hands with hand sanitizer solution, and assisted R27 into his room with the wheelchair by holding the handles and pushing the chair into the room. LPN-A donned gloves, administered an eye drop into both of R27's eyes	F 880	F880 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility□s allegation of compliance. On May 29, 2018, the Infection Control Coordinator and Interim Director of Nursing reviewed Eye drops, instillation of policy to ensure it meets evidence based standards. (Smith, S., Duell D, 2017 Clinical Nursing skills). The review showed policy remains current to best practice evidence based standards. R-27 had no signs of eye infection as a result of this practice. No other residents currently receiving eye drops have signs or symptoms of an eye infection. By June 14, 2018, all Care Center Registered Nurses, Licensed Practical	

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F 880	Continued From page 25 appropriately, and removed her gloves. LPN-A attempted to sanitize her hands in R27's room, but the sanitizer was empty in the room and the bathroom. LPN-A opened the room door with her hands, exited the room and sanitized her hands at the medication cart. On 5/9/18, at 9:49 a.m. LPN-A verified she did not sanitize her hands in the room, after propelling R27's wheelchair and before administering the eye drops, and did not wash her hands prior to leaving R27's room. LPN-A stated she should have washed her hands in the sink after removing her gloves, before leaving the room. On 5/10/18, at 11:17 a.m. registered nurse (RN)-A verified she would expect staff to gather supplies, wash or sanitize, glove, administer eye drops, remove gloves, and wash hands after removing gloves. The facility policy and procedure for Handwashing Protocol revised 7/17, directed hand hygiene should be performed before an aseptic procedure (procedures to prevent contamination from disease-causing pathogens), and after glove removal. The facility policy and procedure for Water Management Program to Reduce Legionella dated 4/2/18, lacked a procedure to identify testing procedures, when they would test for Legionella, how to recognize Legionella, identify those at risk, and how to proceed if Legionella is suspected or identified, treatment procedures, appropriate isolation precautions, and prevention of outbreaks.	F 880	Nurses and Trained Medication Assistants will be required to review and acknowledge understanding of the eye drops, instillation of policy. During the week of June 4, 2018 all Care Center Registered Nurses, Licensed Practical Nurses and Trained Medication Assistants will demonstrate competency for Eye drop instillation per policy. The Interim Director of Nursing or designee will monitor RNs, LPNs, TMAs twice a week for three months and once a month for three months to ensure compliance with eye drops instillation of policy and hand hygiene. The results of this monitor will be reported to Quality Improvement/Peer Review Committee and the monitor will be discontinued if 100% compliance is observed. The Infection Control Coordinator and the Director of Maintenance will update the water management policy by June 15, 2018 to include the following elements: identification of testing procedures, when testing for Legionella would occur, how to recognize Legionella, how to identify those at risk, how to proceed if Legionella is suspected or identified, treatment procedures for Legionella, appropriate isolation precautions for Legionella and prevention of Legionella outbreaks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	05/10/2018

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

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F 880	Continued From page 26 On 5/10/18, at 11:06 a.m. RN-A verified the policy and procedure lacked in the identified areas, primarily in the medical portion of the Legionella procedure. ,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/10/2018

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Cook County Northshore Hospital C & NC was found 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. The facility was inspected as two building: Cook County Northshore Hospital C & NC, is a 1-story building with no basement. The original building was constructed in 1953 and was determined to be of Type II(111) construction. In 1999 additions were constructed to the building that were determined to be of Type V(111) construction. In 2018 the one story without basement 300 wing addition was added to the existing building and were determined to be of Type II(111) construction. Because the original building and its additions have been constructed to both new and existing codes the facility was surveyed as a two buildings. The building also has a hospital attached that is properly separated. The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. It also has smoke detection in all resident rooms. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/10/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 accordance with the Minnesota State Fire Code. The facility has a capacity of 37 beds and had a census of 37 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING **03 - 2018 300 WING ADDITION** B. WING _____	**05/10/2018**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Cook County Northshore Hospital C & NC Bldg 03 300 wing addition was found 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 18 New Health Care. The facility was inspected as two building: Cook County Northshore Hospital C & NC, in 2018 the one story without basement 300 wing addition was added to the existing building and were determined to be of Type II(111) construction. The building is fully sprinklered throughout and also has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 37 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 25, 2018

Ms. Kimber Wraalstad, Administrator
North Shore Health
515 - 5th Avenue West
Grand Marais, MN 55604

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5384029

Dear Ms. Wraalstad:

The above facility was surveyed on May 7, 2018 through May 10, 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.

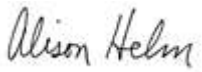
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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.



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@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
	00080	A. BUILDING: _____ B. WING _____	05/10/2018

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

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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		

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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 May 7, 2018, through May 10, 2018, 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.	2 000		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development	2 555		6/19/18

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2 555	Continued From page 2 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop and review the admission and significant change comprehensive care plans with the residents and/or resident representative for 1 of 1 residents (R20) reviewed for comprehensive. Findings include: R20's undated Face Sheet indicated R20 was admitted on 2/28/18. R20's Diagnoses Summary printed 5/10/18, indicated R20's diagnoses included dementia without behavioral disturbance, and cerebral infarction (stroke). R20's admission Minimum Data Set (MDS) dated 3/13/18, indicated R20 was cognitively intact, and participated in the MDS assessment, along with family and legal representative.	2 555	Corrected	

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2 555	Continued From page 3	2 555		

R20's significant change MDS dated 3/28/18, indicated R20 remained cognitively intact, and participated in the MDS assessment, along with family and legal representative.

R20's care plan dated 2/28/18, indicated it was developed the date of R20's admission.

R20's admission nursing note dated 2/28/18, indicated R20 had a severe cognitive impairment, was alert and confused, was able to express needs, and participated in the admission assessment accompanied by a family member. R20's admission nursing note lacked documentation of R20 or representative was provided with a written baseline summary of his care plan.

R20's nursing note dated 5/4/18, (late entry for R20's care conference held on 4/26/18), indicated R20's care conference was attended by R20's family members, but indicated R20 did not attend his care conference.

A review of R20's medical record lacked documentation that R20 or resident representative was provided with a written summary of his care plan, R20 or resident representative and an opportunity to participate in the development of the comprehensive care plan, or the care plan was reviewed with R20 or the resident representative until 4/26/18, which was 57 days after admission, and 29 days after the significant change MDS.

On 5/10/18, at 9:29 a.m. social worker (SW)-I stated a baseline care plan is developed and the assessments are done with the residents and families. SW-I stated the care plans were reviewed at care conference, and the resident

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2 555	Continued From page 4	2 555		

and/or family members sign the attendance sheet.

On 5/10/18, at 2:24 p.m. the director of nursing (DON)-F stated they discuss and review the initial care plan on admission during the admission assessment with the resident and family, but do not provide a written copy of the care plan to the resident or resident representative. DON-F stated an admission care conference is not held; they do care conferences quarterly, and was not sure how they were scheduled. DON-F stated they do not review the comprehensive care plan until the quarterly care conference. DON-F verified R20's care conference, when the care plan was reviewed, was held on 4/26/18, almost 2 months after admission, though R20 had a significant change in status prior to 4/26/18.

The facility policy and procedure for MDS, Resident Assessment and Nursing Care Screening dated 9/14, directed the resident care plans are updated with information from the family and resident at care conferences. The facility policy lacked direction for inclusion of the resident and/or resident representative in the development of the comprehensive care plan and for timeliness of the admission, significant change and quarterly care conferences.

The Resident Assessment Instrument (RAI-a regulatory interdisciplinary assessment that helps the nursing home assess and evaluate a residents strengths and needs, and develop an individualized comprehensive care plan to direct the provision of necessary and appropriate care to the resident with a focus on quality of care and quality of life) manual dated 10/17, directed the baseline care plan to be completed within 48 hours of admission, "To provide effective and

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2 555	Continued From page 5 person-centered care of the resident that meets professional standards of care." The RAI manual directed the MDS and Care Area Assessment must be completed no later than the 14th day after admission (date of admission plus 13 days) and within 14 days a significant change in status has been identified, and the comprehensive care plan must be completed no later than 7 calendar days after the CAA completion. The RAI manual indicated care planning includes input from the resident and/or resident representative, the physician and interdisciplinary team. The RAI manual further indicated the resident has improved outcomes when the resident is actively involved in the care planning process. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop policies and procedures on the development of a comprehensive care plan. All appropriate staff could be educated on the process of developing measurable objectives with specific timetables to meet the resident's needs. The Director of Nursing or her designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 555		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		6/19/18

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21375	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure hand hygiene was completed during eye drop administration for 1 of 2 residents (R27) reviewed for eye drop administration. In addition, the facility failed to ensure the policy and procedure for Legionella identified testing procedures, how to recognize Legionella, identify those at risk, and how to proceed if Legionella was suspected or identified and prevent outbreaks. This had the potential to affect all 37 residents residing in the facility. Findings include: R27's undated Diagnoses Summary printed 5/10,18, indicated a diagnosis of glaucoma. R27's Physician Order sheet dated 5/10/18, included orders for Alphagan-P (brimonidine tartrate ophthalmic solution) 0.15% one drop each eye twice daily for glaucoma. On 5/9/18, at 9:45 a.m. licensed practical nurse (LPN)-A was observed with medication pass. LPN-A sanitized her hands with hand sanitizer solution, and assisted R27 into his room with the wheelchair by holding the handles and pushing the chair into the room. LPN-A donned gloves, administered an eye drop into both of R27's eyes appropriately, and removed her gloves. LPN-A attempted to sanitize her hands in R27's room, but the sanitizer was empty in the room and the bathroom. LPN-A opened the room door with her hands, exited the room and sanitized her hands at the medication cart. On 5/9/18, at 9:49 a.m. LPN-A verified she did	21375	Corrected	

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21375	Continued From page 7	21375		

not sanitize her hands in the room, after propelling R27's wheelchair and before administering the eye drops, and did not wash her hands prior to leaving R27's room. LPN-A stated she should have washed her hands in the sink after removing her gloves, before leaving the room.

On 5/10/18, at 11:17 a.m. registered nurse (RN)-A verified she would expect staff to gather supplies, wash or sanitize, glove, administer eye drops, remove gloves, and wash hands after removing gloves.

The facility policy and procedure for Handwashing Protocol revised 7/17, directed hand hygiene should be performed before an aseptic procedure (procedures to prevent contamination from disease-causing pathogens), and after glove removal.

The facility policy and procedure for Water Management Program to Reduce Legionella dated 4/2/18, lacked a procedure to identify testing procedures, when they would test for Legionella, how to recognize Legionella, identify those at risk, and how to proceed if Legionella is suspected or identified, treatment procedures, appropriate isolation precautions, and prevention of outbreaks.

On 5/10/18, at 11:06 a.m. RN-A verified the policy and procedure lacked in the identified areas, primarily in the medical portion of the Legionella procedure.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff follow infection control

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21375	Continued From page 8 procedures. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
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. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by:	21426		6/19/18

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21426	Continued From page 9 Based on interview and document review, the facility failed to ensure baseline tuberculosis (TB) screening included a two-step tuberculin skin test for 1 of 5 residents (R34) reviewed for TB. Findings include: R34's undated Face Sheet indicated R34 was admitted on 3/27/18. R34's Baseline TB Screening Tool dated 3/27/18, indicated it was unknown if R34 had had a tuberculin skin test previously. R34's medial record lacked evidence of a two-step TB skin test. On 5/10/18, at 11:30 a.m. registered nurse (RN)-A verified they did not do a two-step TB skin test for R34, and should have. The facility policy Mantoux (tuberculin skin test) Testing for Swing Bed Patients and Care Center Residents revised 3/6/18, directed all residents must have a two-step TB skin test performed and recorded within five days prior to or within 72 hours after admission. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure Tuberculosis screening and testing is done on all staff and residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.	21426	Corrected	

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21426	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure fentanyl patches were accurately destroyed to prevent potential diversion for 2 of 2 residents (R1, R26) reviewed for medication storage.	21630	Corrected	6/19/18

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21630	Continued From page 11 Findings include: On 5/10/18, at 11:27 a.m. the medication room was observed with registered nurse (RN)-B. A locked Sharps container attached to the wall was observed, and the container indicated "For patches only." RN-B stated that the used fentanyl patches were discarded into the Sharps container. RN-B stated there were two residents currently prescribed fentanyl patches, and explained that the staff passing medications removed the patch from the resident's skin after three days. The removed patch was shown to a second staff who was passing medications. Either two nurses visualized the patch, or one nurse and a trained medication aide (TMA) observed the patch before one of them discarded the patch into the identified Sharps container. RN-B stated that the second staff person may not always witness the patch going into the container. R1's Physician Order Sheet dated 4/6/18, indicated R1 had an order for Duragesic patch (fentanyl, an opiod pain medication patch) 12 micrograms (mcg) per hour. Apply transdermally (place on the skin) every 3 days at 8:00 a.m. for degenerative joint disease. R26's Physician Order Sheet dated 11/19/17, indicated R26 had an order for Duragesic (fentanyl) 24 mcg per hour patch. Apply transdermally every 3 days at 8:00 p.m. for pain. On 5/10/18, at 11:54 a.m. the director of nursing (DON)-F verified one staff member put the used fentanyl patch into the Sharps container. DON-F stated that the electronic Medication Administration Record (eMAR) prompted staff to document the identity of the second staff member	21630		

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21630	Continued From page 12 who saw the patch being removed, but only one staff member actually placed the patch into the Sharps receptacle. On 5/10/18, at 12:38 p.m. pharmacist-D stated two staff should be watching as the fentanyl patch was being placed in the locked Sharps container in the locked medication room. Pharmacist-D stated staff document on the eMAR the removal of the patch, and a skin assessment if they are reapplying a patch. Both staff sign on the waste documentation assessment that the removed patch was waste. Pharmacist-D and maintenance staff pick up the Sharps container, which is affixed to the wall, and bring the container to the pharmacy where the patches are flushed down the toilet. Two pharmacists witness the flushing of the used patches. The facility's Medication Administration, Transdermal Patch policy dated 9/1/14, directed that the transdermal patch that is being removed needs to be witnessed (i.e. two charge nurses or charge nurse and TMA) disposal into the designated container. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure fentanyl patches were disposed of safely in order to prevent diversion. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21630		

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21630	Continued From page 13 (21) days.	21630		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure CPR(Cardio-Pulmonary Resuscitation)/DNR (Do Not Resuscitate) decisions were discussed and documented for 4 of 4 residents (R17, R20, R31, and R8) reviewed for advance directives. Findings include: R17's Face Sheet printed 5/10/18, indicated R17 was admitted on 2/3/15. R17's annual Minimum Data Set (MDS) dated 2/6/18, indicated R17 had a severe cognitive impairment for daily decision making, understood others and was understood by others, had a	21840	Corrected	6/19/18

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21840	Continued From page 14 diagnosis of dementia, and did not have a terminal condition. R17's care plan initiated on 2/4/15, lacked direction for resuscitation status. R17's Physician Orders for Care Center Admission, lacked direction for resuscitation status. R17's signed Physician Orders dated 3/20/18, lacked direction for resuscitation status. R17's medical record lacked a signed advanced directive or POLST (Provider Orders for Life-Sustaining Treatment) to clearly reflect R17's resuscitation status decision. R17's Minnesota Health Care Directive dated 5/18/04, indicated that if R17 were, "In a terminal condition with no reasonable hope of recover, she would wish to be allowed to die naturally," but did not provide direction or guidance for staff regarding code status at this time. On 5/8/18, at 10:13 a.m. health unit coordinator (HUC)-I stated she did not recall that R17 had a POLST. HUC-I verified R17's paper medical record and electronic medical record lacked a directive for code status. R20's Face Sheet printed 5/10/18, indicated R20 was admitted on 2/28/18. R20's significant change MDS dated 3/28/18, indicated R20 was cognitively intact, understood others, was understood by others, and did not have a terminal condition. R20's care plan dated 2/28/18, lacked direction for resuscitation status.	21840		

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21840	Continued From page 15 R20's signed Physician Orders dated 5/2/18, indicated R20 was a DNR code status. R20's medical record indicated R20 was a DNR status, but lacked a POLST or an advanced directive. R20's admission progress note dated 2/28/18, lacked discussion regarding code status. A review of R20's progress notes indicated there had not been discussion of R20's resuscitation status. R20's physician progress note dated 3/25/18, indicated R20 had a sudden change in condition with a possible stroke, though R20's resuscitation status was not discussed. R20's physician progress notes lacked documentation of discussion with resident regarding resuscitation status. R20's hospital discharge papers had the first page of an incomplete advanced directive dated 1/15/18, scanned, but did not provide guidance for R20's resuscitation status decision. On 5/8/18, at 10:05 a.m. HUC-I verified R20 did not have a POLST, but stated R20 had an advanced directive that was not in R20's nursing home medical record. On 5/9/18, at 10:20 a.m. social worker (SW)-I stated the POLST is included in the admission packet, and she reviews it with new admissions who don't have one when they come in. SW-I stated if they have a health care directive of POLST, it is reviewed on admission, but is not re-addressed with them. SW-I stated if the resident or resident representative does not address it right away, she does not follow up on it;	21840		

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21840	Continued From page 16	21840		

it becomes a team effort and the doctor and nursing department is part of that effort. SW-I stated the physician would write an order for resuscitation status on admission, and she expected the physician would have discussed it with the resident or the family. SW-I stated they would review it if there were a change in the resident's condition as needed, but it was not reviewed routinely or at care conferences.

The facility policy Advance Directives (Living Will) approved 6/17, directed all residents would be given written information regarding the right to participate in their plan of care which would include advance directives information. The policy directed the admitting nurse would place the advance directive in the chart, notify the primary physician, and document the receipt in the progress notes and on the Kardex. The living will would go into effect when the resident was unable to express their wishes, and the physician determined that the medical condition was terminal.

The facility form Physicians Orders for Care Center Admission dated 1/17, included DNR orders and would indicated if advance directives were present. The Physicians Orders for Care Center Admission lacked documentation of the resident's or resident representative's wishes for code status or discussion regarding code status.

R31's Face Sheet printed 5/10/18, indicated R31 was admitted to the facility on 4/21/17. The Face Sheet indicated R31 was a DNR resuscitation status, but lacked documentation or a signature that this was R31's own decision, or her representative's understanding of R31's wishes.

R31's quarterly MDS dated 2/4/18, indicated R31

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21840	Continued From page 17 had severely impaired cognition. R31's Physician Order Sheet dated 4/24/18, indicated R31's resuscitation status was DNR, and further indicated R31 had an advance directive. R31's Minnesota Health Care Directive (HCD) signed 8/20/12, did not indicate R31's desires if R31 were to have a cardiac arrest and her heart stopped. Specifically, the HCD did not specify CPR or DNR. R31's Honoring Choices Minnesota Health Care Directive signed 6/25/14, indicated R31 wanted CPR attempted unless the doctor determined: --R31 had an incurable illness or injury and was dying; or --R31 had no reasonable chance of survival if her heart or breathing stopped; or --R31 had little chance of long-term survival if her heart or breathing stopped and the process of resuscitation would cause significant suffering. On 5/9/18, at 11:00 a.m. HUC-I stated R31's Physician Order Sheet indicated DNR resuscitation status, but there was no Physician Order for Life Sustaining Treatment (POLST) form that indicated a discussion or documented a signature of R31, or R31's representative, in R31's medical record. HUC-I confirmed R31's record indicated she was DNR based on the Physician Order Sheet. R8's Face Sheet printed 5/10/18, indicated R8's resuscitation staus DNR/Do Not Resuscitate (DNI), but lacked documentation or a signature indicating that this was R8's own decision.	21840		

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21840	Continued From page 18 R8's annual MDS dated 3/3/18, indicated R8 was cognitively intact. R8's Physician Order Sheet dated 5/9/18, indicated R8's code status was DNR/DNI, and further indicated R8 had an advance directive. R8's Physician Orders For Care Center Admission form signed 4/26/16, indicated R8 had a DNR/DNI code status, and lacked an advance directive. A progress note dated 5/9/17, indicated the facility social worker discussed completion of a health care directive with R8 and a family member. A progress note dated 5/12/17, indicated the social worker again discussed completion of a health care directive with R8, with R8 deferring the completion decision. R8's Physician Orders note dated 5/2/18, directed the social worker to discuss POLST completion at the next care conference. On 5/8/18, at 9:50 a.m. HUC-I stated they have a form where the physician documents if the resident has a DNR order, and if there was a HCD on file, but there was no other documentation or signatures done on resident resuscitation status. On 5/9/18, at 1:25 p.m. licensed practical nurse (LPN)-A stated she would look in the upper right corner of an electronic record to determine a resident's resuscitation status in an emergency. LPN-A stated if it did not indicate DNR, she would initiate CPR. On 5/9/18, at 1:39 p.m. trained medication aide	21840		

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21840	Continued From page 19 (TMA)-A stated she didn't know where to look for resident's resuscitation status, but in an emergency she would go find a nurse. On 5/9/18, at 3:00 p.m. the administrator stated the facility did not have a POLST policy. On 5/9/18, at 3:19 p.m. the director of nursing (DON) stated their physicians don't do a POLST form, and indicating a resident's CPR/DNR resuscitation status was not part of the nursing admission. The DON stated the Physician Orders for Care Center Admission had an area where physicians indicate a resident's resuscitation status, and if an advance directive was present. The DON further stated they assume physicians have had the conversation of resuscitation status with residents or their representatives, as physicians have had long-standing community relationships with their residents. On 5/9/18, at 3:22 p.m. the administrator stated they do not currently have a system to document if a resident or their representative made the resuscitation status decision or that the resuscitation decision was discussed with a resident or their representative. A Summary of Care Center Advance Directive Policies undated, from the facility admission packet indicated the facility would maintain written policies and procedures for all adults receiving care that provide information (in writing) concerning and individuals's right to make medical care decision, including the right to accept or refuse surgical or medical treatment and the right to formulate advance directives. The policy also directed the facility would inquire at the time of admission whether an individual has an advance directive, and document in the	21840		

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21840	Continued From page 20 individual's medical record whether an advance directive has been executed. A blank copy of the Minnesota POLST dated 2/17, was also available in the admission packet, with no defining information. The facility policy titled Advance Directives (Living Will) approved 6/6/17, lacked information on POLST or resuscitation status in the event of a cardiac arrest. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents identify their code status at the time of admission to ensure they receive the proper care and services needed in the event of a cardiac arrest and that their rights in regard to life choices are honored.. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21840		